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An Examination of the Content of and Engagement in Ongoing Consultation Following Training in Trauma-Focused Cognitive-Behavioral Therapy

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AN EXAMINATION OF THE CONTENT OF AND ENGAGEMENT IN ONGOING CONSULTATION FOLLOWING TRAINING IN TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

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Ashley M. Smith

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The inclusion of ongoing consultation following EBP training in implementation efforts has been shown to enhance the uptake of EBPs into systems of care. Yet, little is known about the types of questions and concerns raised by providers during consultation and methods used by consultants to address those concerns. In addition, it is often difficult to get providers to engage in consultation. The present study examined content and consultative methods during consultation following training in TF-CBT, as part of a community-based learning collaborative (CBLC) to implement TF-CBT for youth served in the child welfare system. Minute-to-minute live coding of consultation calls was conducted to examine content and consultative methods, and results of coding are discussed. Consistent with previous work, findings highlight difficulties with provider engagement in consultation. Results included a significant positive association between providers with more years' professional experience and consultation call engagement and between greater average weekly caseloads and number of case presentations on consultation calls. What takes place during consultation, engagement in consultation, and considering ways in which EBP training efforts may be more targeted to address barriers and increase provider engagement in ongoing support efforts are discussed.

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Chapter 1: Introduction

Youth mental health is an important public health concern in the United States, with an estimated 13-20% of youth experiencing a mental health disorder annually (Perou et al., 2013). Further, only a small percentage of those in need of care (20-30%) receive needed services (APA Presidential Task Force on Evidence-Based Practice, 2006; Kataoka, Zhang, & Wells, 2002). In comparison, approximately 50-70% of youth in the child welfare system meet criteria for a mental health disorder, yet the proportion of these youth that go without needed mental health care is even greater (approximately 85%) than estimates in the general population (Masi & Cooper, 2006). For the small proportion of youth in the child welfare system who are able to access public mental health services, quality of care is often insufficient (e.g., few providers) and is often not grounded in scientific evidence (Cooper & Aratani, 2009).

To help improve the quality of mental health care, evidence-based practices (EBPs), aimed at integrating "the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 1), have been developed for a variety of mental health concerns. Yet, despite having available treatments grounded in research, there remains a substantial gap between research and innovations in mental health and implementation and use of EBPs in the community (President's New Freedom Commission on Mental Health, 2004; U.S. Surgeon General, 1999). This suggests that while hundreds of EBTs have been developed, these treatments are not being effectively integrated into public mental health settings (Hoagwood & Olin, 2002), signaling an

urgent need for efforts aimed at closing the gap between mental health research and community practice to ensure that youth are receiving needed and quality care.

Implementation Science

In response to this need, an emphasis has been placed on implementation science. Several major reports have highlighted the importance of using EBPs in routine care and have called for translational research examining how to effectively disseminate and implement EBPs into varied mental health settings to achieve better mental health outcomes on a national scale (President's New Freedom Commission on Mental Health, 2004; The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; U.S. Surgeon General, 1999). These calls have led to an increased focus on dissemination and implementation science as a way to better understand effective ways to bridge the gap between science and service. While dissemination science focuses on providing targeted and tailored information to an identified audience (Lomas, 1993), the goal of implementation science is to aid in the uptake of findings from research into community settings including identifying and overcoming barriers to improve the quality and effectiveness of mental health services (Eccles et al., 2009; Eccles & Mittman, 2006; Ogden & Fixsen, 2014).

Critical questions in implementation science address the "what," "how," and "who" of implementation (i.e., *What* shall be implemented, *how* will the task be carried out, and *who* shall do the work of implementation; see Ogden & Fixsen, 2014). These questions have helped to shift the field away from passive implementation (e.g., diffusion of information) toward a focus on active implementation (e.g., purveyors working with

systems to help move research into practice with high fidelity) to support the uptake of EBPs into usual care (UC) (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Grimshaw & Eccles, 2004). Although recent efforts in implementation science have aided in the development of more defined approaches to implementation, many questions remain about optimal methods to transport EBPs into community-based settings.

One of the goals of implementation science is to ask questions about specific strategies (e.g., what works) associated with the effective implementation of evidence-based practices into routine care settings (Fixsen, Blase, Naoom, & Wallace, 2009; Greenhalgh et al., 2004; Lomas, 1993). Identification of implementation strategies (also sometimes referred to as core implementation components or implementation drivers; see Fixsen et al., 2009; Lomas, 1993; Powell et al., 2012) is considered a top priority on the research agenda (National Institutes of Health, 2010). Implementation strategies, or processes that aid in the uptake of interventions into UC, include both *methods* (e.g., preservice training, ongoing coaching and consultation) and *models* of EBP implementation that are selected to help facilitate the implementation process (Fixsen et al., 2009; Powell et al., 2012). A review of implementation efforts by Fixsen and colleagues (2005) identified key implementation practices. One such component identified in their review, and the focus of the current study, is that of ongoing consultation (and/or coaching and supervision) following training in EBP.

Training in EBP

Training constitutes a major component of effective EBP implementation, yet one of the greatest challenges for implementation science is identifying optimal ways to train clinicians in a way that promotes fidelity and sustained behavior change (McHugh &

Barlow, 2010). Training is particularly important as many large systems and states have begun to emphasize or mandate the provision of EBPs within their service systems (e.g., (DH Mental Health Programme, 2008; Glisson & Schoenwald, 2005; Jensen-Doss, Hawley, Lopez, & Osterberg, 2009; Levin, 2009). However, with limited available research to guide large-scale rollouts of EBPs, there is significant variability in the format and content of trainings and the types of support services that may be provided after training. For example, some large-scale community rollouts of EBPs may consist of the use of manuals along with a brief training or workshops (e.g., Jensen-Doss et al., 2009), while others may provide long-term training and supervision (e.g., DH Mental Health Programme, 2008). With such great variability in community implementation of EBPs, lack of information on effective EBP training and implementation strategies presents a significant problem for leaders and policymakers who must make decisions about training and implementation across a variety of service systems. To help guide the field, more research is needed to help answer questions about EBP training and implementation strategies that are most effective.

A method commonly used to train community clinicians in EBPs includes the provision of treatment manuals or brief workshops. Evidence from several recent reviews examining single-incident workshops and use of printed education materials and manuals has shown that these methods generally resulted in improvements in clinician attitudes (e.g., an increase in positive attitudes toward EBPs), knowledge, skill, and likelihood of EBP use (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010; Rakovshik & McManus, 2010). However, research suggests that these training methods have little effect on increasing clinician skill mastery and produced little change in

clinician behavior (Baer et al., 2004; Beidas & Kendall, 2010; Forsetlund et al., 2009; Herschell et al., 2010). There is also evidence that effects of training have been shown to deteriorate in the absence of ongoing support (e.g., Baer et al., 2004), and that therapists are unlikely to deliver the EBP at recommended levels of fidelity and may be less likely to continue to use a treatment (Herschell et al., 2010; Lyon, Stirman, Kerns, & Bruns, 2011). These findings regarding effective training indicate that although initial training may serve to increase knowledge and skill to some degree, additional supports may be necessary to support clinicians' effective and sustained use of EBPs.

Augmenting training with ongoing support strategies (e.g., consultation, supervision, feedback, or coaching) has been shown to have positive effects on both clinician skill and behavior (Beidas & Kendall, 2010; Herschell et al., 2010). For example, one RCT explored differences in training approaches and found that community clinicians experienced an increase in skill and ability three months after training in CBT when the training workshop was followed by ongoing supervision, compared to clinicians who were not provided any type of ongoing support (Sholomskas et al., 2005). Another study examined training methods used during training in Motivational Interviewing and found only small effects for therapist skill following a two-day training workshop, which later diminished after four months in the absence of ongoing support (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). However, the addition of ongoing support in this study (i.e., coaching and feedback) led to increases in clinician skill, which extended 12 months post-training (Miller et al., 2004). Further, results from an RCT examining differences between three training modalities (i.e., training as usual, computerized training as usual, and augmented training that emphasized active learning strategies)

found that increased number of consultation hours was associated with higher clinician skill and adherence three months following the training (Beidas, Edmunds, Marcus, & Kendall, 2012).

The literature consistently affirms that the most effective training strategies employ several training techniques and involve multiple sessions over time (Fixsen et al., 2005). In comparison to traditional training approaches, multicomponent trainings generally consist of several training approaches and may include a treatment manual, workshop or training sessions, ongoing support and feedback, booster sessions, and the completion of training cases. Several recent studies examining training methods in EBP implementation efforts have found evidence for the effectiveness of multicomponent trainings compared to less intensive trainings with fewer ongoing supports (Beidas et al., 2012; Edmunds, Beidas, & Kendall, 2013; Nadeem, Gleacher, & Beidas, 2013). A review by Herschell and colleagues (2010) also indicated that multicomponent trainings may lead to increased clinician skill, adherence, knowledge, rates of implementation, and more positive client outcomes. Thus, the field is increasingly turning toward using such training models in EBP implementation efforts.

One type of multicomponent training is the learning collaborative (LC). LCs are modeled after quality improvement collaboratives (QICs) commonly used in the medical field, designed to bring together multidisciplinary teams to more effectively spread practices within a system. A widely used model is the Breakthrough Series (BTS) collaborative model developed by the Institute for Healthcare Improvement (IHI: Institute for Healthcare Improvement, 2003). Though learning collaboratives vary in their structure and components, all have similar goals of building capacity to achieve rapid,

measureable, and sustained improvements in practice within a system. Some of the most common components include in-person didactic trainings or workshops focused on building clinical competency and learning the LC model. Training is typically followed by action periods, during which time providers use the newly learned treatment approaches within their respective work environments, with support from EBP experts (Nadeem, Olin, Hill, Hoagwood, & Horwitz, 2013). During action periods, continuous data collection measures provide feedback on implementation progress and sustainability within a system.

Learning collaborative models have gained traction in the mental health field to help with implementing changes in practice on a large-scale. In fact, the Substance Abuse and Mental Health Services Administration has prioritized the creation of LCs aimed at helping to spread EBPs within state mental health systems through grant funding. LCs to change provider practices have also been established in at least 35 states, through the National Council for Community Behavioral Healthcare (Nadeem, Olin, Hill, Hoagwood, & Horwitz, 2014). Yet, despite the growing popularity of LCs and growing evidence that multicomponent trainings are beneficial for implementation outcomes, little is known about the effectiveness of LCs or about specific components of LCs that may be most impactful (Nadeem, Olin, et al., 2013). In fact, a recent review by Nadeem and colleagues (2014) was unable to determine the effectiveness of LCs or specific components of LCs in mental health due to a lack of research on these topics. This indicates a great need for research examining LCs and components of LCs that may be particularly beneficial for supporting implementation outcomes and sustaining effective implementation of EBPs.

Consultation as part of multicomponent trainings

One component of LCs and other EBP implementation efforts that may be particularly beneficial for supporting the uptake and sustainability of EBPs is ongoing consultation following initial training efforts. Growing evidence has shown that the inclusion of ongoing education or support strategies enhances the uptake of EBPs and leads to increased likelihood of EBP use and increased fidelity (Beidas & Kendall, 2010; Forsetlund et al., 2009). Though a variety of ongoing support strategies have been employed (e.g., supervision, consultation, coaching, monitoring and feedback), of primary interest in the present study is ongoing consultation following initial training in EBT.

Consultation and supervision share similar goals; however, it is important to understand the distinction between the two. In mental health, supervision refers to a relationship between supervisor and clinician in which the clinician is supervised within an agency, clinic, or place of employment (Schoenwald et al., 2008). Consultation (also oftentimes referred to as "coaching") indicates a process of ongoing support following a training that takes place between a consultant and consultee with the primary goal of improving the mental health care provided to a patient (Caplan & Caplan, 1993). Nadeem and colleagues (2013) further specified consultation as referring to *external* support provided to trainees in training and implementation efforts with the goal of improving patient care. This includes both sharing knowledge and experience related to intervention techniques as well as application of techniques as part of the implementation process.

Converging evidence from several reviews has led to similar conclusions regarding ongoing consultation – that use of this strategy has resulted in more successful implementation outcomes compared to training alone (Beidas & Kendall, 2010; Herschell

et al., 2010). Further, in recent years, consultation in mental health has become more widely used by agencies and organizations, in effectiveness studies, and as a component of many state and national policy and EBP implementation efforts (e.g., California Department of Mental Health, 2010; Gleacher et al., 2011). Currently, limited research on consultation suggests that inclusion of consultation leads to more positive provider-level outcomes. However, despite its growing popularity and evidence that it can lead to more positive outcomes, little research has directly described what takes place during consultation.

Consultation Content and Methods

The literature describes several key purposes and strategies of consultation. A recent introduction to a special issue on consultation processes and the relationship to implementation outcomes defined several purposes of consultation including: continued training, problem-solving implementation barriers, provider engagement, case support, accountability, master skill-building, treatment adaptation, and planning and sustainability (Nadeem, Gleacher, & Beidas, 2013). Further, processes and methods used during consultation in the issue were agenda-setting and goal setting, formulation, planning, discussion, didactic instruction, modeling, role-play, monitoring or observation, review, summarizing, confidence-building, praise and reinforcement, and feedback (Nadeem, Gleacher, & Beidas, 2013). Though several common key functions and processes of consultation have been described, there remains great variability in consultation call content and consultative methods.

One study examined the process of a statewide implementation of CBT and indicated that, although the content of ongoing consultation calls varied among

consultants and across the span of consultation, most calls within the study typically followed a similar structure (Gleacher et al., 2011). This included a brief period devoted to agenda setting and check-in, in-depth case presentations by clinicians, case review and problem-solving, and intervention and programmatic issues. Though this study described the overall structure of consultation calls, it did not include any formal observation or data collection examining the content and consultative methods of calls.

Two additional studies have examined content and methods used by consultants during consultation calls as a part of EBP implementation efforts. One study did this as a part of the same statewide EBP implementation effort described above in the study by Gleacher and colleagues (2011), but included systematic coding of topics discussed during supervisor consultation calls (Nadeem, Gleacher, Pimentel, et al., 2013). Call topics included case review, EBP techniques, supervision issues, fidelity and adaptation, child and family engagement, other clinically oriented discussion, programmatic or administrative issues, and off-task discussion. Results also indicated that consultants spent more time speaking than clinic supervisors overall, with consultants speaking nearly twice as much as consultees. Distribution of call topics by consultants included approximately equal amounts of time across clinically relevant topics, with one-third of clinically relevant discussion covering administrative issues, while conceptualization, program administration, and parent and child engagement were the most frequently discussed topics among clinic supervisors.

The second study examined consultative methods provided to therapists as part of an RCT aimed at training therapists in CBT using different training modalities (Beidas & Kendall, 2010). This study focused on coding the content and consultative methods of

ongoing consultation calls provided to clinicians, as well as understanding the relationship between active learning techniques (e.g., behavioral rehearsal, role-play) employed during consultation and therapist adherence to the EBP, skill, self-efficacy, and satisfaction (Edmunds, 2014). This study found that the highest proportion of time on calls was spent discussing exposures and reviewing cases, while less time was spent talking about components of the EBP. The most common consultative methods used were case discussion and informing, with less time devoted to didactics and active learning components (e.g., behavioral rehearsals).

Further, studies that have examined consultation lack codes to capture organizational- and provider-level barriers raised by providers and fail to provide information about differences between providers who did and did not participate in consultation calls. This limits our current understanding of the kinds of concerns and questions raised by clinicians and supervisors during consultation, as we know little about the types of client-, provider-, and organizational-level barriers discussed. Without knowledge of provider concerns that arise on calls, it is difficult to make EBP training and consultation efforts targeted to better address common concerns. Thus, there is a need for future work that explores 1) what takes place during ongoing consultation, 2) barriers that occur at the client-, provider-, and organization-level, including any barriers related to engagement in consultation, and 3) methods commonly used by consultants to address concerns raised by providers and convey information during consultation.

This information has broad implications for EBP training and ongoing support efforts. For example, increased knowledge about common concerns raised during consultation may highlight areas in which EBP implementation efforts may preemptively

address provider concerns during training. Information about commonly cited barriers to engagement in consultation could provide insights about barriers to participation (e.g., organizational-level barriers) that may also be addressed during the earlier phases of the implementation process to help facilitate provider participation. Further, the field could benefit from learning more about the structure of consultation and strategies used by consultants that may be most potent and beneficial for providers for facilitating skill development and sustaining EBP use.

Predictors of Consultation Engagement

Although there is strong evidence for the inclusion of ongoing consultation to promote uptake and sustainability of EBPs in implementation efforts, a significant challenge often encountered is that it can be difficult to get clinicians to engage in consultation (Ebert, Amaya-Jackson, Markiewicz, Kisiel, & Fairbank, 2012; Fritz et al., 2013; Hoagwood et al., 2007). For example, a recent observational study by Ebert and colleagues (2012) evaluating the feasibility of adapting the Breakthrough Series Collaborative (BSC) collaborative model for trauma-focused cognitive-behavioral therapy (TF-CBT) in community mental health agencies found that among supervisors, only 39% participated in six or more out of seven consultation calls, and just 78% participated in over half of the calls. Clinician participation was much lower in comparison, with less than 40% of clinicians participating in four or more calls (Ebert et al., 2012). Another study focused on understanding barriers and facilitators of participation in ongoing training efforts following EBT implementation and found that 42% of clinicians completed 12-15 of 15 total consultation calls, whereas 14% completed

1-9 calls and nearly 44% of individuals did not attend any consultation calls (Pemberton et al., 2015).

