



## Moving School Mental Health Practitioners Toward Trauma-Informed, Evidence-Based Practice: *A Model That Works*

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for Schools and Communities  
School Mental Health  
Los Angeles Unified School District  
[www.tsaforschools.org](http://www.tsaforschools.org)

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## Presenter Disclosures



**Joshua Kaufman, L.C.S.W.**

- (1) The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

**No relationships to disclose**

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## Overview

- Background & Context
- Reflective Learning Group Model
- CBITS Program
- Implementation Phases
- Outcomes

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## Response to Intervention and School Mental Health

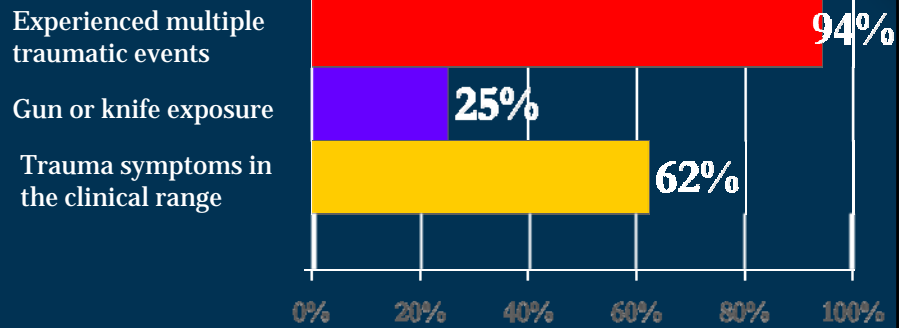
- *Rather than...* wait for students to fail or struggle and then wait for someone to refer them to mental health services,
- *What if...* we provided evidence-based services and had a screening process to identify students who needed targeted group or intensive individual interventions?

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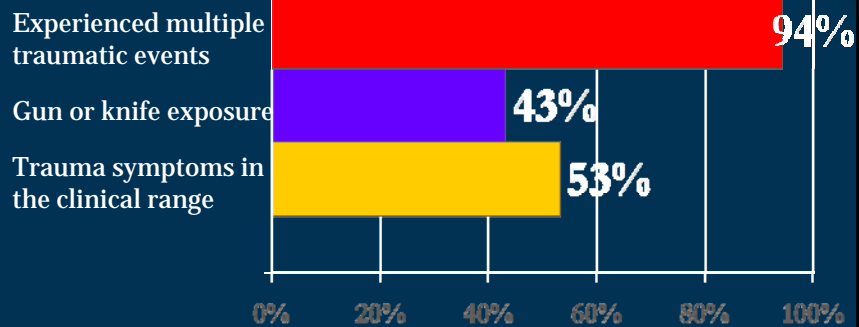


## Screening at Belmont HS (N=145) 2007-2008



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## Fall, 2008: Screening at Harmony ES (N=49)



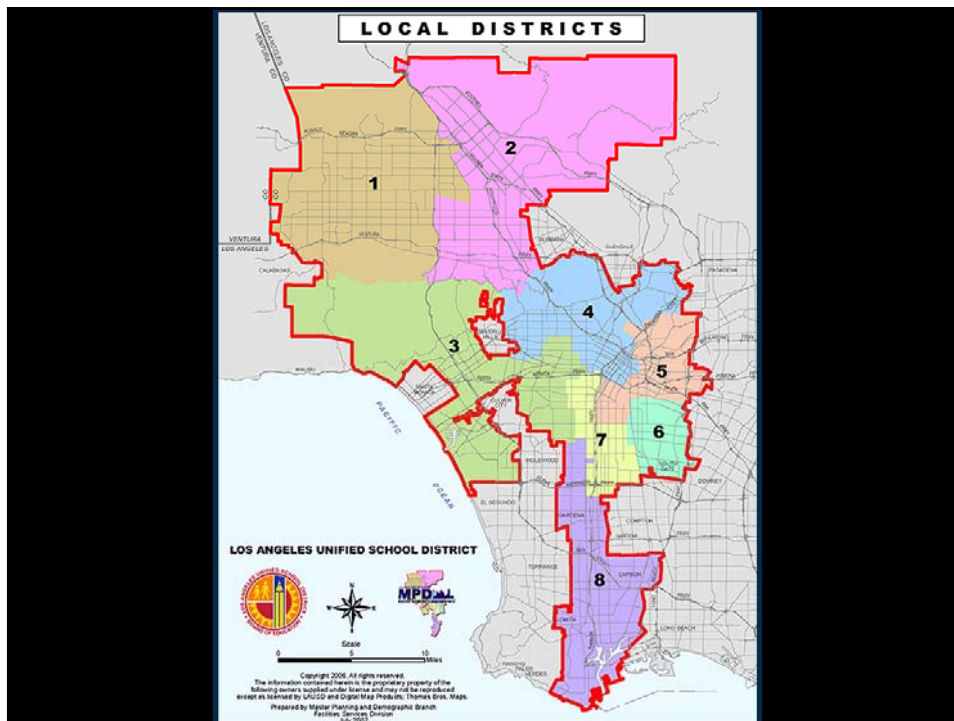
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# Welcome to LAUSD