Unfortunately, limited data are available to address these engagement difficulties, as research has primarily focused on the outcomes of consultation, rather than processes that might impede or facilitate its success. In particular, it would be very helpful to know differences between providers who do and do not engage in consultation, issues commonly raised during calls by providers who do engage, strategies employed by consultants to address those issues, and how engagement in consultation affects provider-level outcomes (e.g., attitudes). Such data would help identify providers at risk for consultation non-engagement, highlight whether consultation calls are meeting provider needs, and provide information about the importance of consultation engagement.

Demographic and Professional Predictors. There is some evidence that provider demographic and professional characteristics may be important predictors of engagement in consultation. However, this evidence is limited, as much of the literature has focused on provider-level variables that may predict client-level outcomes in EBP implementation efforts, while less work has focused on provider-level demographic and clinical characteristics that may enhance provider-level engagement. In fact, only a single study has directly examined demographic and clinical differences between providers who engaged and did not engage in consultation calls following EBP training (Fritz et al., 2013). Demographic and clinical provider-level variables examined in the study were limited to type of license, number of years licensed, degree, and practice setting, and findings indicated no significant differences between participating and nonparticipating clinicians on any of these variables (Fritz et al., 2013).

Attitudes Toward EBP. Implementation science has emphasized the importance of provider attitudes toward EBPs, as attitudes have been shown to predict the likelihood of EBP use (e.g.,T. D. Nelson & Steele, 2007) and are frequently cited as a clinician-level barrier to using EBPs (e.g., Cook, Biyanova, & Coyne, 2009). Further, the literature suggests that the relationship between clinician attitudes toward EBPs may be particularly important and influential for provider engagement in consultation. To our knowledge, only a few studies have directly examined the relationship between provider attitudes toward EBPs at baseline, and engagement in consultation. One study found that more positive provider attitudes towards EBTs at baseline were not predictive of consultation call attendance or number of cases presented on calls, but were predictive of increased use of evidence-based assessment measures post-training (Pemberton et al., 2015). Similarly, results from a second study indicated that more positive attitudes did not predict use of EBP intervention at post-training (Shapiro, Prinz, & Sanders, 2011). In contrast, another study examined differences in attitudes post-consultation between providers who did and did not participate in consultation calls following training in TF-CBT and found that providers who participated in consultation calls reported more positive attitudes toward TF-CBT compared to nonparticipating providers (Fritz et al., 2013). However, this study examined attitudes retrospectively, at post-consultation only, using brief-self report. There is also evidence that more positive attitudes toward EBTs predicted increased participation in post-training activities, including consultation calls (M. M. Nelson, Shanley, Funderburk, & Bard, 2012). Though these findings suggest that attitudes may be related to engagement in some post-training activities, results remain mixed. One study that employed an LC method to implement TF-CBT found that

provider participation in EBP training was associated with significantly more positive attitudes toward EBPs from pre- to post-training; however, this study did not specifically examine the relationship between engagement in ongoing support strategies and provider attitudes toward EBPs (Haine-Schlagel, Brookman-Frazee, Janis, & Gordon, 2013). The present study addresses current gaps in the literature by examining whether provider engagement was related to baseline attitudes toward EBP, and will also describe attitudes at mid- and post-CBLC.

EBP Knowledge. Provider EBP knowledge is commonly examined as a predictor of client-level outcomes in implementation efforts; however, there is a dearth of information about the relationship between baseline provider knowledge and engagement in consultation. It is widely known that ongoing supervision generally leads to increased clinician knowledge of EBPs from baseline to post, as well as more positive client-level outcomes compared to clinicians who do not receive ongoing supervision or consultation (e.g., Schoenwald, Sheidow, & Letourneau, 2004; Sholomskas et al., 2005). The literature also provides numerous examples of how trainings and workshops are beneficial for increasing clinician knowledge (e.g., Herschell et al., 2010). Yet, in comparison, less is known about the relationship between baseline provider knowledge of EBPs and engagement in consultation in EBP implementation efforts. It is possible that providers who know more about an EBP feel less need to participate in consultation due to greater confidence in using the model. On the other hand, providers with less prior knowledge might also be less willing to participate in consultation due to less interest in learning the model or other motivational differences. The present study examined these

possibilities by looking at baseline provider knowledge of TF-CBT as a predictor of engagement in ongoing consultation.

Implementation Climate & Implementation Leadership. The importance of implementation climate and leadership in EBP implementation efforts is well established (Aarons, Ehrhart, & Farahnak, 2014; Aarons, Ehrhart, Farahnak, & Sklar, 2014; Ehrhart, Aarons, & Farahnak, 2014). Both have been shown to be important for encouraging positive attitudes toward EBP and a commitment to change (Aarons, Ehrhart, Farahnak, et al., 2014). Thus, an emphasis on cultivating positive implementation climate and leadership prior to EBP implementation efforts may be particularly important, as common barriers cited by providers include those at the organizational level. For example, in a study examining differences in reported barriers between providers who participated and did not participate in ongoing consultation as part of a TF-CBT implementation effort, nonparticipating providers were more likely to indicate an increased number of barriers related to agency productivity requirements, and project-related barriers such as inflexibility in consultation call schedule, number of required consultation calls, and identification of appropriate training cases (Fritz et al., 2013). Both participators and non-participators indicated that the greatest organizational barriers were productivity requirements and lack of time, while the greatest project-related barriers were the required number of consultation calls and completion of treatment records (i.e., paperwork) (Fritz et al., 2013). Further, non-completers also reported that getting a reduction in their agency-specific productivity requirements was one of the greatest facilitators of call participation (Fritz et al., 2013). These findings suggest ways in which implementation climate and leadership may help to foster positive attitudes

toward EBP implementation and training efforts. Though no study has directly examined implementation climate and leadership as predictors of engagement in consultation calls, previous work provides evidence for the importance of these factors for encouraging positive attitudes toward EBP implementation.

Present Study Aims and Hypotheses

The overarching goal of the current study was to expand our knowledge about ongoing support strategies provided to clinicians and supervisors following training in EBP and to deepen our understanding of factors that influence engagement in consultation, within a community implementation of TF-CBT taking place in the child welfare system. Though previous studies have examined content and methods used during ongoing consultation in EBP implementation efforts, we are still lacking information about the kinds of concerns and questions raised by providers on these calls. Further, as there is currently limited research examining distribution of call topics and methods, additional research is needed to help understand what takes place during consultation calls over time.

The present study addressed these gaps and expanded upon previous work by examining: 1) content and methods of ongoing consultation provided by expert EBP trainers to both clinicians and supervisors, 2) potential baseline predictors of consultation engagement in a sample of clinicians and supervisors, 3) whether engagement in consultation was related to provider-rated satisfaction with consultation and provider-rated working alliance with consultants during consultation calls

Aim 1. The aims of the present study were twofold. The first aim was primarily descriptive. First, the study examined the content and consultative methods of

consultation calls led by expert consultants provided to clinicians and supervisors, as a part of a larger learning collaborative consisting of a community implementation of TF-CBT. Consultation calls were coded using live minute-to-minute coding conducted by four trained graduate-level coders familiar with TF-CBT. Please see Measures for a description of coding training and procedures. To date, there is limited research investigating the content of ongoing expert consultation calls delivered as part of EBP implementation efforts (e.g., Edmunds, Kendall, et al., 2013; Nadeem, Gleacher, Pimentel, et al., 2013). Therefore, the current study provides important descriptive information about the content and consultative methods of consultation calls, including an expanded set of organizational- and provider-level barriers and facilitators.

Further, examination of content and methods during consultation calls was described across time, which is a novel approach to examining what takes place during consultation. For example, it may be the case that consultants emphasize didactics on earlier calls and may be more likely to use active strategies, such as modeling and behavioral rehearsal, on later calls as consultees become more comfortable with TF-CBT. It was also hypothesized that discussion of the Trauma Narrative would be more likely to occur on later calls, as providers begin to develop the Trauma Narrative with clients. Throughout calls, it was hypothesized that we would see an equal distribution of discussion related to flexibly implementing treatment components and addressing barriers to treatment (i.e., client, provider, organizational).

Aim 2. The second aim of the study examined predictors of consultation engagement (i.e., number of consultation calls attended, number of case presentations during consultation calls, and the number of minutes each provider spoke during

consultation calls) from baseline demographic and professional information, attitudes toward EBPs, TF-CBT knowledge, implementation climate (i.e., organizational climate facilitative of using EBPs), and implementation leadership (i.e., organizational leadership facilitative of using EBPs). Further, it was planned to explore differences on provider satisfaction with consultation, and provider-rated working alliance with consultants during consultation calls at mid- and post-CBLC, between providers who engaged and did not engage in consultation.

Consistent with the literature reviewed above, we hypothesized that more positive attitudes toward EBP at baseline would predict increased engagement in consultation (Fritz et al., 2013; M. M. Nelson et al., 2012). We also hypothesized that more positive implementation climate and implementation leadership would be related to consultation engagement (Aarons, Ehrhart, Farahnak, et al., 2014). Given the lack of previous research on provider demographic and professional characteristics and engagement in consultation, these analyses were exploratory. Additionally, EBP knowledge was exploratory and no direct hypotheses were made regarding the direction of the relationship with engagement. As previous work suggests a positive relationship between satisfaction and engagement (Edmunds, Kendall, et al., 2013), we predicted hypothesized that higher satisfaction with consultation would be associated with higher engagement. Further, we hypothesized that providers who were more engaged in the learning collaborative would have more positive ratings of working alliance with consultants (Ladany, Ellis, & Friedlander, 1999).

Chapter 2: Method

Participants

Clinicians and Supervisors. The study sample included 40 clinicians and 7 supervisors learning TF-CBT through a community-based learning collaborative (CBLC) in Miami-Dade County. Clinicians and supervisors were from 8 agencies serving youth in the child welfare system. Both clinicians and supervisors participated in the same training and were required to meet the same requirements for certification through the learning collaborative. Examination of differences in demographic, professional, and baseline scores on measures indicated few significant differences between supervisors and clinicians. Relative to clinicians, supervisors were older (Supervisor $M = 49.7$, $SD = 13.6$; Clinician $M = 38.3$, $SD = 9.2$; $t(43) = 2.81$, $p = .008$), more likely to be state licensed (Supervisor $M = 1.0$, $SD = 0.0$; Clinician $M = .29$, $SD = .46$; $t(43) = 4.05$, $p > .001$), and had more years of professional experience (Supervisor $M = 17.0$, $SD = 9.0$; Clinician $M = 6.5$, $SD = 6.3$; $t(43) = 3.50$, $p = .001$). Clinicians and supervisors were combined into a single group for the present study and are hereafter referred to collectively as *providers* due to having the same training and requirements as part of the collaborative. However, professional role (supervisors vs. clinicians) was included as one of the study predictor variables (see below). Please see Table 1 for information on study providers. Providers were primarily female ($n = 43$, 91.5%) and ranged in age from 26–65 years ($M = 40.0$, $SD = 10.7$). Provider race included 70.2% Caucasian, 19.1% African-American, 2.1% American Indian/Alaskan Native, and 2.1% Native Hawaiian/Pacific Islander (6.4% missing), and 57.4% reported Hispanic ethnicity (0.7% missing). Providers had an average of 8.1 years ($SD = 7.7$) professional experience, and over one-third ($n = 18$,

38.3%) reported being state licensed. Providers worked primarily in counseling (*n* = 13, 27.7%), social work (*n* = 15, 31.9%), psychology (*n* = 5, 10.6%), and marriage and family therapy (*n* = 4, 8.5%). The majority reported having a CBT theoretical orientation (*n* = 26, 76.5%).

Of note, two of the providers who participated in consultation calls had completed all other training requirements during the previous round of the learning collaborative, aside from attending the required number of consultation calls. Therefore, some demographic (e.g., age, race and ethnicity, professional field, licensure status, years of professional experience, and theoretical orientation) and engagement data (e.g., learning session attendance, number of completed cases, and certification) were unavailable for these participants.

Eligible study participants included any providers who participated in the round of the community-based learning collaborative of interest in the present study. Additionally, all study participants were enrolled in the clinical track of the collaborative. Participants in other tracks of the learning collaborative (i.e., broker, senior leader) were not included in the present study.

Procedure

A leading child advocacy center in large, ethnically diverse county in the southeast United States established a Community Treatment and Services Center (C-START) aimed at building community-wide capacity to deliver evidence-based, trauma-informed, culturally-competent treatment interventions for child victims of sexual abuse and children with sexual behavior problems served in the child welfare system. C-START is funded by a grant from the Substance Abuse and Mental Health Services

Administration (SAMHSA). As a part of the establishment of C-START the child advocacy agency partnered with a community-based lead care agency for the state's privatized child welfare system responsible for overseeing six full case management agencies that provide case management and mental health services to children and foster families. C-START employed the Community-Based Learning Collaborative (CBLC) model to train participants in TF-CBT and Culturally Modified Trauma Focused Cognitive Behavioral Therapy (CM-TF-CBT).

The CBLC of interest in the present study consisted of several learning sessions and action periods, which took place over the period of February 2015–December 2015. Prior to the start of the first learning session in February 2015, clinicians and clinical supervisors were required to complete a free web-based training in TF-CBT (TF-CBT*Web*, accessible at http://tfcbt.musc.edu/). The first learning session consisted of a two-day in-person TF-CBT training led by expert TF-CBT trainers. Following training, the first action period was characterized by clinicians and supervisors using and implementing TF-CBT with identified training cases at their respective agencies. A sequence of two additional learning sessions and action periods took place over the course of the collaborative, for a total of three learning sessions and action periods. Subsequent learning sessions and action periods focused on TF-CBT competency, implementation, and sustainability.

Providers were required to participate in a series of twice-monthly consultation calls scheduled during the CBLC. The calls consisted of 8-10 providers assigned to each call group, with a total of 4 call groups, led by an expert TF-CBT trainer. To complete the

training requirements, providers were required to participate in at least 12 of 14 required consultation calls offered throughout the learning collaborative.

Providers completed a series of measures required by the CBLC prior to the first learning session. Completion of these measures was a requirement for participation in the training. The two participants who completed the previous round of the LC but who continued to participate in consultation calls were not administered baseline measures for the round of the collaborative included in this study and were therefore missing all baseline data. At the mid-point and end of the CBLC, providers were administered the same measures with the addition of several new measures given only at mid-point and post-CBLC. This included a measure assessing perception of collaboration success, a measure giving feedback about consultation calls, and a measure assessing working alliance. Participants received $10 for completing measures at mid-point and post-CBLC. Additionally, as a part of this study, trained doctoral student coders conducted live minute-to-minute coding of content and consultative methods of consultation calls using a codebook adapted for the current study. Development of the codebook was an iterative process that continued as coders worked to establish reliability. Content areas that were coded included case discussion, EBP treatment questions, components, and techniques, trauma narrative, flexibility and adaptation, barriers (i.e., client-, clinician-, and organizational-level), programmatic and administrative issues, satisfaction and success, collaboration, peer consultation, other consultee-raised questions or comments, and off-task discussion. Consultative methods included case discussion, passive learning techniques (i.e., didactics, questioning), active learning techniques (i.e., modeling, role-play), other consultant methods, and off-task learning.

Measures

Provider Demographics and Background Information. Clinician and supervisor demographics (age, gender, race, ethnicity), and professional information (theoretical orientation, degree, licensure status, years of professional experience, average weekly caseload, professional field) were collected prior to the start of the learning collaborative training sessions.

Evidence-Based Practices Attitudes Scale (EBPAS; Aarons, 2004). The EBPAS (see Appendix A) consists of 15 items measuring mental health provider attitudes toward EBPs. It includes four subscales assessing theoretically derived dimensions of attitudes toward adoption of EBP: appeal, requirements, openness, and divergence, as well as a total score. The Appeal scale represents the extent to which a provider would adopt an EBP if it were intuitively appealing. The Requirements scale assesses the extent to which a provider would adopt an EBP if it was required by their supervisor, agency, or state. The Openness scale assesses the extent to which a provider is generally open to trying new interventions. The Divergence scale assesses the extent to which the provider perceives EBPs as lacking clinical utility. Responses indicate level of agreement with each item on a scale from 0 ("not at all"), to 4 ("a very great extent"). The psychometric properties of the EBPAS have been well-supported in several samples of practicing therapists (e.g., Aarons, 2004; Aarons, et al., 2007). Cronbach's αs of the EBPAS subscales and EBPAS total scale were conducted. At baseline, Cronbach's $\alpha = .95$ for the requirements subscale, .78 for the appeal subscale, .80 for the openness subscale, and .85 for the divergence subscale. Cronbach's α for the EBPAS total score was .77. These internal consistency estimates are similar to those reported by Aarons (2004).

Boulder IMPACT TF-CBT Knowledge Survey. The Boulder Impact TF-CBT Knowledge Survey (see Appendix A) consists of 17 multiple-choice items assessing clinician knowledge about TF-CBT and trauma. Internal consistency using Cronbach's α of the total score for this measure was .61.

Implementation Climate Scale (Ehrhart et al., 2014). The Implementation Climate Scale (see Appendix A) consists of 18 items assessing the degree to which an organization is supportive of EBP implementation using a 5-point Likert scale ranging from 0 ("not at all") to 4 ("a very great extent"). Internal consistency was .93, suggesting excellent internal consistency.

Implementation Leadership Scale – Supervisor and Staff Versions (Aarons, Ehrhart, & Farahnak, 2014). The Implementation Leadership Scale (see Appendix A) includes 12 items rated on a 5-point Likert scale from 0 ("not at all") to 4 ("a very great extent") that assess the degree to which a leader is proactive, knowledgeable, supportive, and perseverant regarding EBP implementation. The ILS demonstrated good internal consistency, with alphas of .81 on the supervisor version and .97 on the staff version. Of note, the supervisor and staff versions of the ILS included the same questions with language adapted for supervisors and staff. Providers who completed the ILS – Supervisor or Staff versions self-identified as either a supervisor or staff; therefore, some providers completed the supervisor version of the ILS, while others completed the staff version. Since providers all participated in the clinical track of the collaborative, and because both versions of the ILS contained identical questions with slight wording changes, supervisor and staff versions of the ILS were grouped together for analyses in the present study.

*Consultation Feedback Form – Clinician Version (*CFF). The CFF (see Appendix A) was adapted from the Consultation Feedback Form used in a study by Edmunds and colleagues (2013), which was previously modified from the Beck Initiative Practicum Feedback Form (Stirman, Buchhofer, McLaulin, Evans, & Beck, 2009). The CFF consists of 19 items assessing perceived quality of consultation, satisfaction with consultation structure, and comfort in applying TF-CBT techniques following consultation. Items are measured on a 5-point Likert scale (0= Poor, 4= Excellent; or 0= Strongly Disagree, 4= Strongly Agree) and one open response item soliciting any additional comments about consultation calls. Estimates of internal consistency were 1.00 at mid- and .72 at post-CBLC.

Working Alliance Inventory – Consultation – Clinician Version. The Working Alliance Inventory – Consultation – Clinician Version (see Appendix A) is adapted from the Supervisory Working Alliance Inventory (SWAI) Trainee Form by Efstation and colleagues (1990). The Working Alliance Inventory – Consultation – Clinician Version assesses consultees' perception of the supervisory relationship with the consultant during consultation. The measure consists of 22 items rated on a 7-point Likert scale from 1 (“almost never”) to 7 (“almost always”), with higher scores indicating more positive ratings of alliance. The Trainee Form of the original SWAI evidenced two distinct factors – Rapport and Client Focus. The Rapport factor reflects the extent to which consultees perceive consultants’ effort to build good rapport by supporting and encouraging them during consultation calls. The Client Focus factor reflects consultees’ perceptions of the emphasis consultants place on promoting understanding of clients and client perspectives.

The measure demonstrated excellent internal consistency of .97 at mid- and .99 at post-CBLC.

Consultation Engagement. Engagement in consultation included provider attendance on consultation calls, number of minutes spoken during calls, and number of case presentations during calls. Call attendance data was recorded by C-START grant staff during consultation calls, and was provided to the external evaluation team. During consultation calls, trained research assistants coded during which minutes providers spoke during consultation calls and whether a provider presented a case on a call. We opted to use three different measures of engagement in consultation to describe different aspects of provider engagement. For example, provider attendance on consultation calls suggests a provider's ability to set aside time to show up on a call. On the other hand, provider participation during a call is only possible if a provider is first able to attend the call. Once a provider is on a call, speaking during calls may reflect the amount of effort or level of investment, a provider's natural tendency to be talkative, the degree to which a provider is currently experiencing difficulty with a case and would like to use the call to seek help, etc. Similarly, engagement as measured by the number of case presentations a provider delivers during consultation calls is first related to the provider's ability to attend calls, and second, the ability to obtain training cases. If providers experience difficulty getting training cases, it would, in turn, be more difficult to present cases on a call. However, if providers are able to identify and obtain training cases, it is then up to the provider to make a decision to present a case on a call. In this way, number of case presentations could be considered to be both reflective of ability to secure training cases and effort.

Consultation Coding Manual. The Consultation Coding Manual (see Appendix A) was based on a measure by Pimentel, Regan, Comer, Hoagwood, and Albano (2013), and was adapted for the purposes of the present study. The codebook included general coding guidelines and detailed instructions for coding minute-to-minute counts of content topics raised by providers and consultative methods employed during consultation calls. Coding included minute-to-minute frequency counts of content and method codes. Fifteen content codes are described, including case discussion, questions about the TF-CBT model and specific components, how to implement TF-CBT with clients, trauma narrative, flexibility and adaptations, client and family engagement, provider-level barriers, organizational-level barriers, programmatic issues, satisfaction and success, collaboration, peer consultation, technology issues, other topics, and off-task discussion. Additionally, seven methods codes cover a range of ways in which consultants may respond to providers on calls, including case discussion, didactic methods (e.g., didactics/informing), questioning, and active methods (e.g., modeling, behavioral rehearsal), other strategies, and off-task discussion.

Of note, due to the similarity of content codes, the code for treatment questions for analyses included a combination two separate codes, including: 1) questions about the general TF-CBT model and theory, and 2) questions related to the delivery of TF-CBT and how to do each component. In addition, the code capturing technology issues was folded into a code covering all other topics of discussion that arose during consultation calls. The goal was to capture the core or essential meaning of each verbalization. However, often verbalizations were complex and more than one code was required to adequately capture its core content. To help guide coding, the coding manual (see

Appendix A) describes common instances and examples of when such double-coding occurred (e.g., Provider-Level Barriers and Organizational-Level Barriers), as well as cases that would not call for double coding (e.g., we did not double code Specific TF-CBT Components and Flexibility, but would have only coded Flexibility). Additionally, Figure 1 provides a representation of coding guidelines and strategies used to double-count content codes.

Coder Training and Reliability. The coding strategy for the proposed study was similar to the method used by Nadeem and colleagues (2013). Audiotaping of consultation calls was not permitted. Therefore, coders conducted live minute-to-minute coding of verbalizations of call participants (i.e., consultants, clinicians, supervisors) during consultation calls, which took place over the phone.

Coders included four clinical psychology doctoral students, all of whom were familiar with TF-CBT and completed TF-CBT*Web* (accessible at http://tfcbt.musc.edu/). Prior to beginning coding practice, the investigator met with coders to explain the study coding scheme in detail and to review examples of each code.

Existing transcripts from a prior study of consultation (Edmunds, Kendall, et al., 2013) were used to practice live minute-to-minute coding of consultation calls. As the transcripts were from a study examining CBT implementation in the community, transcripts were edited to better reflect content related to TF-CBT as well as potential content and methods that were likely to arise during live coding of calls. Transcripts were read aloud and audio-recorded to mimic the pacing of live consultation calls and were then coded for practice. Prior to the start of the live consultation calls, coders practiced coding one to three audio-recorded consultation calls weekly. Coding included listening

to the audio-recorded sample transcripts, while coding for call content and consultative methods. After coding a set of calls, codes were entered into a database and Cohen's kappa was calculated to determine coder reliability between each pair of coders (Cohen, 1960). Reliabilities were discussed in weekly or biweekly coding meetings among the coding team. During these meetings, reliability calculations guided discussion about areas of coding weakness, which was used to inform codebook development. This continued to be an iterative process during the first weeks of coding practice. In addition, coders discussed questions about codes and reconciled coding disagreements. The codebook was updated to help clarify codes and decision rules. Prior to the start of calls, coder reliability reached an ICC of ≥.60 across all codes, with most codes reaching an ICC of ≥.70. Therefore, coders continued to code in pairs on live calls until an ICC of ≥.70 was reached on all codes for at least 3 calls, indicating substantial inter-rater reliability (Landis & Koch, 1977). This same standard for reliability has been used in other studies employing similar coding techniques (Edmunds, Kendall, et al., 2013). Once reliability was established, the primary investigator began to code independently and random reliability checks were performed.

During live consultation calls, undergraduate research assistants were trained to take minute-to-minute notes on call content and participation. Notes were used by coders to reconcile coding mismatches during consensus coding. In addition, at the end of each call, undergraduate research assistants indicated call attendance, whether a participant spoke during the call, and if a participant's case was discussed. Further, the number of minutes each provider spoke during each call and the number of minutes each case was discussed was coded on each call.

Chapter 3: Data Analysis

Analyses for Aim 1: Descriptive analyses examined the frequency of call content and methods using codes from the Minute-to-Minute Coding Sheets. This included examination of the proportion of time spent on each content area and method during consultation calls. To examine content and methods on calls over time, calls were aggregated by call number and descriptive analyses were conducted to look at the mean percent of minutes each topic or method was discussed or was used calls, and patterns over time (see Figures 2 and 3).

Analyses for Aim 2: The second aim included examination of predictors of engagement in consultation. First, all provider demographic and professional characteristics were entered into separate models to examine their independent effects on the outcome variables, with the exception of race which was dummy coded with Caucasian as the reference group, to allow all dummy coded race variables to be entered simultaneously. Professional field was dummy coded with Social Work as the reference group, and all dummy coded variables were entered into a single model to examine the effect of professional field on each outcome. Additionally, the relationship between baseline attitudes toward EBPs, EBP knowledge, and implementation climate and leadership on the three engagement outcomes was examined.

Providers (level-1) in the present study were nested within agencies (level-2); therefore, the design effect due to clustering was estimated to correct for sampling variance and to determine if nesting within groups was needed. The estimated design effect ranged from 1.30 to 1.83 on the dependent variables (i.e., number of consultation calls attended, number of minutes spoke during calls, number of case presentations).

Although the design effect was <2.0, similar studies with small cluster sizes (<10) suggest that a design effect >1.1 should be used to determine if multilevel modeling is indicated (Lai & Kwok, 2015; Weisz, Bearman, Santucci, & Jensen-Doss, 2017). Therefore, analyses included multilevel models to account for agency-level dependencies in the models.

Regression and logistic regression analyses were conducted in HLM 7.01 to examine provider demographic variables, professional and practice variables, and baseline scores on measures of attitudes toward EBPs, EBP knowledge, implementation climate (i.e., organizational climate facilitative of using EBPs), and implementation leadership (i.e., organizational leadership facilitative of using EBPs), as predictors of engagement in consultation calls. Continuous predictors, including age and years of experience, were centered around their grand means to reduce multicollinearity and aid interpretation. First, all predictors were examined separately. Then, significant predictors were entered simultaneously into a single model to examine the effects of all significant predictors.

Additionally, we intended to explore provider satisfaction with consultation and working alliance, as reported at mid-and post-CBLC, and the relationship with engagement in consultation. However, due to high rates of missing data at mid- and post-CBLC, attempts to impute missing data would not converge. Therefore, we elected to compare differences on these measures at mid- and post-CBLC by providers who met the requirements of the collaborative and those who did not meet all requirements of the collaborative, as measured by number of consultation calls completed and number of case presentations, using Mann-Whitney *U* tests.

Missing Data. It was expected that little data would be missing at baseline with increasing rates of missing data at mid- and post-CBLC. As a first step, all measures collected at baseline were examined for missingness. First, the expectation maximization (EM) algorithm feature of SPSS Version 22 was used to impute data for missing items within questionnaires that had at least some item-level data present and questionnaires were scored based on these data. Next, missing data on study variables were examined using Little's MCAR test. Results from Little's MCAR test suggested that data were MCAR [χ^2 (130) = 109.22, p = .91]. The Multiple Imputation (MI) feature of SPSS Version 22 was then used to create five imputed datasets. MI uses a regression-based approach to create several datasets, each with different estimates of missing values. Using this technique, each dataset is analyzed separately, generating parameter estimates that are then pooled into a single set of results (Baraldi & Enders, 2010).

Chapter 4: Results

Aim 1. Overall, consultants spoke during more minutes on calls (2899 minutes of 3285 total call minutes, or 88.2% of minutes) than providers (2134 minutes of 3285 total call minutes, or 65.0% of minutes). Next, consultation call content and methods were explored. Figure 2 depicts the percentage of total minutes each topic was discussed across all consultation calls combined. As multiple topics could be discussed each minute during calls, the percentages in the figure indicate the percentage of minutes across all calls each topic was discussed or came up during calls. That is, percentages reflect the summation of the number of call minutes from all calls (total number of call minutes = 3285 minutes), divided by the number of minutes each topic was discussed across calls.

The most frequently discussion topic was case discussion (52.0% of minutes across calls). Treatment questions, including topics related to using TF-CBT and the TF-CBT model, as well as how to do specific components of the treatment were discussed on 11.6% of minutes across calls. However, specific discussion of the Trauma Narrative was more frequent and came up during 13.8% of minutes. Discussion related to flexible applications and adaptations of TF-CBT took place during 7.6% of minutes. When barriers were discussed, most often the discussion was about client-level barriers (16.2%), followed by provider-level barriers (7.0%), and less frequently, organizational-level barriers (2.6%). Programmatic issues related to the learning collaborative came up in 9.6% of call minutes. Additionally, calls included discussion related to provider satisfaction and successes in 13.2% of minutes. Though increasing collaboration between providers and among community members was a key goal of the collaborative, topics related to collaboration were only discussed in 2.3% of call minutes. Similarly, peer

consultation was only present in 3.4% of minutes. Finally, other topics (e.g., technology issues, mention of supervision not related to the learning collaborative, case details including emergencies, crises requiring police involvement, or court issues) were discussed in 13.9% of minutes, while off-task discussion was infrequent and occurred during only 3.2% of minutes.

Types of methods used by consultants during calls were also explored. Figure 3 provides a description of the total percentage of minutes each method was used during consultation calls. As noted above, percentages do not sum to 100 as multiple consultative methods may have been used during a single minute. Results indicated that the most common methods used by consultants during calls were case discussion (47.7% of minutes across calls), didactics (63.2%), and questioning (49.9%). In comparison, active learning strategies including modeling and role-play were only employed during 12.6% of call minutes. Other methods (e.g., agenda setting, praising, validation, offering support, call wrap-up) were somewhat common, occurring in 36.7% of minutes. Lastly, off-task discussion (e.g., chit chat) was relatively infrequent and came up in 4.8% of minutes.

Next, total minutes spent on each topic and method during consultation calls were examined over time. This allowed us to explore changes and patterns in the percentage of minutes spent on each topic and method over the course of the collaborative. To examine changes in call content and methods over time, codes from each call group (n = 4) were collapsed by call number across the span of the collaborative (see Figures 4a-4l and 5a-5f). Consistent with study hypotheses, discussion about the trauma narrative became increasingly more prevalent across calls, on average, compared to earlier calls. Results

showed that number of minutes of discussion related to flexible implementation of TF-CBT slightly increased across the course of the collaborative, with call 1 only including one minute of discussion related to flexibility and call 16 including 20% of minutes with discussion about flexibility, contrary to study hypotheses. Contrary to study hypotheses, there was no discernable pattern related to discussion of barriers (i.e., client-level barriers, provider-level barriers, and organizational-level barriers).

The mean percentage of minutes spent discussing case discussion ranged from approximately 37%-65% of minutes on calls. On calls 1-11, case discussion was discussed during 49-62% of minutes. The amount of time spent on case discussion then decreased slightly on calls 12-15 (34-44% of minutes), before increasing once again on the 16th call (65% of minutes), or final call. Minutes involving treatment questions (i.e., questions related to the general model and theory of TF-CBT and questions about how to do specific components of TF-CBT) was generally low, on average, about 10% of minutes, and showed little variability across most calls with the exception of a somewhat large increase on later calls.

Though no direct hypotheses were made regarding discussion of programmatic issues related to the learning collaborative, results indicate that most calls included approximately 8% of minutes of discussion of programmatic issues, with a sharp increase to 50% of minutes spent on this topic on the penultimate call. Over time, the percentage of minutes including talk about satisfaction or successes related to the collaborative experienced a slight increase, beginning at 5% of minutes and ending at 22% of minutes. Interestingly, though one of the main goals of the collaborative was to enhance community-wide collaboration, very little time was spent directly discussing

collaboration during consultation calls (*M* = 2%, calls 1-14), with the exception of calls 15 and 16 during which collaboration was discussed an average of 14% of minutes. Similarly, minutes involving peer consultation ranged from 0-9%, with only 3% of minutes including peer consultation, on average. Technology issues related to use of call technology (e.g., call-in details, voice conferencing software) indicated no discernable pattern, but were present on all but one call. Lastly, other discussion topics and off-task talk appeared on most calls at low rates.

Changes in methods used by consultants on calls over time were examined. The amount of time spent on case presentation, didactics, and questioning mostly remained constant across calls, contrary to study hypotheses indicating that we expected to see a marked decrease in didactics on later calls. Overall, these three methods were used at a high rate, at or above about 45% of minutes on average across calls. Use of active learning strategies, including modeling and role-play, occurred at a lower rate of about 12% of minutes on average across calls. During calls 12-15, facilitation and discussion of case presentation decreased while the number of minutes of active learning strategies slightly increased. Though it is unclear whether the observed decrease in time spent on case presentation is related to the increase active learning strategies, this warrants further consideration. Consultants used other strategies not captured in the previously mentioned categories (e.g., praise, validation, agenda setting) during 37% of minutes on average. Finally, off-task discussion slightly increased toward the end of the collaborative but generally occurred in few minutes on average (*M* = 5% of call minutes).

Aim 2. Aim 2 examined predictors of provider engagement in consultation, including number of calls attended, number of case presentations on consultation calls,

and number of minutes spent talking during calls. First, descriptive analyses for consultation call attendance and number of case presentations on call are presented in Figures 5 and 6. Consistent with study hypotheses, these descriptive analyses suggest that may have been difficult for providers to fully engage in consultation. Although all providers participated in at least one call, only 25 providers (53%) attended the 12 consultation calls required for certification. Examination of case presentations during calls indicated that nearly three-quarters (n = 35, 74%) of providers completed the required 2 case presentations during consultation calls, whereas 6 providers (13%) completed a single case presentation, while another 6 providers (13%) did not complete any case presentations during calls.