- **Current student population total:**
  - 877,010
    - Includes k-12 enrollment, community adult schools, and early education centers.
    - More than 700 schools.
    - The total area of LAUSD is 710 square miles. The district serves many cities and several unincorporated areas of LA County.

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## LAUSD School Mental Health



- More than 275 School Mental Health professionals.
- School-Based, Special Education & DMH contract make-up the bulk of our services.
- Other programs include Suicide Prevention, Adult Education Work Center, Early Childhood Education Consultants

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## LAUSD and SMH, moving forward



- SMH is moving toward EBP
- LAUSD is moving toward RTI

Both utilize a multi-tiered model of intervention stressing Primary/Universal, Secondary/Targeted and Tertiary/Intensive levels of care

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Problem: How do you move such a large agency/system toward EBP?

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## Approaches to EBP training, dissemination and implementation



- **Web-based**
  - TF-CBT*Web*
- **Multi-day intensive**
  - Usual care for EBP training
  - May include f/u consultation
- **Learning Collaboratives / Learning Communities**
  - 4-10 agency teams
  - Three 2-day learning sessions
  - Monthly phone calls

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## The EB-Advocate, Spring 2009



- Training alone does not lead to effective, sustainable implementation. We tend to rely on one-shot training approaches, often referred to as “spray and pray” methods of teaching and “sit and grit” learning approaches.
- Paraphrased comments of NIRN Co-Director Karen Blase

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## LAUSD – Taper grant



- Multi-year project designed to disseminate CBITS and develop trainers within LAUSD
    - March 05-August 07
      - 32 PSWs trained
      - Fewer than 10 ran one group.
      - 1 continued to provide CBITS after first cycle.
- 2 Become certified as trainers, 1 is still training...

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## The EB-Advocate, Spring 2009



- It takes careful selection of staff, training that builds skills, and coaching for performance to build front-line workers' competence, confidence and adherence to fidelity
- Paraphrased comments of NIRN Co-Director Karen Blase

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## Spring 2008-Spring 2009: Current School Mental Health Efforts



- 66 Staff trained...
- 51 groups offered...
- 312 students served...
- 46 schools supported...

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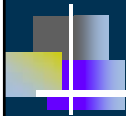
Universal training for all School Based PSWs: In August, 2009, 150 staff participated in:



- **A series of 3 professional developments**
  - Looking Through a Trauma Lens (2 hours)
  - Trauma-Informed, Evidence-Based Practice in Schools (2 hours)
  - Introduction to CBITS (4 hours)
    - Included a panel of early-phase clinicians.

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## Reflective Learning Group Model



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## The Reflective Learning Group (RLG) Model



- A weekly training and supervision process that begins with the pre-implementation activities of school buy-in and screening & identification, and continues through outcome evaluation

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## RLG Components



- Teaching & Learning while engaged in practice activities
- Supervision
- Assessment and feedback
- Provision of emotional support

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## RLG Group Meeting Protocol

- Check-in
- Reflect on previous week's group/activity
- Learning Session
- Planning for upcoming group/activity and discussion

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## RLG Model Rationale

- Training

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## Adult learning theory and problem based learning



- Scaffolding
- Personal relevance
- Facilitator monitors and connects personal experience to theory.

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## Training and Coaching



- One continuous set of operations designed to produce actual changes in behavior. One without the other is insufficient
  - Concepts & components (Why/What) needs to be supplemented with
  - Skills (how) so practitioners can learn to see the relevance of what they have learned to the situations at hand.

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## Moving from Knowledge to Practice (Joyce & Showers, 2002)



	Know	Show	Do
Theory/Discuss	10%	5%	0%
Demonstration	30%	20%	0%
Practice	60%	60%	5%
Coaching	95%	95%	95%

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## Coaches



- Share knowledge & observation
- Help clinicians to integrate personal beliefs and attitudes with the skills, knowledge, philosophy, values, and principles of the program and the clinical context
- Provide emotional and personal support
- Help clinicians develop a personal style that incorporates the core intervention components of the evidence-based practice.

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## Coaching

Practitioners must be motivated to adopt new practices, know what actions constitute the practices, have the tools to perform those actions, and have the ability and confidence to perform those actions.

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## RLG Model

- Training
- Supervision

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Reflection:\ri- flek-  
shən\ :Contemplation, A calm, lengthy,  
~~intent consideration~~

**Reflective Supervision:** A process requiring reflection, collaboration, and regularity, provides an opportunity for therapists to deepen and broaden knowledge, discuss reactions to experiences, discuss individual goals and progress, and develop and refine their individual style through self understanding. Reflective supervision is carried out regularly in a safe and trusting environment.

**Joy Osofsky, Ph.D. 2004**

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## Parallel Process

### RLG

- Scaffolding
- Personal Relevance

### CBITS

- Maintaining affective window of tolerance
- Culturally relevant and linguistically competent services

**They may forget what you said, but they will never forget how you made them feel – Carl Buechner**

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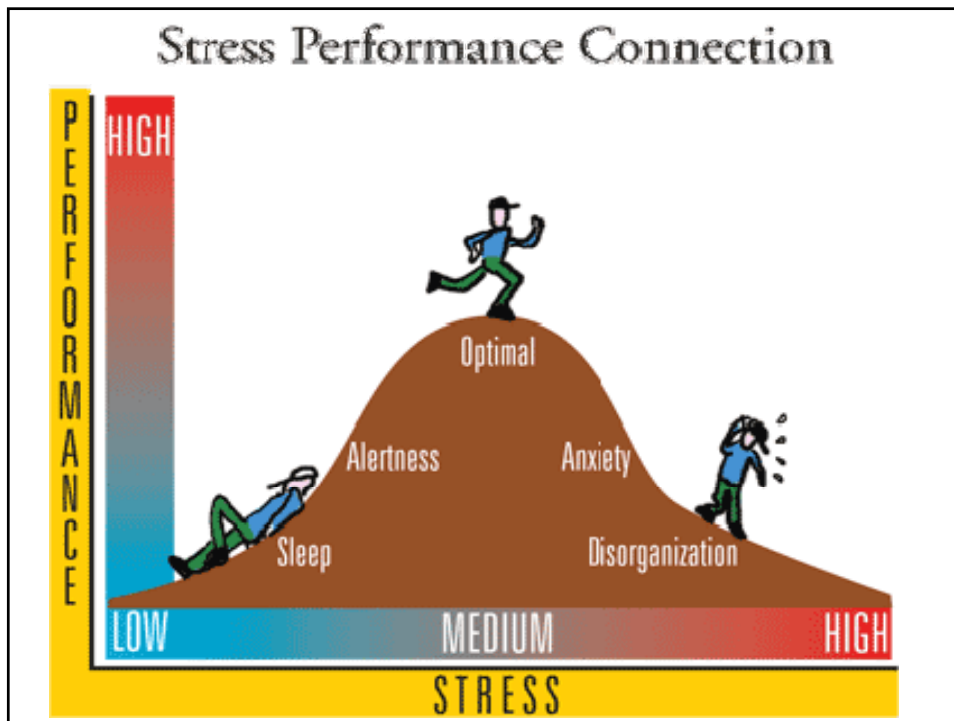


# Trauma-Informed Practice as a foundation for the intervention and the RLG



- Safety
- Affect Regulation
- Control
- Connection
- Support

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## RLG Model

- Training
- Supervision
- **Fidelity Monitoring**

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## Fidelity: Our intention is to stay true to the model

*A commitment to maintain*

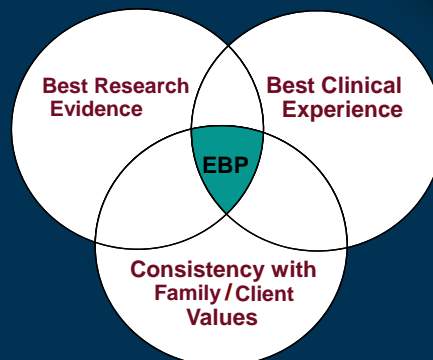
- ❑ *the best research evidence*

*while integrating*

- ❑ Our unique professional expertise and judgment

*with*

- ❑ The language, cultural and community values of our clients



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## Fidelity and Adaptation using the RLG model



- Clinicians completed fidelity rating forms per session.
  - Each session had between 1-4 fidelity points.
  - Clinicians self-assessed on a 4 point scale
- Clinicians were encouraged to document adaptations made/moves away from fidelity.