A description of provider demographic and professional characteristics, and provider ratings on study measures at baseline are displayed in Table 1. Table 2 presents correlations between study variables. Analyses examining provider demographic characteristics (age, gender, and race and ethnicity) as predictors of engagement in consultation are displayed in Table 3. Results demonstrated that providers who identified as other racial minorities (i.e., including American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, and Other) spoke significantly fewer minutes during consultation calls relative to Caucasians (B = -1.17, p = .02). Age and gender were not significant predictors of consultation engagement.

Next, professional and practice characteristics, as well as baseline attitudes toward EBPs, EBP knowledge, and implementation climate and leadership were examined as predictors of consultation engagement (see Table 3). Of note, baseline attitudes toward EBPs, implementation climate, and implementation leadership indicated generally high

mean baseline attitudes toward EBP and ratings of positive implementation climate and leadership (see Table 1). Ratings of attitudes toward EBP ranged from 0 to 4, with 4 indicating more positive attitudes toward EBP. In the present study, the EBPAS mean total score was 3.00 (*SD* = .57), suggesting higher than average attitudes toward EBP when compared to Aarons and colleagues' (2004) original sample. Similarly, baseline provider ratings of implementation climate and leadership had mean scores of 2.47 (*SD* = .72) and 2.78 (*SD* = .86), respectively. Ratings of implementation climate and leadership were on a 5-point Likert scale ranging from 0-4, with 4 indicating more positive ratings of implementation climate and leadership. When predictors were entered separately, results indicated that Master's level providers were significantly less likely to attend calls than doctoral level providers (B = -2.06, $p < .001$), while more years of professional experience (B = .19, $p = .001$) significantly predicted attending more consultation calls. Being state licensed significantly predicted completing fewer case presentations during consultation calls (B = -1.58, $p = .02$). In contrast, having a greater average weekly caseload was significantly associated with completing more case presentations during calls (B = .04, $p = .009$). At the same time, supervisors were less likely to present a case on consultation calls relative to clinicians (B = -2.26, $p = <.001$). Regarding professional field, working in Juvenile Justice was predictive of completing a greater number of case presentations during consultation calls, when compared to social workers (B = 8.12, $p = .004$). Though no direct hypotheses were made regarding knowledge of TF-CBT at baseline, results demonstrated that greater TF-CBT knowledge significantly predicted attending more consultation calls (B = .06, $p = .03$) and speaking more minutes during calls (B = .05, $p <.001$). Theoretical orientation was not a significant predictor of

engagement. Contrary to study hypotheses, attitudes toward EBP and implementation climate and leadership were not associated with engagement.

All significant predictors were then entered simultaneously into models to examine their combined effects on each outcome. Having more years of professional experience continued to significantly predict participating in more consultation calls (B = .16, p = .016). However, neither degree nor baseline scores on a measure of TF-CBT knowledge remained significant predictors of consultation call attendance. Having a higher weekly caseload continued to be a significant predictor of number of case presentations on calls (B = .03, p = .04). Licensure status, professional role (supervisors vs. clinicians), and working in the juvenile justice system were no longer significant predictors of number of case presentations. Racial minority status and baseline TF-CBT knowledge no longer remained significant predictors of minutes spoke during consultation calls.

Additionally, it was planned to explore provider satisfaction with consultation and working alliance at mid- and post-CBLC and the relationship with engagement in consultation. Although it was hypothesized that higher satisfaction with consultation and more positive ratings of working alliance would be associated with increased engagement, response rates at mid- and post-CBLC did not allow for such analyses due to high rates of missing data at mid (40.4%) and post (70.2%). Even though Little's MCAR test indicated that the data were MCAR [χ^2 (350) = 328.50, p = .79], attempts to impute these data did not converge.

Instead, a series of Mann Whitney U tests were conducted to examine the relationship between provider engagement and scores on measures of satisfaction with

consultation and working alliance at mid- and post-CBLC. No significant differences were found at mid- and post-CBLC for providers who completed the required number of consultation calls and number of case presentations for certification and providers who did not meet these requirements, on provider-rated satisfaction with consultation and working alliance. There was no difference in provider satisfaction with consultation at mid-CBLC for providers who completed the required number of consultation calls (Mann-Whitney *U*-test $z = -.296$, $p = .772$) or for those who completed at least 2 case presentations (Mann-Whitney *U*-test $z = -.855$, $p = .427$). Similarly, no differences were found between providers (completion of required consultation calls and completion of required case presentations, respectively) at mid-CBLC on provider-rated working alliance (Mann-Whitney *U*-test $z = -.764$, $p = .468$; Mann-Whitney *U*-test $z = -.493$, $p = .635$). At post-CBLC, no differences between provider-rated satisfaction with consultation and working alliance were found between providers (completion of required consultation calls and completion of required case presentations, respectively). Specifically, on a measure of provider-rated satisfaction with consultation (Mann-Whitney *U*-test $z = -.873$, $p = .571$; Mann-Whitney *U*-test $z = -1.621$, $p = .143$), and on a measure of working alliance (Mann-Whitney *U*-test $z = -1.258$, $p = .286$; Mann-Whitney *U*-test $z = -1.510$, $p = .143$), results indicate no differences between providers.

Chapter 5: Discussion

As the field is increasingly more focused on dissemination and implementation science, it is becoming more important to identify effective implementation strategies while also understanding barriers and facilitators to engagement in ongoing support efforts following training in EBT. This study was one of the first to explore the types of topics discussed and methods used during consultation as a part of a community implementation of TF-CBT using observational coding, as well as predictors of provider engagement in consultation calls. Consistent with previous work, we found that it is difficult for providers to engage in consultation. In the present investigation, only 53% of providers completed the required 12 consultation calls for certification through the collaborative. As expected, examination of the content and methods of consultation calls revealed that case discussion was most frequently discussed and brought up by providers, and at the same time, consultants most commonly used case discussion and didactics to respond to provider questions and comments during calls. This study included an expanded set of facilitators and barriers to help increase our understanding of the most common types of barriers providers are citing during consultation.

When predictors of provider engagement were explored, we found that more years of professional experience and higher weekly caseload significantly predicted provider engagement in consultation. Contrary to hypotheses, provider attitudes toward EBP and implementation climate and leadership were not significantly related to engagement. Further, we did not find any differences between providers who attended the required number of consultation calls and presented at least two cases on calls on measures of consultation satisfaction and working alliance at mid- and post-CBLC.

Results of this study have implications for training and ongoing support efforts in community based implementation efforts.

There is a growing body of literature documenting the use of ongoing consultation to enhance implementation success compared to training alone (Beidas & Kendall, 2010; Herschell et al., 2010; Miller et al., 2004; Sholomskas et al., 2005). Though the importance of ongoing consultation is widely acknowledged, less is known about what takes place during consultation (Beidas & Kendall, 2010; Gleacher et al., 2011; Nadeem, Gleacher, Pimentel, et al., 2013). Similar to previous work, the present study found that a large proportion of time during calls included case discussion (Edmunds, 2014), which is widely considered one of the primary goals of consultation (Nadeem, Gleacher, & Beidas, 2013).

Consistent with study hypotheses, discussion of treatment questions most commonly included the trauma narrative, and more minutes were spent discussing the trauma narrative on later calls. This is likely due to the trauma narrative being a central focus of the treatment (i.e., TF-CBT implementation) and providers needing additional support with the trauma narrative as they began that part of treatment with their clients. A majority of providers reported having a CBT orientation, so it may have been the case that study providers were already familiar with CBT basics. Consequently, providers may have needed less time devoted to basic CBT components of TF-CBT and instead may have benefitted more from learning about unfamiliar or more advanced aspects of the EBT, such as the trauma narrative. In the present investigation, consultation calls frequently focused on provider questions about the trauma narrative and call leaders appeared to adapt calls to fit the needs of providers. However, it is unclear to what extent

this took place versus to what extent call leaders may have adhered to a predetermined agenda. Future training efforts would benefit from gathering background information about the providers to best adapt training and consultation to their needs to maximize the benefit of training, and would benefit from checking in with providers on each call to set call priorities.

Contrary to prediction, use of active learning strategies remained relatively constant but infrequent across calls, while didactics and case presentation were consistently the most commonly used methods used by consultants. Previous work examining the use of active learning techniques during consultation calls as part of an effort to implement CBT for youth anxiety found that these techniques were used at a rate comparable to the current study (Edmunds, Kendall, et al., 2013). Overall, these results provide further evidence that passive learning techniques are more commonly used during consultation calls compared to active learning strategies. As noted above, the majority of questions and discussion about TF-CBT treatment questions were about the trauma narrative. Although active learning strategies were used during calls, it may have been the case that more didactic means of instruction were used when discussing the trauma narrative, as this was novel to many providers. However, we do not have information on what topics were being addressed during the times that active learning strategies were being used. It would be interesting for future investigations to examine whether consultants base tailor their use of passive or active learning based on variables such as the topics being addressed during the call or clinician familiarity with the content being covered.

Although it was hypothesized that an equal amount of time would be spent on discussion of client-, provider-, and organizational-level barriers during consultation calls, results indicated that discussion of client-level barriers was relatively more common, occurring in 16.2% of minutes. Nonetheless, discussion of provider-level barriers was not uncommon and occurred in 7.0% of call minutes, whereas organizational-level barriers came up during just 2.6% of minutes. It may be the case that the primary focus of consultation calls is on consolidation and use of skills learned during training toward skill mastery, leaving less time to address a wider array of barriers and facilitators at the provider- and organizational-level. Or it may be that providers do not see their consultants as being able to assist with organizational barriers and would therefore be less likely to bring these up during calls. If this is the case, it may be important for future implementation efforts to consider building discussion of barriers and facilitators into the initial training and ongoing support efforts to help increase engagement by being able to preemptively addressing barriers to engagement providers may face at the client, provider, and organizational level. Incorporating regular check-ins from senior leadership could also ensure that all parties involved in the effort have the opportunity to discuss questions and concerns, and would further serve to increase collaboration within agencies.

Additionally, the CBLC model in the present study *required* participation from agency senior leadership in order for agencies to be included in the collaborative. Attitudes toward EBP at baseline, as measured by the EBPAS, indicated that providers had higher average baseline attitudes across subscales when compared to Aaron's (2004) original EBPAS sample. Study participants evidenced higher baseline scores on the

Appeal (*M* = 3.1, versus *M* = 2.9), Requirements (*M* = 3.0, versus *M* = 2.5), and Openness (*M* = 2.9, versus *M* = 2.5) scales, and lower scores on Divergence (*M* = .93, versus *M* = 1.3), compared to Aaron's (2004) original sample. Similarly, the study sample reported higher mean baseline scores on all 6 subscales of the ICS compared to Ehrhart and colleagues' (2014) original sample. Mean baseline scores compared to Ehrhart and colleagues (2014) are as follows: Focus on EBP (*M* = 3.2, versus *M* = 2.3), Educational Support for EBP (*M* = 2.9, versus *M* = 2.0), Recognition for EBP (*M* = 2.6, versus *M* = 1.7), Rewards for EBP (*M* = .8, versus *M* = .7), Selection for EBP (*M* = 2.3, versus *M* = 2.0), and Selection for Openness (*M* = 2.9, versus *M* = 2.8). Lastly, mean baseline scores on the ILS indicated more positive mean baseline scores relative to Aarons and colleagues' (2014) original sample. This included mean higher scores on all four subscales including providers viewing their supervisors as more Proactive (*M* = 2.3, versus *M* = 2.1), Knowledgeable (*M* = 2.9, versus *M* = 2.5), Supportive (*M* = 3.1, versus *M* = 2.6), and Perseverant (*M* = 3.0, versus *M* = 2.4). It is possible that these same findings would not hold for implementation efforts that do not involve participation from senior leadership, or from providers who do not have such positive attitudes toward EBP and implementation climate and leadership at baseline.

Surprisingly, though a key aspect of the CBLC model is to increase community-wide collaboration, discussion of collaboration occurred only during 2.3% of call minutes in the present study. Although increased collaboration was discussed during the initial training and learning sessions, it is interesting that continued discussion about collaboration did not arise more frequently during calls. Again, it may be that the primary focus of consultation is on skill mastery and clinically oriented issues. Additionally,

perhaps providers would not have identified the call consultants as point persons to go to with questions or concerns related to collaboration. Rather, perhaps discussions or check-ins about collaboration during calls would need to be initiated by call consultants, should this be a priority of consultation. At the same time, it may have been the case that because the senior leader and broker groups were not in attendance on clinical calls, that discussions about collaboration were instead discussed on other calls (e.g., senior leader calls) or at other points during the collaborative. As noted previously, discussions about organizational-level concerns or collaboration may be best addressed during meetings that involve all levels of stakeholders. Nonetheless, future work may consider how to more thoroughly incorporate specific a priori goals of the learning collaborative into ongoing support strategies.

As noted previously, the current study lends further support to the notion that it is difficult to get providers to engage in consultation calls (Ebert et al., 2012; Fritz et al., 2013; Hoagwood et al., 2007). Although no providers attended zero consultation calls, only 53% attended the number of consultation calls needed to meet certification requirements (i.e., at least 12 calls), suggesting considerable difficulties with engagement. The low rates of call attendance are similar to those found in other studies (Ebert et al., 2012), adding to existing evidence that presenting to consultation calls may be a primary challenge for providers. Of note, the mean number of calls attended by providers in the present study was 9.79 (*SD* = 4.16). Examination of distribution of call attendance illustrates that although only about half of providers reached the 12 call cutoff (53%), an additional 9% attended 11 calls, 4% attended 10 calls, and another 9% attended 9 calls, with a total of 75% of providers attending at least 9 calls. This suggests that

perhaps some providers who were just shy of participating in all 12 required calls still attempted to attend a large number of calls, but may have been unable to meet the full requirements for certification due to experiencing a variety of possible barriers. Therefore, although providers who missed just a few calls did not meet requirements for certification, it may be that they derived a similar benefit from consultation relative to providers who attended at least 12 calls. Future research should examine the relationship between consultation "dose" and outcomes such as treatment fidelity and client improvement to assess whether this certification cutoff is empirically justified. Further, even though providers were initially placed into a call group based on their availability, they were allowed flexibility to miss two of the 14 provided calls and could make up calls by attending another consultation group's call. Yet, the difficulty with attending calls may not be due to concerns about flexibility, but perhaps with perceived burden or experiencing numerous other demands on time. It will be important for future implementation and training efforts to incorporate these research questions into their efforts to better understand specific difficulties with engagement.

A second measure of engagement revealed that 74% of providers completed the 2 case presentations during consultation calls for certification requirements. This is somewhat surprising given that several providers cited difficulties getting cases, while other providers left their agencies or transferred to new agencies. However, this finding suggests that perhaps providers who were able to get training cases made a strong effort to present the required cases on calls. It is possible that it is more challenging for providers to *attend* consultation calls, perhaps due to scheduling conflicts or other demands on time, but once they are on a call they try to get the most out of the calls by

presenting a case. In the present collaborative, providers volunteered to present cases on a specific call date, suggesting that providers may be more likely to attend a call when they have an active role in that call, but may be less motivated to attend other calls. Increasing structure on consultation calls, such as by assigning case presentations at the start of the collaborative, may be one way to motivate providers to meet case presentation requirements. Though some time on calls was spent troubleshooting barriers to getting training cases, devoting additional time and resources to problem-solving and securing training cases for providers could help to increase engagement and completion of this requirement. This may need to be initiated by senior leadership at each agency and could be a priority on leadership calls. Providing adequate opportunities to secure training cases could remove one of the key barriers to engagement and may enable increased engagement and completion of case presentations, subsequently increasing the number of providers who are able to meet all requirements of the collaborative.

Despite encountering numerous barriers to getting training cases, a larger percentage of providers were able to complete the two required case presentations on calls compared to the percentage of providers who attended at least 12 required consultation calls (74% versus 53% of providers). Once again, this underscores the notion that it will be important for future training and supervision efforts to consider the smallest number of consultation calls needed to meet the goals of the training. Attendance data from this collaborative suggests that attending at least 12 consultation calls was challenging for providers, yet a larger majority of providers were able to attend at least 9 calls (75%). It may be that some providers begin to experience diminishing benefit from consultation once they attend a number of calls. Identifying at what point providers begin

to experience optimal benefit from consultation will be important to better increase engagement while decreasing burnout from training. Or, perhaps implementation and training efforts should consider ways to preemptively try to increase engagement in consultation. For example, perhaps sending out call agendas prior to consultation and eliciting feedback or questions from providers prior to calls would help providers to feel more invested or involved in consultation. Then, providers could have assurances that calls would be tailored to fit their specific needs and may see consultation as an asset versus a burden on time.

It will also be important to consider the structure of consultation calls to know to what extent calls differ among consultation groups or how adherent call leaders are to the planned goals of each call. For this study we did not gather data about the structure or goals of consultation calls. However, calls generally consisted of attendance and agenda setting, case presentations and/or didactics, and any administrative issues. It appeared that calls attempted to adhere to a planned topic of discussion (e.g., how to adapt the trauma narrative for a diversity of clients); however, at times, call discussion appeared to be flexible and seemed to adapt to provider challenges and needs. A deeper understanding of planned call structure, differences across calls as, well as when consultants generally adhered to calls and times when they might have been more flexible can inform future agenda-setting for consultation calls.

Additionally, it would be interesting to learn more about provider preferences about topics and the style of supervision on calls. Although these data were not collected in the present study, future work may explore the benefits and drawbacks of different models of supervision for a variety of implementation efforts to better understand optimal

ways of supporting adherence and sustained use of EBPs, as well as provider preferences. For example, understanding preferred topics such as case discussion, ongoing didactics, use of active learning strategies (e.g., modeling, role play), or discussion of programmatic issues, to name a few, could further help optimize ongoing support efforts.

Although several individual predictors were associated with engagement, when significant predictors were entered simultaneously, two seemed to be driving the findings. First, providers with more years of professional experience attended more calls. It may be providers with more years of experience have learned to value and appreciate collaborating with or learning from other providers and supervisors. Or, it could be that more time has passed since these providers have finished their degree, making them more willing to engage in additional training or to seek opportunities to learn from other providers. For providers who already have a high baseline knowledge of TF-CBT, they may be more likely to attend consultation calls as a way to meet their higher training needs. For example, as the first learning session primarily focuses on skill acquisition, basics of the treatment, and goals of the collaborative, perhaps providers with greater TF-CBT knowledge seek to use consultation as a means to address more complex questions or novel topics (e.g., trauma narrative), issues, or barriers related to TF-CBT or the collaborative (e.g., How to flexibly implement the treatment). Additionally, providers may have liked TF-CBT, perhaps due to this treatment filling a gap in their training, which could have motivated them to get additional training. Future implementation efforts may consider other ways to encourage engagement, such as providing CEUs for attending or participating in consultation calls.

Previous work examining demographic and clinical predictors of consultation engagement is scant and has not found any demographic or professional variables related to engagement in consultation (Fritz et al., 2013). Therefore, it may be that more years of professional experience is related to greater knowledge of TF-CBT, as greater knowledge was a significant predictor of call attendance and speaking more minutes during consultation calls, but only when predictors were entered separately. Previous work has found that providers who were more engaged in consultation reported greater TF-CBT knowledge at post-study when compared to providers who did not engage in consultation (Fritz et al., 2013). Consistent with this idea, correlations between these variables in the present study indicate a significant positive relationship (all *p*'s < .05) between greater TF-CBT knowledge at baseline, attending more calls, and speaking more minutes on calls. It is further possible that more years of professional experience is related to attitudes toward EBP. In this case, correlations (see Table 2) suggest a significant negative relationship between years of professional experience and more positive attitudes toward EBP ($p < .5$).

Second, having a higher weekly caseload was significantly associated with completing more case presentations. This finding is not surprising, given that these clinicians likely had an easier time finding training cases to present. In addition, perhaps providers with greater caseloads appreciate additional feedback and supervision on challenging cases, when possible. Consequently, they may be more likely to make time to attend supervision or consultation. Such differences highlight potential important differences between definitions of engagement. The pattern observed with these results may be due to more experienced providers prioritizing and valuing attending consultation

to further their training, while at the same time not necessarily being highly participatory on calls perhaps due to lacking specific questions and concerns to bring up. On the other hand, providers with higher caseloads may logically have an easier time identifying appropriate training cases to discuss on calls.

Although we predicted that more positive attitudes toward EBP, implementation climate, and implementation leadership would be associated with increased consultation engagement, this was not the case (cf. Fritz et al, 2013). Further, contrary to study hypotheses, scores on provider satisfaction with consultation and provider-rated working alliance were not significantly different between providers who did and did not engage in consultation. Once again, it is possible that we are seeing ceiling effects on these measures such that providers generally reported high levels of satisfaction with consultation and positive ratings of working alliance. These findings suggest that perhaps it may be important to consider additional predictors of engagement in consultation were not included in the present study. For example, it may be that practical barriers (e.g., time, productivity requirements) are actually the most robust predictors of provider engagement in consultation across providers. Future research may consider exploring provider-cited barriers to engagement more directly to better ascertain possible barriers to engagement.

This study had multiple strengths. It is one of the first to use live minute-to-minute coding to examine both content of topics discussed *and* consultative methods of ongoing consultation, resulting in a naturalistic investigation to better understand what takes place during consultation. Further, an expanded set of predictors deepens our understanding of who is more likely to engage in consultation calls. This study also

contains an expanded set of variables to examine predictors of engagement at several time points (i.e., baseline, mid-, and post-CBLC) during the learning collaborative to allow us to explore engagement over time.

Several study limitations should also be acknowledged. First, although providers were carefully selected for participation in the collaborative by identifying key players in the community involved with the provision of trauma-informed services for youth, several providers were not currently providing direct clinical services as a major part of their job. For example, a couple of supervisors noted that they were less likely to provide direct services, which led to increased difficulty securing training cases in order to meet certification requirements through the collaborative. Because examination of engagement in consultation was a key component of the present study, it is important to bear in mind that, in several cases, what might appear to be non-engagement may actually be related to a provider's role in the workplace (e.g., supervisor who generally does not provide direct clinical services) rather than being a precise indicator of non-engagement.

Another important study limitation is that the study did not include a measure to capture information about barriers and facilitators to engagement in consultation. This limits our understanding of potential key barriers and facilitators to engagement, as such concerns may not have been discussed during consultation calls. It may also be the case that providers most affected by barriers have increased difficulty attending calls, or it may be that some providers would have derived less benefit from calls. Therefore, it is possible that we would not have heard about specific barriers or facilitators faced by these providers. For example, providers who have increased difficulty attending calls may report increased organizational-level barriers, which could explain why the

frequency of discussion related to organizational-level barriers was low in the present study (i.e., providers facing barriers at the organizational-level may have been less likely to attend calls). It is also possible that providers who attended fewer calls may experience greater provider-level barriers, such as difficulty getting training cases. Providers who were not actively seeing training cases may have been less likely to attend calls perhaps in part due to having fewer questions about treatment delivery or client-level barriers. Future work should further explore barriers and facilitators to engagement through more direct means (i.e., provider-report of barriers and facilitators gathered at pre-training and throughout the collaborative) in order to gain a deeper understanding of provider barriers and facilitators during learning collaboratives and multicomponent trainings. Knowledge about perceived or actual barriers prior to the start of a collaborative could allow space to address such concerns during the initial training, thus potentially allowing opportunities to increase engagement.

The present study included a large number of providers who identified as having a CBT orientation (55.3%). Although this is similar to other recent studies on consultation (e.g., Beidas et al., 2012; Edmunds et al., 2013; Nelson et al., 2012), it is not clear whether this is representative of providers at agencies in the present study, or whether providers who had a CBT orientation were more likely to be selected or to opt-in to the collaborative. If study providers were more likely to have a CBT orientation relative to others within their agencies, this could have several important implications. First, it could be that these providers may have had more positive attitudes toward evidence-based treatments, as well as receiving additional training and supervision, which could have had a positive effect on engagement in the collaborative. Additionally, if study providers were

more likely to have a CBT orientation relative to others within their agencies, this may have affected the degree of support providers received from their agencies and/or supervisors. Further, differences in orientation could potentially impact the level and quality of ongoing support and supervision providers receive within their agencies both during and after the collaborative. These factors will be important to consider in future efforts to better understand how to optimize benefit from EBP training and ongoing support efforts.

Findings from the present study expand upon previous work examining what takes place during consultation and predictors of provider engagement in calls. The present investigation provides valuable information regarding the types of topics discussed on calls and the kinds of methods used by consultants. Consistent with previous work, case discussion was found to be the most common topic brought up by providers, while consultants were also observed to use didactics, questioning, and facilitation of case discussion during calls. This study also supports a converging picture that it is difficult for providers to engage in consultation. Results suggest that more years of professional experience and higher weekly caseload were significant positive predictors of provider engagement in calls. Future studies aimed at understanding provider engagement in ongoing support efforts should consider probing for information about potential barriers to engagement. Though the present study examined potential demographic and clinical characteristics, as well as provider baseline measures thought to be related to engagement, study results suggest there may be barriers related to engagement that were not measures in the current study (e.g., time, productivity requirements). Further, it will be important for future training and implementation efforts

to carefully consider the primary goals of implementation efforts and to consider incorporating these goals into a wider array of training activities. For example, the CBLC in the present study may have considered how to incorporate topics on collaboration into consultation calls. Importantly, future work should continue to identify barriers to engagement prior to training, in order to best increase potential for positive uptake and sustainability of EBPs into systems of care.

References

Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research, 6*(2), 61-74. doi:10.1023/B:MHSR.0000024351.12294.65

Aarons, G. A., Ehrhart, M. G., & Farahnak, L. R. (2014). The implementation leadership scale (ILS): Development of a brief measure of unit level implementation leadership. *Implementation Science, 9*(1), 45. doi:10.1186/1748-5908-9-45

Aarons, G. A., Ehrhart, M. G., Farahnak, L. R., & Sklar, M. (2014). The role of leadership in creating a strategic climate for evidence-based practice implementation and sustainment in systems and organizations. *Frontiers in Public Health Services and Systems Research, 3*(4), 3. doi:10.13023/FPHSSR.0304.03

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285. doi:10.1037/0003-066X.61.4.271

Baer, J. S., Rosengren, D. B., Dunn, C. W., Wells, E. A., Ogle, R. L., & Hartzler, B. (2004). An evaluation of workshop training in motivational interviewing for addiction and mental health clinicians. *Drug and Alcohol Dependence, 73*(1), 99-106. doi:10.1016/j.drugalcdep.2003.10.001

Baraldi, A. N., & Enders, C. K. (2010). An introduction to modern missing data analyses. *Journal of School Psychology, 48*(1), 5-37. doi:10.1016/j.jsp.2009.10.001

Beidas, R. S., Edmunds, J. M., Marcus, S. C., & Kendall, P. C. (2012). Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services, 63*(7), 660-665. doi:10.1176/appi.ps.201100401

Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice, 17*(1), 1-30. doi:10.1111/j.1468-2850.2009.01187.x

California Department of Mental Health. (2010). Mental Health Services Act (Proposition 63). Retrieved from http://www.dhcs.ca.gov/services/MH/Documents/MHSAafterAB100.pdf

Caplan, G., & Caplan, R. B. (1993). *Mental Health Consultation and Collaboration*: Jossey-Bass Publishers San Francisco, CA.

Cohen, J. A. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 20*(1), 37-46. doi:10.1177/001316446002000104

Cook, J., Biyanova, T., & Coyne, J. (2009). Barriers to adoption of new treatments: An internet study of practicing community psychotherapists. *Administration and Policy in Mental Health and Mental Health Services Research, 36*(2), 83-90. doi:10.1007/s10488-008-0198-3

Cooper, J. L., & Aratani, Y. (2009). The status of states' policies to support evidence-based practices in children's mental health. *Psychiatric Services, 60*, 1672-1675. doi:10.1176/ps.2009.60.12.1672

DH Mental Health Programme. (2008). *Improving access to psychological therapies implementation plan: National guidelines for regional delivery* Retrieved from http://www.iapt.nhs.uk/silo/files/implementation-plan-national-guidelines-for-regional-delivery.pdf

Ebert, L., Amaya-Jackson, L., Markiewicz, J. M., Kisiel, C., & Fairbank, J. A. (2012). Use of the breakthrough series collaborative to support broad and sustained use of evidence-based trauma treatment for children in community practice settings. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(3), 187-199. doi:10.1007/s10488-011-0347-y

Eccles, M. P., Armstrong, D., Baker, R., Cleary, K., Davies, H., Davies, S., . . . Leng, G. (2009). An implementation research agenda. *Implementation Science, 4*(1), 18. doi:10.1186/1748-5908-4-18

Eccles, M. P., & Mittman, B. S. (2006). Welcome to implementation science. *Implementation Science, 1*(1), 1. doi:10.1186/1748-5908-1-1

Edmunds, J. M. (2014). *An examination of active learning as an ingredient of consultation following training in cognitive-behavioral therapy for youth anxiety.* (74), ProQuest Information & Learning, US. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2014-99081-088&site=ehost-live Available from EBSCOhost psyh database.

Edmunds, J. M., Beidas, R. S., & Kendall, P. C. (2013). Dissemination and implementation of evidence–based practices: Training and consultation as implementation strategies. *Clinical Psychology: Science and Practice, 20*(2), 152-165. doi:10.1111/cpsp.12031

Edmunds, J. M., Kendall, P. C., Ringle, V. A., Read, K. L., Brodman, D. M., Pimentel, S. S., & Beidas, R. S. (2013). An examination of behavioral rehearsal during consultation as a predictor of training outcomes. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(6), 456-466. doi:10.1007/s10488-013-0490-8

Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology, 37*(3), 322-329. doi:10.1037/0022-0167.37.3.322

Ehrhart, M. G., Aarons, G. A., & Farahnak, L. R. (2014). Assessing the organizational context for EBP implementation: the development and validity testing of the Implementation Climate Scale (ICS). *Implementation Science, 9*, 157. doi:10.1186/s13012-014-0157-1

Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531-540. doi:10.1177/1049731509335549

Fixsen, D. L., Naoom, S. F., Blase, K. A., & Friedman, R. M. (2005). Implementation research: A synthesis of the literature.

Forsetlund, L., Bjørndal, A., Rashidian, A., Jamtvedt, G., O'Brien, M. A., Wolf, F., . . . Oxman, A. D. (2009). Continuing education meetings and workshops: Effects on professional practice and health care outcomes. *Cochrane Database System Review, 2*(2). doi:10.1002/14651858.CD003030.pub2

Fritz, R. M., Tempel, A. B., Sigel, B. A., Conners-Burrow, N. A., Worley, K. B., & Kramer, T. L. (2013). Improving the dissemination of evidence-based treatments: Facilitators and barriers to participating in case consultation. *Professional Psychology: Research and Practice, 44*(4), 225-230. doi:10.1037/a0033102

Gleacher, A. A., Nadeem, E., Moy, A. J., Whited, A. L., Albano, A. M., Radigan, M., . . . Eaton Hoagwood, K. (2011). Statewide CBT training for clinicians and supervisors treating youth: The New York State evidence based treatment dissemination center. *Journal of Emotional and Behavioral Disorders, 19*(3), 182-192. doi:10.1177/1063426610367793

Glisson, C., & Schoenwald, S. K. (2005). The ARC organizational and community intervention strategy for implementing evidence-based children's mental health treatments. *Mental Health Services Research, 7*(4), 243-259. doi:10.1007/s11020-005-7456-1

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Quarterly, 82*(4), 581-629. doi:10.1111/j.0887-378X.2004.00325.x

Grimshaw, J. M., & Eccles, M. P. (2004). Is evidence-based implementation of evidence-based care possible? *Medical Journal of Australia, 180*(6), S50.

Haine-Schlagel, R., Brookman-Frazee, L., Janis, B., & Gordon, J. (2013). Evaluating a learning collaborative to implement evidence-informed engagement strategies in community-based services for young children. *Child & Youth Care Forum, 42*(5), 457-473. doi:10.1007/s10566-013-9210-5

Herschell, A. D., Kolko, D. J., Baumann, B. L., & Davis, A. C. (2010). The role of therapist training in the implementation of psychosocial treatments: A review and critique with recommendations. *Clinical Psychology Review, 30*(4), 448-466. doi:10.1016/j.cpr.2010.02.005

Hoagwood, K. E., & Olin, S. S. (2002). The NIMH Blueprint for Change Report: Research Priorities in Child and Adolescent Mental Health. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(7), 760-767. doi:10.1097/00004583-200207000-00006

Hoagwood, K. E., Vogel, J. M., Levitt, J., D'Amico, P. J., Paisner, W. I., Kaplan, S. J., & Hamilton, J. D. (2007). Implementing an evidence-based trauma treatment in a state system after September 11: The CATS project. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(6), 773-779. doi:10.1097/chi.0b013e3180413def

IHI (Institute for Healthcare Improvement). (2003). *The Breakthrough Series: IHI's Collaborative Model for achieving breakthrough improvement*. Retrieved from Boston:

Jensen-Doss, A., Hawley, K. M., Lopez, M., & Osterberg, L. D. (2009). Using evidence-based treatments: The experiences of youth providers working under a mandate. *Professional Psychology: Research and Practice, 40*(4), 417. doi:10.1037/a0014690

Kataoka, S., Zhang, L., & Wells, K. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*(9), 1548-1555. doi:10.1176/appi.ajp.159.9.1548

Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling and Development, 77*(4), 447. doi:10.1002/j.1556-6676.1999.tb02472.x

Lai, M. H. C., & Kwok, O.-m. (2015). Examining the rule of thumb of not using multilevel modeling: The "design effect smaller than two"rule. *The Journal of Experimental Education, 83*(3), 423-438. doi:10.1080/00220973.2014.907229

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *biometrics, 33*(1), 159-174. doi:10.2307/2529310

Levin, A. (2009). Evidence-based therapies encounter difficulty transitioning into practice. *Psychiatric News, 44*, 15-29.