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Date: \_\_\_\_\_  
 Facilitator: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Number of students in session: \_\_\_\_\_

### Group Session 3: Introduction to Cognitive Therapy

Session Objective	How well did your group meet each objective?			
	1 = Not Met	2	3	4 = Objective Met
Objective 1: Develop common language for "level" of feelings	1	2	3	4
Objective 2: Teach link between thoughts and feelings	1	2	3	4
Objective 3: Build skills: Challenging negative thoughts.	1	2	3	4

Activity	Did group complete activity?	Comments
I: Activities Review	YES NO	
II: Fear Thermometer	YES NO	
III: Thoughts and Feelings (Introduction to Cognitive Therapy)	YES NO	
IV: Linkage Between Thoughts and Feelings	YES NO	
V: Hot Seat: Combating Negative Thoughts	YES NO	
VI: Activities Assignment	YES NO	

Notes:  
 What Worked/What did not work?

Any changes that you made (additions, modifications, etc) to the session?

## RLG Model

- Training
- Supervision
- Fidelity Monitoring
- **Secondary Traumatic Stress Prevention**

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## What is Trauma

- Trauma is extreme stress which overwhelms a person's ability to cope, most often associated with the fear of injury or death.
- Trauma can cause a fundamental alteration of one's biological and psychological functioning, including one's sense of self.

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## Traumatic Stress impacts...

- Affect regulation
- Attention and consciousness
- Self-perception
- Relationships to others
- Systems of meaning

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## Hearing and holding the stories of others...

...can indirectly have a similar impact.

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## Impact of Indirect Trauma



- Decreased energy
- Feeling that there is no time for one's self
- Disconnection from others
- Social Withdrawal
- Physical illness/absences from work
- Cynicism, despair, and hopelessness
- Increased/decreased sensitivity to violence, threat or fear
- Memory impairment

Indirect Trauma = Compassion Fatigue=Vicarious Trauma

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## Compassion Fatigue



- “There is a cost to caring. We professionals who are paid to listen to the stories of fear, pain, and suffering of others may feel, ourselves, similar fear, pain and suffering because we care.”
- “Compassion fatigue is the emotional residue of exposure to working with the suffering, particularly those suffering from the consequences of traumatic events.”
- Charles R. Figley, Ph.D.

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# Vicarious Trauma



It is the cumulative transformative effect on the identity, world view, psychological needs, beliefs, and memory system of those who work with the traumatized.

-Saakvitne & Pearlman

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# Risk factors



- Length, duration, intensity, type of exposure
- Suicidal or child clients
- Trauma history
- Organizational factors (e.g. high caseloads, organizational denial of impact of VT)
- Inadequate self-care
- Insufficient supervision and consultation
- Overwork

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# Who is Most Susceptible



## Those

- who work in emergency/crisis settings
- new to the field
- new to trauma work
- who work in agency settings
- have more than 50% trauma clients
- Work with children or in situations involving suicide
- live everyday with traumatized children
- Who in addition to working with traumatized children, work in aversive systems

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# Protective Factors



- **Competent consultation and supervision**
- **Self-care**
- **Training**
- **Sense of control**
- **Spirituality**
- **Exercise**
- **Humor**
- **Satisfying personal relationships**
- **Context**
- **Organizational recognition and change**
- **Guiding professional ethical principals**

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## Resilience Intervention

Claude Chemtob, PhD, et al.  
Mt Sinai School Of Medicine & NYC Children's Services



- *Decrease stress on the worker through enhancing resilience skills and increasing social support as a means of preventing adverse work-related outcomes of trauma exposure*
- Integrate trauma knowledge with positive psychology to increase staff resilience (well-being) and efficacy
- Create a "psychological Hazmat suit"
- Teach new Child Protective Specialists, and their supervisors and managers, about secondary trauma and how to proactively manage work-related stresses and challenges