Lomas, J. (1993). Diffusion, dissemination, and implementation: who should do what? *Annals of the New York Academy of Sciences, 703*(1), 226-237. doi:10.1111/j.1749-6632.1993.tb26351.x

Lyon, A. R., Stirman, S. W., Kerns, S. E., & Bruns, E. J. (2011). Developing the mental health workforce: Review and application of training approaches from multiple disciplines. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(4), 238-253. doi:10.1007/s10488-010-0331-y

Masi, R., & Cooper, J. L. (2006). *Children's mental health: Facts for policymakers*. New York: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist, 65*(2), 73. doi:10.1037/a0018121

Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology, 72*(6), 1050. doi:10.1037/0022-006X.72.6.1050

Nadeem, E., Gleacher, A., & Beidas, R. S. (2013). Consultation as an implementation strategy for evidence-based practices across multiple contexts: Unpacking the black box. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(6), 439-450. doi:10.1007/s10488-013-0502-8

Nadeem, E., Gleacher, A., Pimentel, S., Hill, L. C., McHugh, M., & Hoagwood, K. E. (2013). The role of consultation calls for clinic supervisors in supporting large-scale dissemination of evidence-based treatments for children. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(6), 530-540. doi:10.1007/s10488-013-0491-7

Nadeem, E., Olin, S. S., Hill, L. C., Hoagwood, K. E., & Horwitz, S. M. (2013). Understanding the components of quality improvement collaboratives: A systematic literature review. *Milbank Quarterly, 91*(2), 354-394. doi:10.1111/milq.12016

Nadeem, E., Olin, S. S., Hill, L. C., Hoagwood, K. E., & Horwitz, S. M. (2014). A literature review of learning collaboratives in mental health care: Used but untested. *Psychiatric Services, 65*(9), 1088-1099. doi:10.1176/appi.ps.201300229

Nelson, M. M., Shanley, J. R., Funderburk, B. W., & Bard, E. (2012). Therapists' attitudes toward evidence-based practices and implementation of parent–child interaction therapy. *Child Maltreatment, 17*(1), 47-55. doi:10.1177/1077559512436674

Nelson, T. D., & Steele, R. G. (2007). Predictors of practitioner self-reported use of evidence-based practices: Practitioner training, clinical setting, and attitudes toward research. *Administration and Policy in Mental Health and Mental Health Services Research, 34*(4), 319-330. doi:10.1007/s10488-006-0111-x

Ogden, T., & Fixsen, D. L. (2014). Implementation science: A brief overview and a look ahead. *Zeitschrift für Psychologie, 222*(1), 4-11. doi:10.1027/2151-2604/a000160

Pemberton, J. R., Conners-Burrow, N. A., Sigel, B. A., Sievers, C. M., Stokes, L. D., & Kramer, T. L. (2015). Factors associated with clinician participation in TF-CBT post-workshop training components. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-10. doi:10.1007/s10488-015-0677-2

Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., . . . Schieve, L. A. (2013). Mental health surveillance among children-United States, 2005-2011. *Morbidity and Mortality Weekly Report, 62*(Suppl 2), 1-35.

Powell, B. J., McMillen, J. C., Proctor, E. K., Carpenter, C. R., Griffey, R. T., Bunger, A. C., . . . York, J. L. (2012). A compilation of strategies for implementing clinical innovations in health and mental health. *Medical Care Research and Review, 69*(2), 123-157. doi:10.1177/1077558711430690

President's New Freedom Commission on Mental Health. (2004). *Report of the President's New Freedom Commission on Mental Health*. Retrieved from http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html

Rakovshik, S. G., & McManus, F. (2010). Establishing evidence-based training in cognitive behavioral therapy: A review of current empirical findings and theoretical guidance. *Clinical Psychology Review, 30*(5), 496-516. doi:10.1016/j.cpr.2010.03.004

Schoenwald, S. K., Chapman, J. E., Kelleher, K., Hoagwood, K. E., Landsverk, J., Stevens, J., . . . Rolls-Reutz, J. (2008). A survey of the infrastructure for children's mental health services: Implications for the implementation of empirically supported treatments (ESTs). *Administration and Policy in Mental Health and Mental Health Services Research, 35*(1-2), 84-97. doi:10.1007/s10488-007-0147-6

Schoenwald, S. K., Sheidow, A. J., & Letourneau, E. J. (2004). Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. *Journal of Clinical Child and Adolescent Psychology, 33*(1), 94-104. doi:10.1207/S15374424JCCP3301_10

Shapiro, C. J., Prinz, R. J., & Sanders, M. R. (2011). Facilitators and barriers to implementation of an evidence-based parenting intervention to prevent child maltreatment: The Triple P-Positive Parenting Program. *Child Maltreatment, 17*(1), 86-95. doi:10.1177/1077559511424774

Sholomskas, D. E., Syracuse-Siewert, G., Rounsaville, B. J., Ball, S. A., Nuro, K. F., & Carroll, K. M. (2005). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 73*(1), 106. doi:10.1037/0022-006X.73.1.106

Stirman, S. W., Bhar, S. S., Spokas, M., Brown, G. K., Creed, T. A., Perivoliotis, D., . . . Beck, A. T. (2010). Training and consultation in evidence-based psychosocial treatments in public mental health settings: The ACCESS model. *Professional Psychology: Research and Practice, 41*(1), 48-56. doi:10.1037/a0018099

Stirman, S. W., Buchhofer, R., McLaulin, J. B., Evans, A. C., & Beck, A. T. (2009). Public-academic partnerships: The Beck Initiative: A partnership to implement cognitive therapy in a community behavioral health system. *Psychiatric Services, 60*(10), 1302-1304. doi:10.1176/ps.2009.60.10.1302

The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment. (2001). *Blueprint for Change: Research on Child and Adolescent Mental Health*. Washington, D.C.

U.S. Surgeon General. (1999). *Mental Health: A Report of the Surgeon General - Executive Summary*. Retrieved from Rockville, MD: http://www.surgeongeneral.gov/library/mentalhealth/summary.html

Weisz, J., Bearman, S. K., Santucci, L. C., & Jensen-Doss, A. (2017). Initial test of a principle-guided approach to transdiagnostic psychotherapy with children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 46*(1), 44-58. doi:10.1080/15374416.2016.1163708

Figure 1. Venn Diagram of coding rules for double-counting content codes

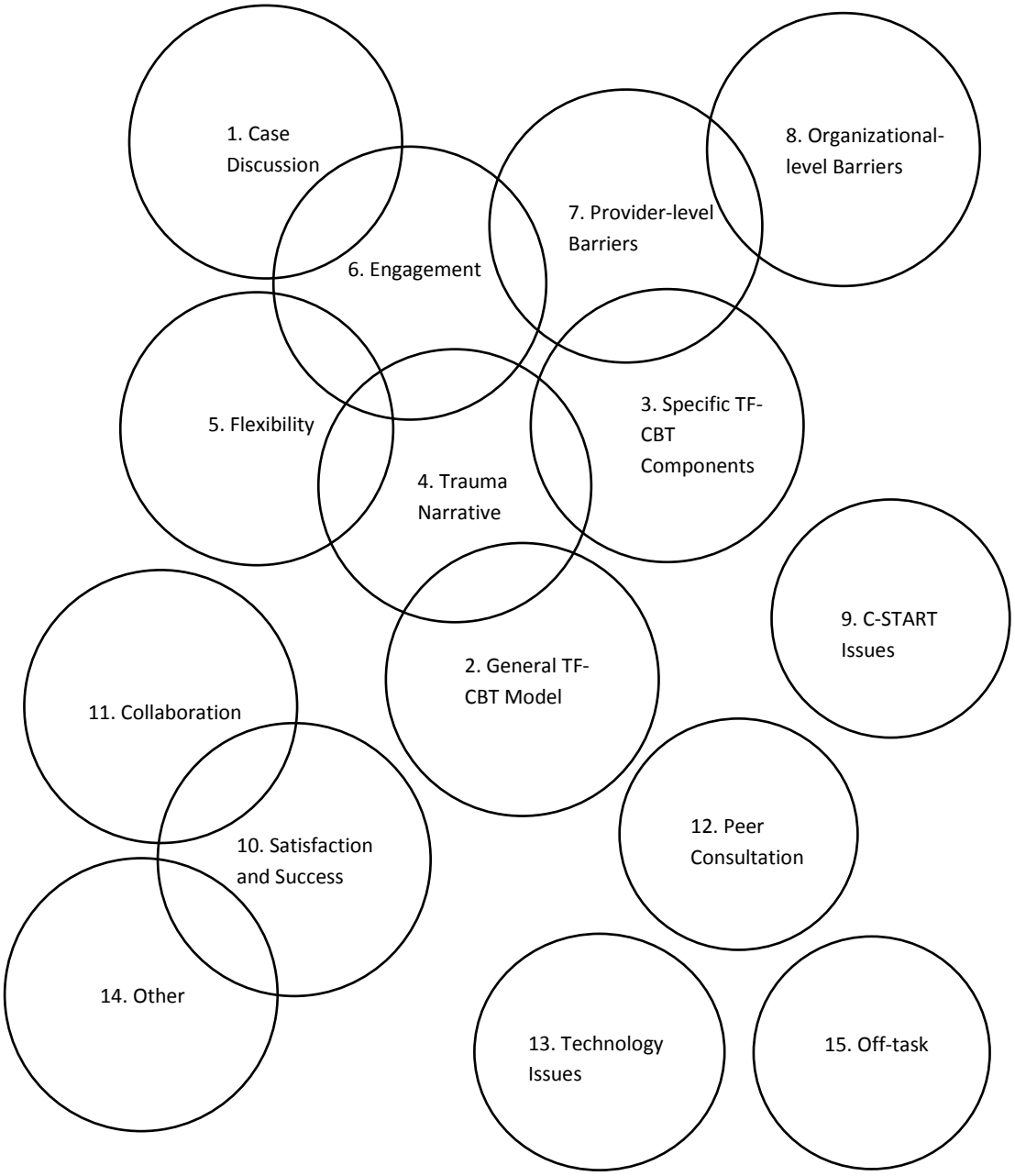

Figure 1. Venn diagram depicting how content codes were applied and how verbalizatons were double-coded during live minute-to-minute coding of consultation calls. See Appendix A for additional details and coding examples.

Figure 2. % Total minutes topic was discussed during consultation calls

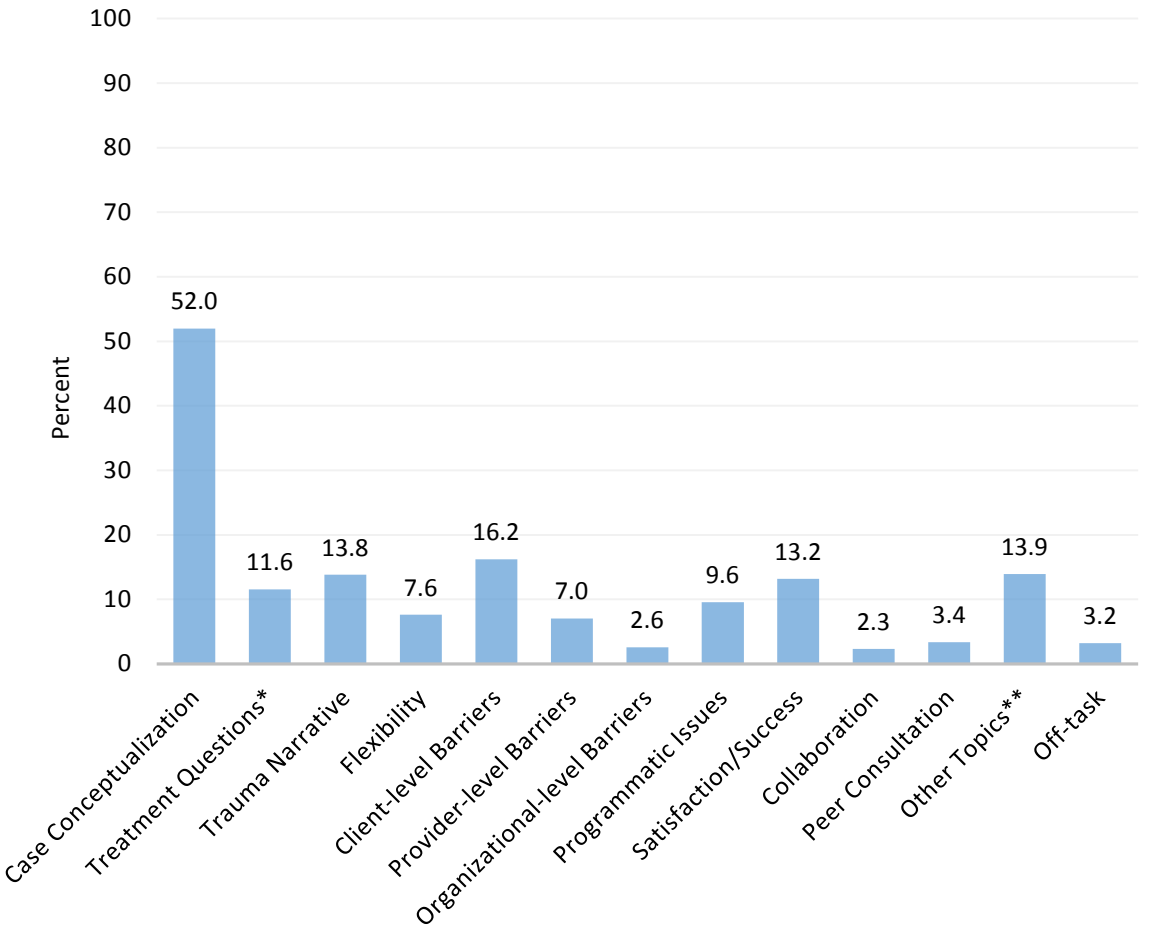

Figure 2. Percent of total minutes topic was discussed across consultation calls.[1]

1. Percents do not sum to 100. For each minute during calls, coders indicated Yes if a topic was discussed, allowing multiple topics to be discussed each minute. Therefore, the graph represents the percent of minutes within calls each topic was discussed.

*Includes questions about the general TF-CBT model and How to do TF-CBT

**Includes questions and difficulties with use of Technology during calls

Figure 3. % Total minutes method was used during consultation calls

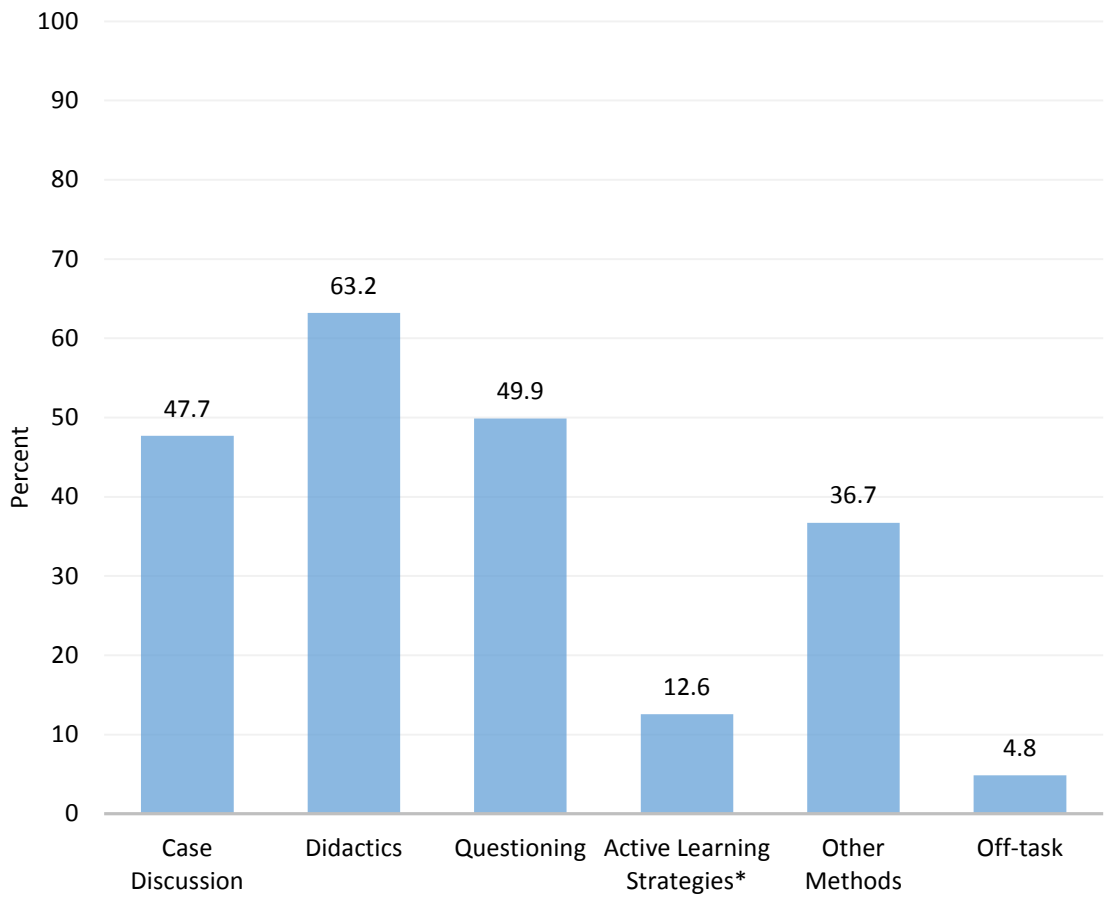

Figure 3. Percent total minutes consultative method was used during consultation calls.[1]
1. Percents do not sum to 100. For each minute during calls, coders indicated Yes if a method was used, allowing multiple methods to be used each minute. Therefore, the graph represents the percent of minutes within calls each method was used by consultants.
*Includes Modeling and Role-Play

Figures 4(a-l). Mean % minutes of each content code across consultation call groups

Figure 4a.

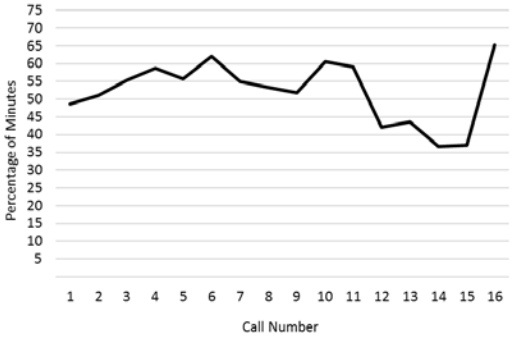

Figure 4a. Mean percent of minutes Case Conceptualization was discussed across consultation calls

Figure 4b.

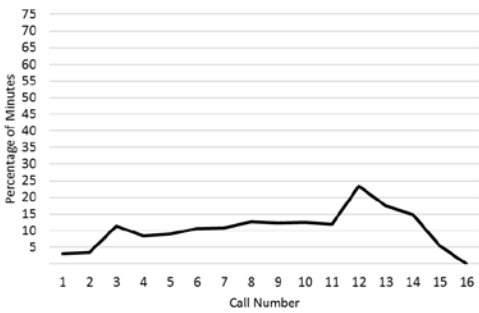

Figure 4b. Mean percent of minutes Treatment Questions were discussed across consultation calls
1. Summation of the following codes: Why, How To

Figure 4c.

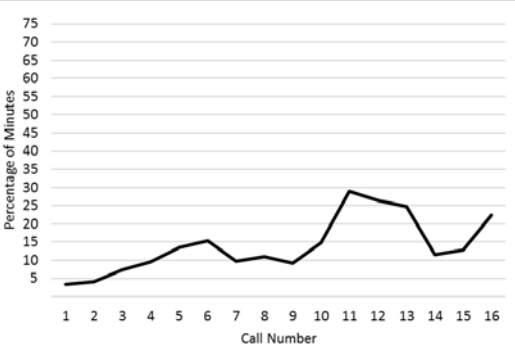

Figure 4c. Mean percent of minutes Trauma Narrative was discussed across consultation calls

Figure 4d.

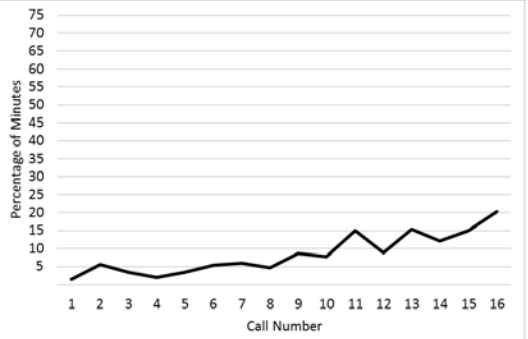

Figure 4d. Mean percent of minutes Flexibility was discussed across consultation calls

Figure 4e.

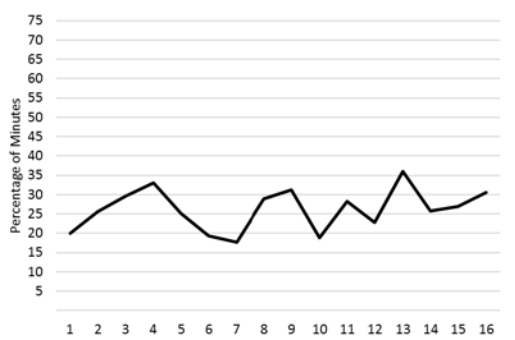

Figure 4e. Mean percent of minutes Barriers were discussed across calls.
1. Summation of the following codes: Client Engagement, Provider-Level Barriers, and Organizational-Level Barriers

Figure 4f.

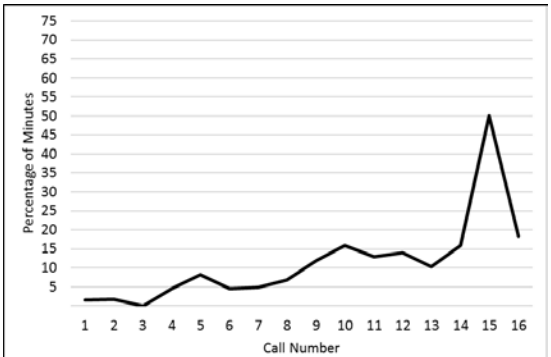

Figure 4f. Mean percent of minutes Programmatic Issues were discussed across consultation calls

Figure 4g.

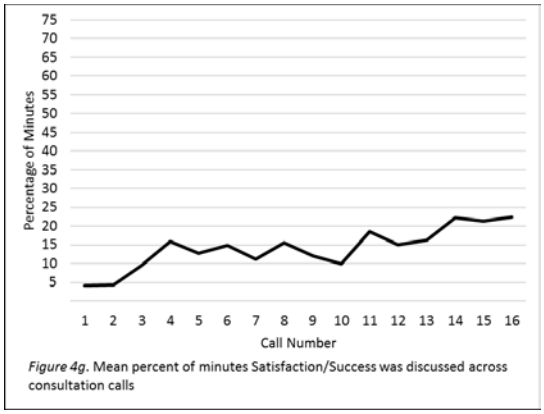

Figure 4g. Mean percent of minutes Satisfaction/Success was discussed across consultation calls

Figure 4h.

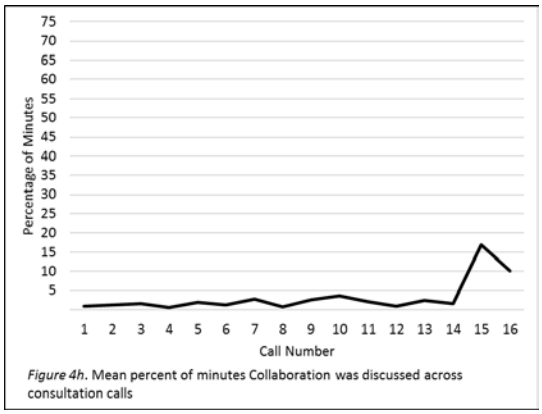

Figure 4h. Mean percent of minutes Collaboration was discussed across consultation calls

Figure 4i.

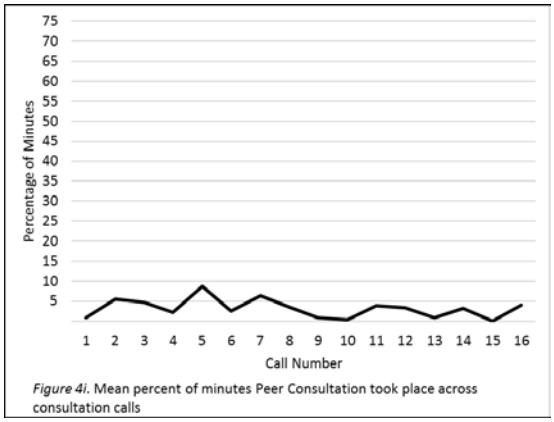

Figure 4i. Mean percent of minutes Peer Consultation took place across consultation calls

Figure 4j.

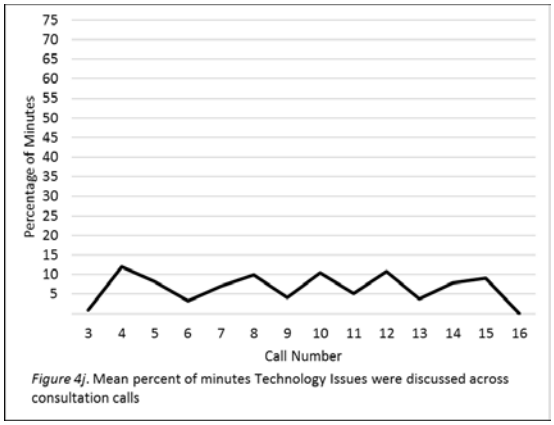

Figure 4j. Mean percent of minutes Technology Issues were discussed across consultation calls

Figure 4k.

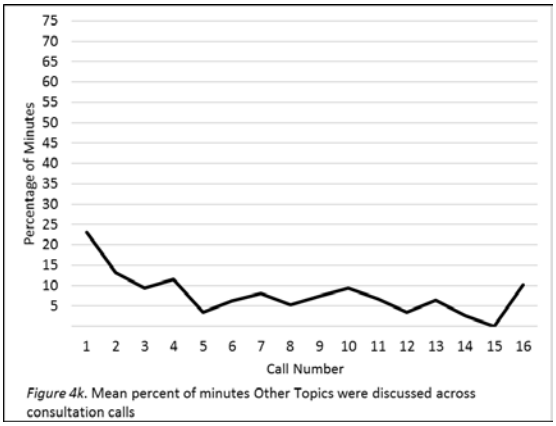

Figure 4k. Mean percent of minutes Other Topics were discussed across consultation calls

Figure 4l.

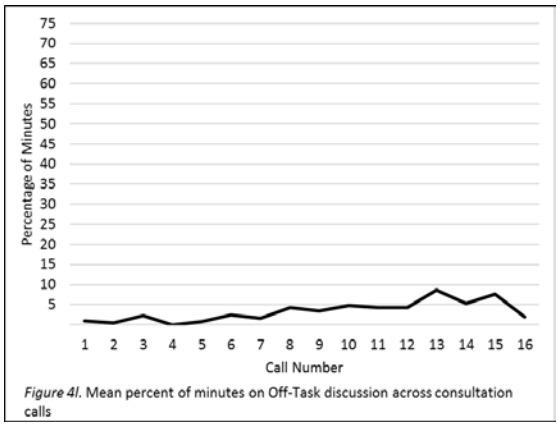

Figure 4l. Mean percent of minutes on Off-Task discussion across consultation calls

Figure 5 (a-f). Mean % minutes of each method code across consultation call groups

Figure 5a.

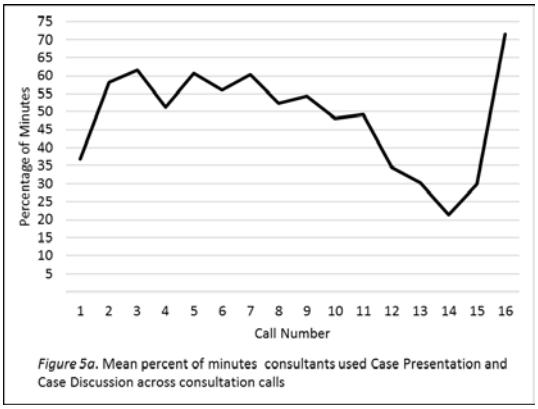

Figure 5a. Mean percent of minutes consultants used Case Presentation and Case Discussion across consultation calls

Figure 5b.

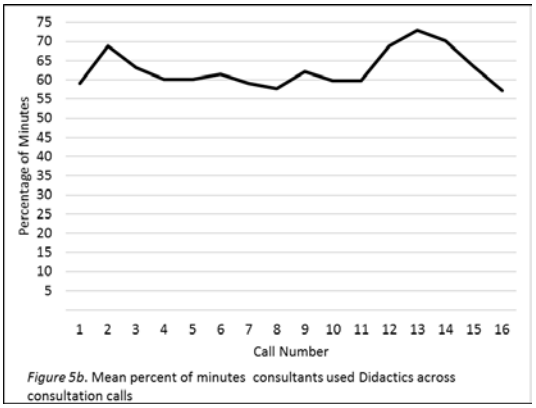

Figure 5b. Mean percent of minutes consultants used Didactics across consultation calls

Figure 5c.

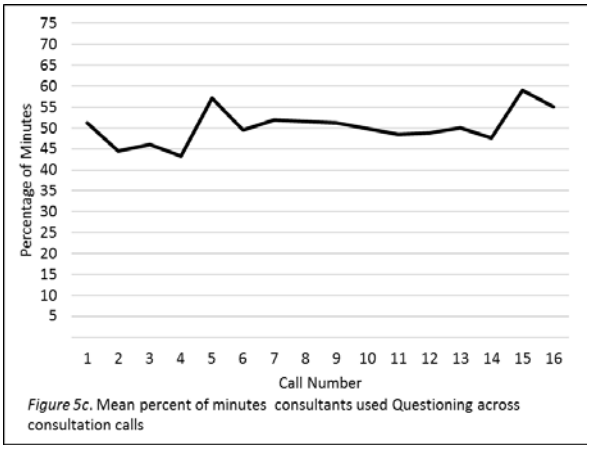

Figure 5c. Mean percent of minutes consultants used Questioning across consultation calls

Figure 5d.

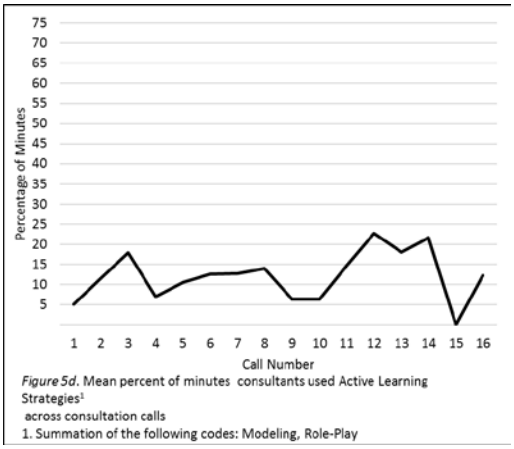

Figure 5d. Mean percent of minutes consultants used Active Learning Strategies[1] across consultation calls

1. Summation of the following codes: Modeling, Role-Play

Figure 5e.

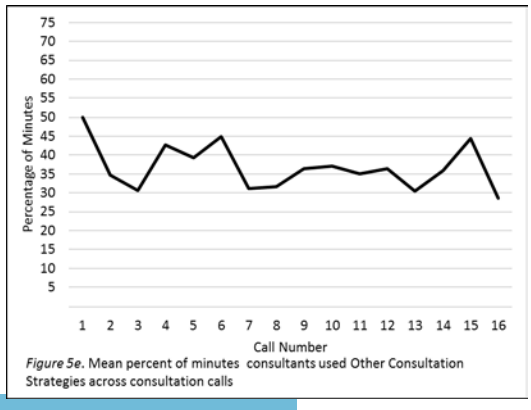

Figure 5e. Mean percent of minutes consultants used Other Consultation Strategies across consultation calls

Figure 5f.

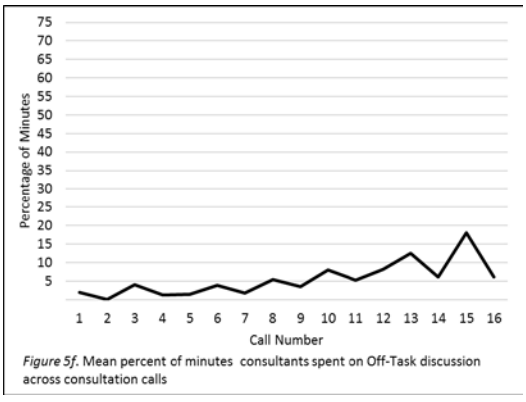

Figure 5f. Mean percent of minutes consultants spent on Off-Task discussion across consultation calls