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## Chemtob, et. al

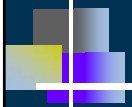


- Weekly one hour sessions for three months for new staff, supervisors and managers, followed by every other week sessions
  - psycho-education and skills
  - case practice examples, and group application of learned resilience skills
  - Three-fold focus on Optimism, Mastery & Collaborative Alliance
- **Pilot project in Harlem Field Office demonstrated:**
  - Increased job satisfaction, optimism, resilience
  - Improved productivity
  - Decreased stress reactivity, burnout
  - Decreased attrition

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## CBITS Program

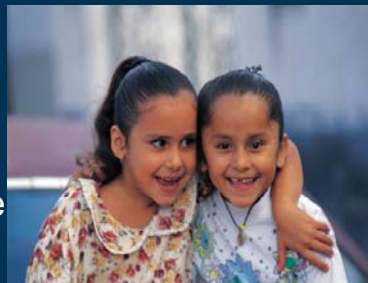


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## Cognitive Behavioral Intervention for Trauma in Schools (CBITS)



- **Symptom Reduction**
  - PTSD symptoms
  - General anxiety
  - Depressive symptoms
  - Low self-esteem
  - Behavioral problems
  - Aggressive and impulsive
- **Build Resilience**
- **Peer and Parent Support**



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## CBITS Program



- 10 child group therapy sessions
- 1-3 individual child sessions
- 2 Parent sessions
- 1 teacher session

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## CBITS as Recommended Practice



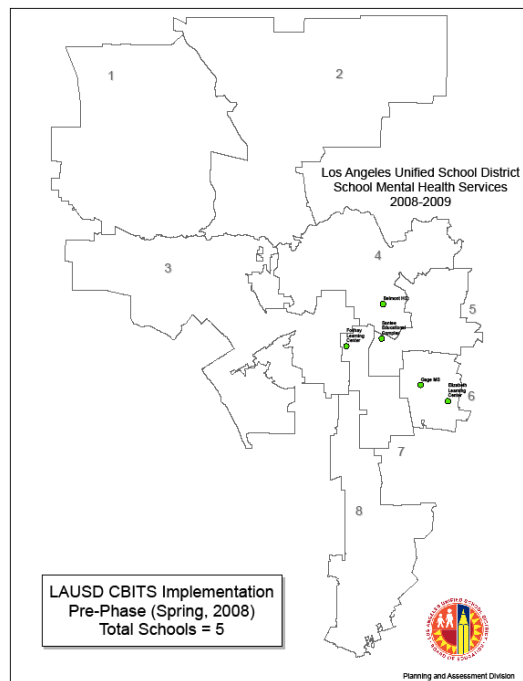
- U.S. Department of Education: CBITS meets standards of the No Child Left Behind policy
- Recognized as evidence-based program by:
  - National Child Traumatic Stress Network
  - Promising Practices Network
  - Office of Juvenile Justice and Delinquency Prevention (OJJDP)
  - California Depts. of Education & Mental Health

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## Implementation Phases

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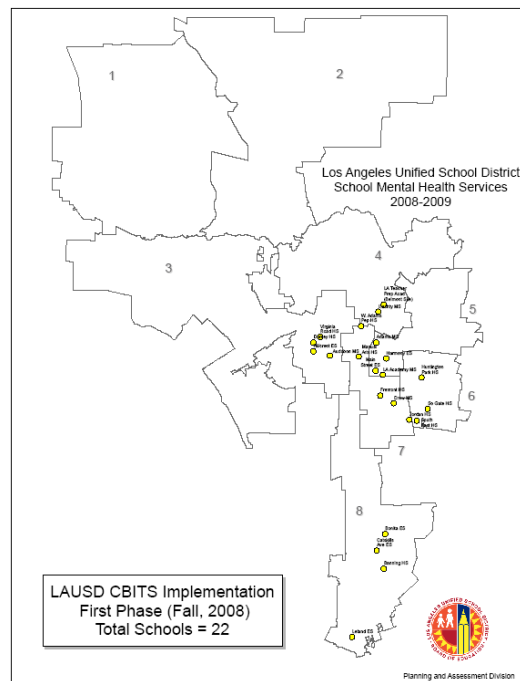


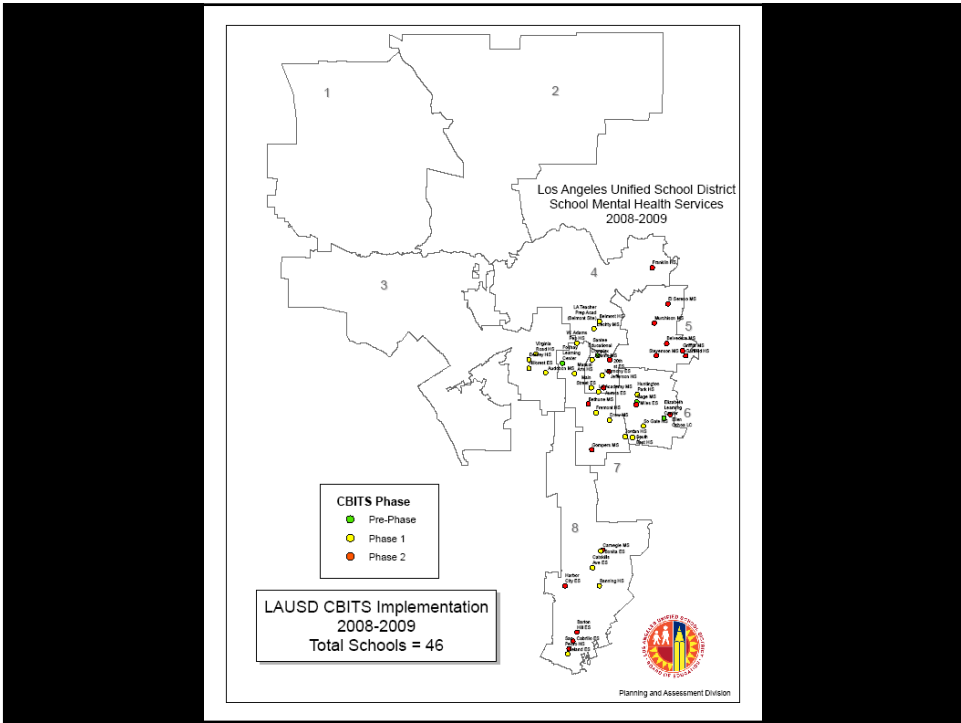
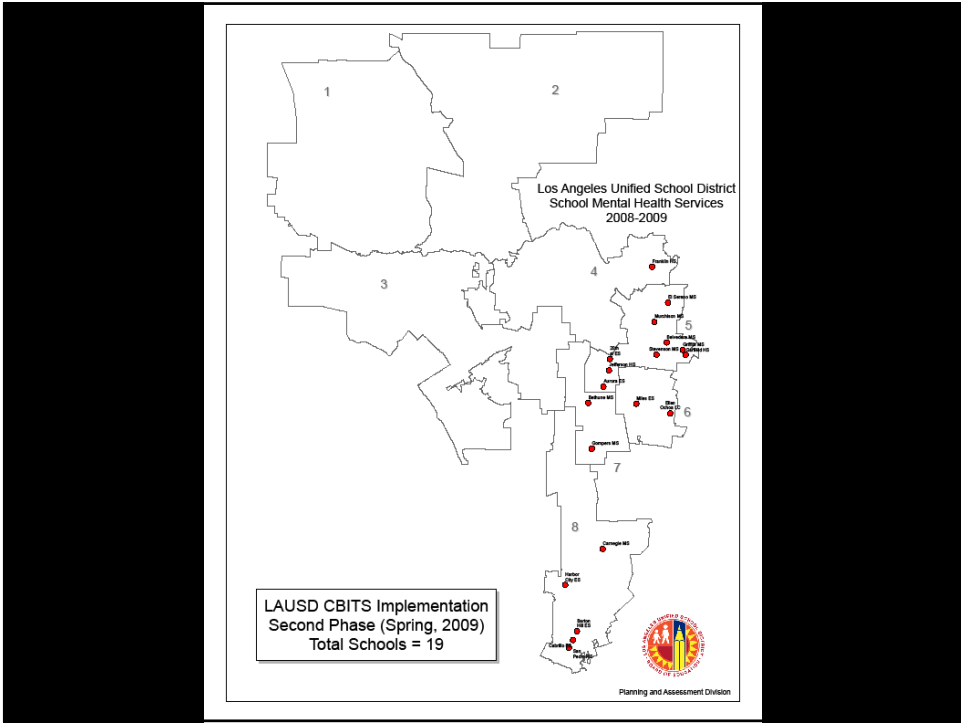
## Phase One: Fall, 2008



- **161 Students from Elementary (grade 5) to High School participated in 22 CBITS Groups**
- **43 PSW's were trained and lead CBITS groups**
- **at 22 schools**
- **throughout LAUSD**

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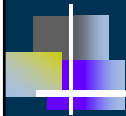
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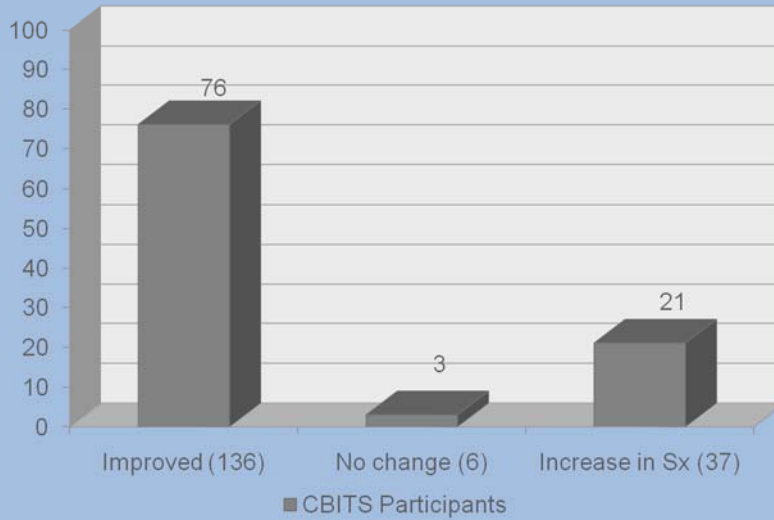
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## Outcomes



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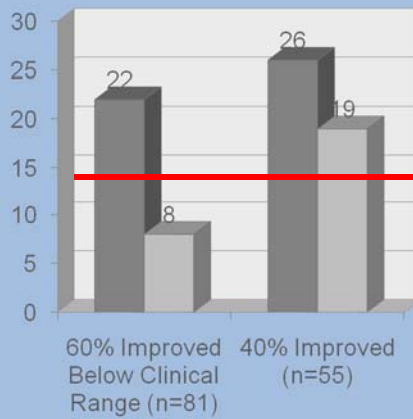
Of those surveyed, 76% (136) Reported Improvement in Symptom Scores (N=179)



Symptom scores reduced by an average of 7 to 14 points



■ Average Pre-test Foa Symptom Score □ Average Post-test Foa Symptom Score

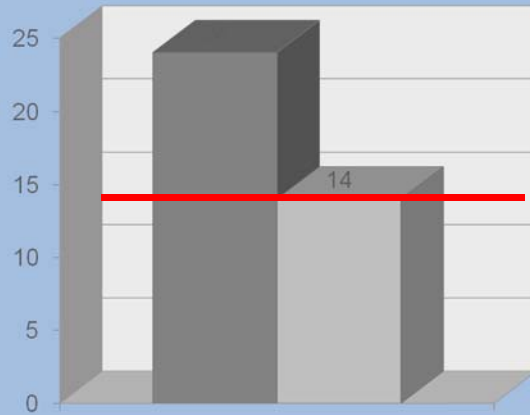


14 points and above is considered within the clinical range

## Elementary Schools: Symptom scores reduced by an average of 10 points (n=62)



■ Average Pre-test Foa Symptom Score □ Average Post-test Foa Symptom Score

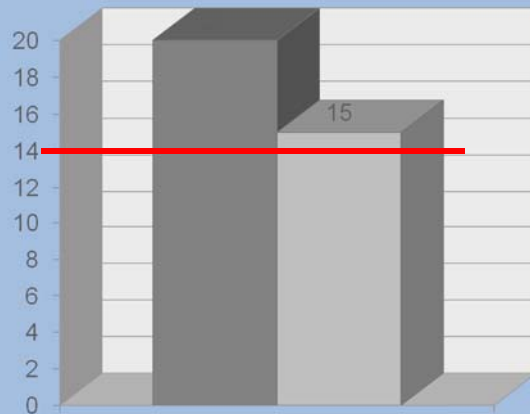


14 points and above is considered within the clinical range

## Middle Schools: Symptom scores reduced by an average of 5 points (n=46)



■ Average Pre-test Foa Symptom Score □ Average Post-test Foa Symptom Score

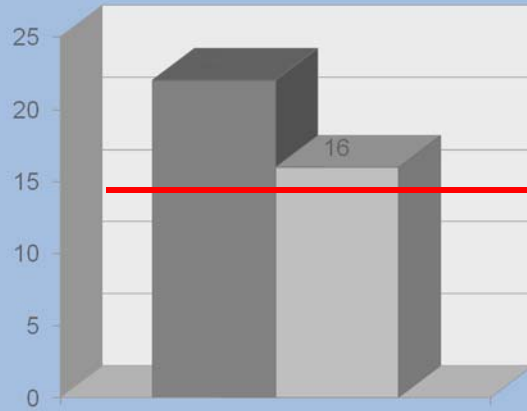


14 points and above is considered within the clinical range

## High Schools: Symptom scores reduced by an average of 6 points (n=71)

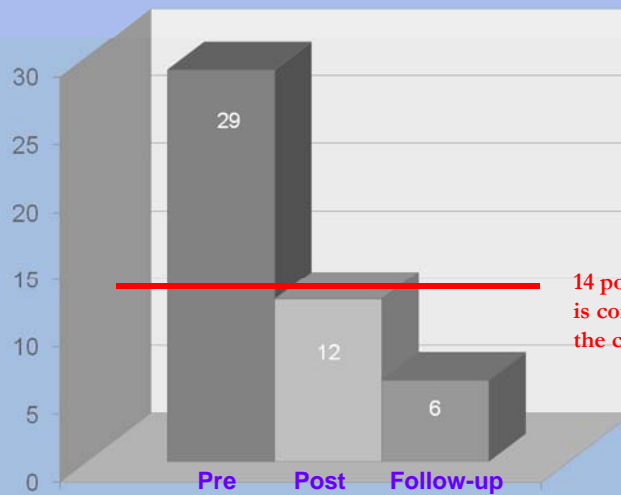


■ Average Pre-test Foa Symptom Score ■ Average Post-test Foa Symptom Score



14 points and above is considered within the clinical range

## Follow-up at 2 to 4 months (n=24)



14 points and above is considered within the clinical range

## After CBITS, this is what students said...

- **...now I can concentrate more and not lose track when I'm in class or at home when I'm reading or doing math. (32 → 2)**
- **...it helped me to release my fear, anger and sadness. When we talk about the things that happened, the techniques (the stretching and breathing) helped me release my anger and stress. (45 → 15)**
- **...this group helped me to be a little bit stronger – to believe in myself. (36 → 2)**
- **...it helped me release the pain so now I can feel calmer. (32 → 6)**
- **...it helped me to not get scared with nobody anymore. (38 → 10)**



Fidelity Data collected by group.  
15 groups (30 clinicians) represented below



## Pre/Post Clinician Surveys



### I feel comfortable doing CBT



## Pre/Post Clinician Surveys



### I am able to treat traumatized students effectively



## Pre/Post Clinician Surveys (n=36)

- 97% “learned adequately” from the RLG process...
- and...
- ...plan to use CBITS again



## Voices from the field

- “...the “play by play” nature of the supervision. The way I was prepared with material fresh in my mind for the following session. The reflection piece helped to reinforce what I learned and helped to keep me motivated. I enjoyed hearing others’ experiences”



## Voices from the field



- "...more beneficial than a 1 or 2 day training, especially since this is a new model for us."
- "...the weekly sessions that prepared us for the next session were extremely beneficial in implementing the intervention and reducing our anxiety about facilitating the groups."

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## Voices from the field



- "It made me work. It made me take a step outside of my comfort zone, and that's extremely valuable."
- "...made it more real to me as a treatment intervention and how theory of CBT can be effective across culture and age group"

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## Lessons Learned

- Focus more time on the affect regulation skills of the clinicians.
- Make STS prevention more explicit in the model.
- Monitor attendance and participation with an eye toward clinician avoidance.

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## Next Steps

- Expand the RLG model to include interventions at other levels of the IOM spectrum (TF-CBT)/ Universal Interventions
- Utilize the RLG Model to address other primary “presenting problems”
- Utilize the RLG process for Core Skills Development

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Thank you for your attention



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