Figure 6. Number of consultation calls attended by providers

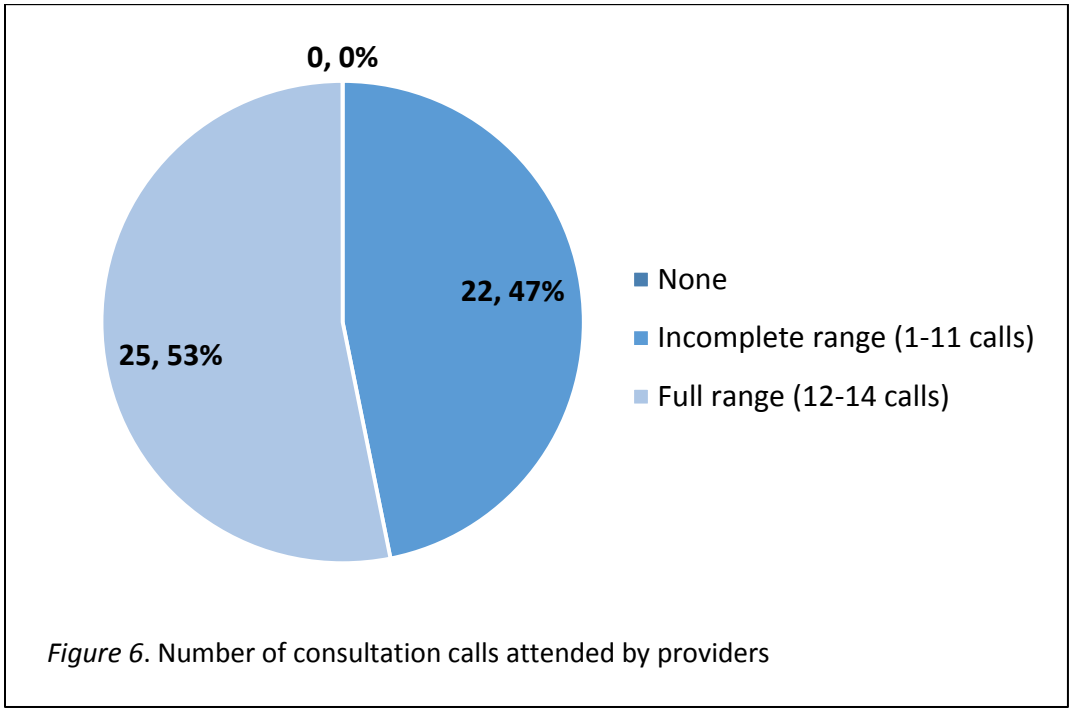

Figure 6. Number of consultation calls attended by providers

Figure 7. Number of case presentations on consultation calls

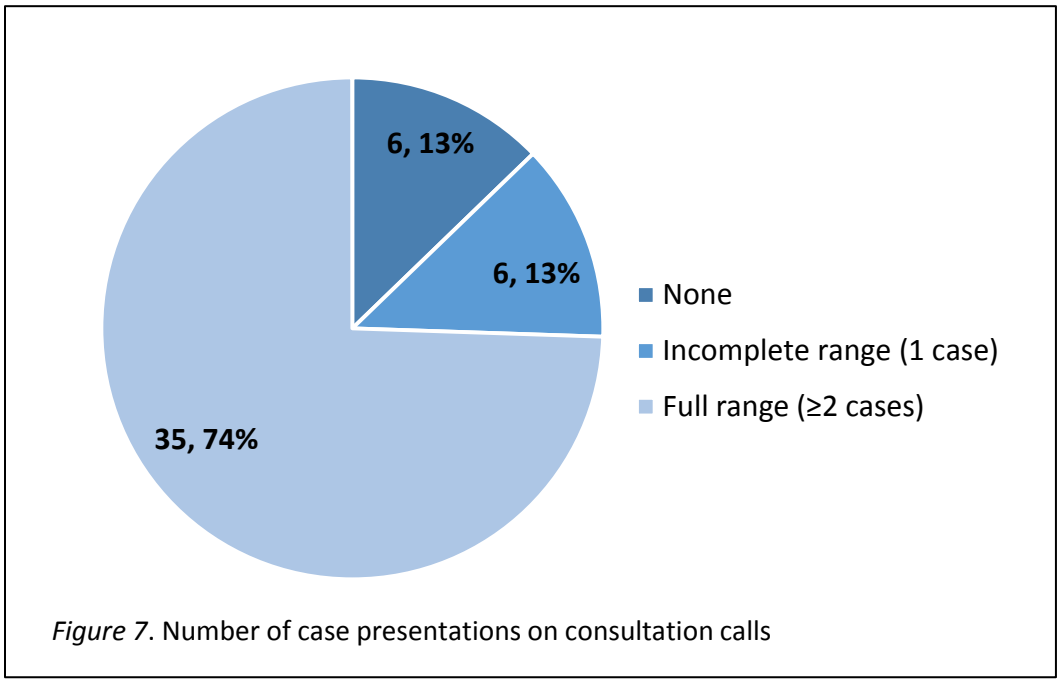

Figure 7. Number of case presentations on consultation calls

Table 1. Provider Demographic and Professional Characteristics

	Total Sample (*N*= 47)
Demographic Characteristics	
Mean (SD) Age	40.0 (10.7)
% Male	8.5%
% Caucasian	70.2%
% African American	19.1%
% American Indian/Alaskan Native	2.1%
% Native Hawaiian/Other Pacific Islander	2.1%
% Hispanic	57.4%
Professional/Practice Characteristics	
Degree	
% MS/MA	40.4%
% MSW	34.0%
% Psy.D.	19.1%
% Ph.D.	2.1%
% Other	4.3%
Professional Field	
% Counseling	27.7%
% Psychology	10.6%
% Social Work	31.9%
% Child Welfare/Child Protection	4.3%
% Marriage and Family Therapy	8.5%
% Juvenile Justice	2.1%
% Other	10.6%
% Licensed	38.3%
Mean (SD) Years of Professional Experience	8.1 (7.7)
Theoretical Orientation	
% CBT	55.3%
% Eclectic	4.3%
% Solution-focused	2.1%
% Person-centered	4.3%
% Psychodynamic	2.9%
% Social work field	2.1%
% None	2.1%
Mean (SD) Average Weekly Caseload	18.5 (18.8)
Mean (SD) Minutes Spoke During Calls	3.09 (2.21)
Mean (SD) Call Attendance	9.79 (4.16)
Mean (SD) Case Presentations	3.85 (3.06)
Baseline Measures	
Mean (SD) EBPAS Total	3.00 (.57)
Mean (SD) EBPAS Appeal	3.10 (.64)
Mean (SD) EBPAS Requirements	2.96 (.93)
Mean (SD) EBPAS Openness	2.88 (.68)
Mean (SD) EBPAS Divergence	.93 (.90)
Mean (SD) TF-CBT Knowledge	50.96 (16.98)
Mean (SD) ICS Total	2.47 (.72)
Mean (SD) ILS Total	2.78 (.86)

Table 2. Bivariate correlations between baseline predictor variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Age																	
2. Female Gender	.013																
3. Hispanic	-.031	.096															
4. African -American	-.101	-.08	.123														
5. Caucasian	-.101	-.08	.123	1.000**													
6. American Indian/Pacific Islander	-.101	-.08	.123	1.000**	1.000**												
7. CBT Orientation	-.134	-.228	-.245	.097	.097	.097											
8. Master's level degree	.114	.159	.159	-.290*	-.290*	-.290*	-.035										
9. State Licensed	.388**	.064	.111	-.123	-.123	-.123	-.019	-.159									
10. Years of Professional Experience	.667**	-.073	-.048	-.067	-.067	-.067	.129	-.400*	.411**								
11. Average Weekly Caseload	-.054	.042	-.093	.014	.013	.014	-.176	.007	-.299	-.253							
12. Number of Consultation Calls Attended	.206	.175	-.086	-.135	-.135	-.135	.098	-.229	-.162	.381*	.116						
13. Number of Case Presentations	.037	.809	.019	.128	.128	.128	.010	-.111	-.309*	.091	.357*	.627**					
14. Mean Min Spoke during Calls	.142	-.109	.135	-.183	.265	-.195	-.054	-.170	-.077	.205	260	.732**	.757**				
15. EBPAS Total Score	-.053	.094	.100	-.132	-.132	-.132	.019	.344*	-.071	-.336*	-.206	-.090	-.023	-.142			
16. TF-CBT Knowledge	.092	-.017	-.031	.073	.073	.073	-.036	-.419**	.261	.432**	-.259	.315*	-.044	.437**	-.015		
17. ICS Total Score	-.082	-.116	.05	-.041	-.041	-.041	.146	.074	.126	.159	-.273	-.061	-.108	-.224	.061	.336*	
18. ILS Total Score	-.062	.130	.181	-.143	-.143	-.143	.148	.336*	-.096	-.152	-.164	.054	.119	-.032	.595**	.102	.314*

*p<.05; **p<.01

Table 3. Demographic, professional/practice, and baseline attitudes, knowledge, implementation climate, and implementation leadership predictors of consultation engagement entered separately

	Number of Calls Attended[9]			Number of Case Presentations[10]			Mean Minutes Spoke per Call		
	B	SE	*p*	B	SE	*p*	B	SE	*p*
Demographic Characteristics									
Age	.05	.04	.21	-.03	.03	.42	.01	.02	.59
Gender[1]	.88	.76	.26	.34	1.02	.74	-.60	.38	.12
Hispanic[2]	-.17	.96	.09	-.22	.89	.81	.28	.56	.58
Race[3]									
African-American	-.93	1.32	.49	-.86	.99	.39	-.81	.42	.06
Other[4]	-4.02	4.44	.37	-.99	2.24	.66	-1.17	.47	.02*
Professional/Practice Characteristics									
CBT Orientation[5]	1.48	1.53	.34	.76	1.03	.46	-.005	.92	1.00
Masters-level Degree[6]	-2.06	.53	<.001***	.01	1.12	.99	-.11	.42	.79
Licensed[7]	-1.00	1.28	.44	-1.58	.64	.02*	-.19	.54	.73
Years Experience	.19	.05	.001**	.02	.04	.68	.05	.04	.16
Average Weekly Caseload	.00	.02	.82	.04	.02	.009**	.02	.01	.05
Role[8]	.43	.53	.42	-2.26	.61	<.001***	-.10	.83	.91
Professional Field[9]									
Counseling	1.30	1.55	.41	-.15	.98	.88	-.60	.69	.39
Psychology	1.36	2.14	.53	-1.20	1.35	.38	.64	1.02	.53
Child Welfare/Child Protection	2.81	2.92	.34	.47	1.85	.80	-.50	.82	.55
Marriage and Family Therapy	-.43	2.18	.84	-.44	1.38	.76	-.30	.53	.58
Juvenile Justice	3.59	4.12	.39	8.12	2.61	.004**	.03	1.72	.99
EBPAS Total	-.30	.87	.74	.12	1.16	.92	-.43	.43	.32
EBPAS Appeal	-.18	.81	.83	.18	.95	.85	-.17	.35	.64
EBPAS Requirements	-.36	.67	.59	.11	.18	.86	-.37	.24	.14
EBPAS Openness	-.30	.58	.66	-.10	-.11	.92	-.36	.37	.34
EBPAS Divergence	-.03	.69	.97	-.07	.57	.91	.05	.26	.84
TF-CBT Knowledge	.06	.03	.03*	-.03	.03	.23	.05	.01	<.001***
ICS Total	-.41	.98	.68	-.39	.42	.36	-.70	.42	.11
ILS Total	-.10	.67	.89	.22	.51	.67	-.20	.20	.31

1. Female is reference group. 2. Hispanic versus non-Hispanic. 3. Caucasian is reference group. 4. Includes providers identifying as American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, and Other. 5. CBT versus other. 6. Masters-level degree versus doctoral. 7. Licensed versus not licensed. 8. Supervisor role is reference group. 9. Social work is reference group. 9. 12 or more consultation calls were required to meet certification. 10. 2 or more case presentations during consultation calls were required for certification.

APPENDIX A

STUDY MEASURES

LIST OF MEASURES

1. Clinician and Supervisor Demographics and Background Information
2. Evidence-Based Practices Attitudes Scale
3. Boulder IMPACT TF-CBT Survey
4. Implementation Climate Scale
5. Implementation Leadership Scale
6. Consultation Feedback Form*
7. Working Alliance Inventory – Consultation – Clinician Version*
8. Consultation Coding Manual*
9. Minute-to-Minute Coding Sheets*

*Indicates measure was created by the Investigator

1. Clinician and Supervisor Demographics and Background Information

1. Date: _____
2. Age: _____
3. Gender: _____
4. Race/Ethnicity: _____
5. What is your highest academic degree?

☐ BA	☐ MSN
☐ BS	☐ Med
☐ BSW	☐ Ph.D.
☐ MS	☐ Psy.D.
☐ MA	☐ MD
☐ MSW	☐ JD

☐ Other (please specify) _____

6. What is your primary professional field?

☐ Child Welfare/Child Protection	☐ Rape Crisis Center Worker
☐ Guardian ad Litem	☐ Clinical Social Work
☐ Juvenile Justice	☐ Professional Counseling
☐ Family Advocate	☐ Psychiatry
☐ Educator	☐ Psychology
☐ CAC caseworker (nonclinical)	☐ Nursing
☐ Victim Advocate	☐ Marriage and Family Therapy
☐ Domestic Violence Worker	☐ Guidance Counseling

☐ Other (please specify) _____

7. Are you currently state licensed? **Y** **N**
8. How many years of full-time professional/clinical experience have you had?

   _____
9. What is your primary theoretical orientation? _____
10. What is your current position?

    _____
11. How many active cases do you typically carry at one time?* _____
12. About how many hours of supervision do you receive each week?* _____

2. Evidence-Based Practices Attitudes Scale

Evidence Based Practices Attitude Survey

Instructions: The following questions ask about your feelings about using new types of therapy, interventions or treatments. Manualized therapy, treatment, or intervention refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured or predetermined way. Indicate the extent to which you agree with each item using the following scale.

	Not at All	To a Slight Extent	To a Moderate Extent	To a Great Extent	To a Very Great Extent
1. I like to use new types of therapy/interventions to help my clients.	☐	☐	☐	☐	☐
2. I am willing to try new types of therapy/interventions even if I have to follow a treatment manual.	☐	☐	☐	☐	☐
3. I know better than academic researchers how to care for my clients.	☐	☐	☐	☐	☐
4. I am willing to use new and different types of therapy/interventions developed by researchers.	☐	☐	☐	☐	☐
5. Research based treatments/interventions are not clinically useful.	☐	☐	☐	☐	☐
6. Clinical experience is more important than using manualized therapy/interventions.	☐	☐	☐	☐	☐
7. I would not use manualized therapy/interventions.	☐	☐	☐	☐	☐
8. I would try a new therapy/intervention even if it were very different from what I am used to doing.	☐	☐	☐	☐	☐
	For questions 9-15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:				
9. It was intuitively appealing?	☐	☐	☐	☐	☐
10. It "made sense" to you?	☐	☐	☐	☐	☐
11. It was required by your supervisor?	☐	☐	☐	☐	☐
12. It was required by your agency?	☐	☐	☐	☐	☐
13. It was required by your state?	☐	☐	☐	☐	☐
14. It was being used by colleagues who were happy with it?	☐	☐	☐	☐	☐
15. You felt you had enough training to use it correctly?	☐	☐	☐	☐	☐

3. Boulder IMPACT TF-CBT Survey

Boulder IMPACT TF-CBT Survey

This first set of questions asks you about the use of TF-CBT treatment components in therapy with trauma-exposed children.

Instructions: Please indicate one answer for each question. If you do not know the answer it is okay to indicate "I don't know."

1. When presenting Psychoeducation to a child who has experienced complex trauma (i.e., multiple forms of trauma/victimizations), you should:
    a. Present information about all types of trauma experienced when you begin
    b. Present information about different types of trauma in a graduated fashion, starting with one type of trauma and then moving onto the next
    c. Ask the child which type of trauma they would like to learn about first
    d. B and C
    e. I don't know

2. Psychoeducation runs throughout all of TF-CBT treatment and involves gradual exposure.
    a. True
    b. False
    c. I don't know

3. Children must show complete mastery of the Affect Expression/Modulation skills before they move on to the Trauma Narrative
    a. True
    b. False
    c. I don't know

4. Clinicians should stop and develop some type of intensity/severity scale during the most difficult part of the Trauma Narrative to assess the child's level of anxiety/fear.
    a. True
    b. False
    c. I don't know

5. When children and parents are first learning new relaxation techniques such as deep breathing, they should start by practicing the skills during highly stressful situations
    a. True
    b. False
    c. I don't know

6. "Unhelpful thoughts" related to trauma, (e.g., "We should have left town when the storm came," "I never should have gotten in the car") can sometimes be accurate.
    a. True
    b. False
    c. I don't know

7. When teaching Cognitive Coping to children, it is important to immediately challenge the distorted/unhelpful cognitions (blame, shame, disgust) related to the traumatic event.
    a. True
    b. False
    c. I don't know

8. When determining whether a child is ready to begin the Trauma Narrative, the therapist should assess current stability as well as:
    a. Whether the child has received PRAC: Psychoeducation, Relaxation, Affective Expression, and Cognitive Coping and demonstrates some skills for tolerating distress
    b. Whether the child has achieved total mastery of coping skills
    c. The child's interest in beginning the trauma narrative
    d. A and B
    e. A and C
    f. B and C
    g. I don't know

9. Which of the following is NOT TRUE?
    a. If the child talks or writes about the traumatic experience without providing specific details, the clinician should encourage the child to give specific details
    b. If possible, the clinician should arrange for the child to share his or her Trauma Narrative with a parent or caregiver
    c. Clinicians should not do a Trauma Narrative if the child gets very upset when talking about the abuse or if the parent feels it will be too distressing for the child
    d. Children who share details of the traumatic experience can do this verbally, in the form of a story, or by using songs, pictures, or dolls
    e. I don't know

10. Common reason(s) that therapists avoid direct discussion of traumatic events with children are:
    a. Child discomfort
    b. Parent discomfort
    c. Therapist discomfort
    d. Legal issues

e. A and D
f. All of the above
g. I don't know

11. Most kids will talk about the traumatic event when they are ready, so there is no real reason to "push" or prompt kids to do the Trauma Narrative.
    a. True
    b. False
    c. I don't know

12. The Trauma Narrative needs to be completed as a story or book to be most effective and therapeutic
    a. True
    b. False
    c. I don't know

13. In in-vivo exposure, the clinician should do all of the following EXCEPT:
    a. Find out as much as he/she can about the feared situation
    b. Get "buy in" and involvement from caregivers, school personnel, and/or other key participants
    c. Develop a plan that eases the child into facing the feared cues
    d. Make the plan general instead of specific so as not to frighten the child
    e. Make sure the plan progressively increases exposure
    f. I don't know

14. When challenging children's distorted/unhelpful thoughts about the abuse/trauma, clinicians should:
    a. Initially reframe from telling the child how he/she should feel or think differently
    b. Supportively list all of the reasons why those types of thoughts are inaccurate, hurtful, and should be changed
    c. Think about what alternative, more helpful thought(s) they would like the child to ultimately have
    d. Use Socratic questioning, psychoeducation, and role play strategies to disprove the thought or provide more of a balanced perspective
    e. B, C, and D
    f. A, C, and D
    g. I don't know

15. Clinicians teach caregivers to respond to inappropriate sexual behaviors in which of the following ways?
    a. Treat sexual behavior problems like any other problematic/undesirable behaviors (e.g., tantrums/hitting)
    b. Assess parent's views about sexual behaviors (e.g., masturbation, nudity)
    c. Determine if behavior is developmentally inappropriate
    d. Avoiding shaming the behavior and increase monitoring of the child

e. All of the above
f. I don't know

16. Which of the following cognitive behavior therapy (CBT) components are important for dealing with and reducing children's minor sexualized behaviors?
    a. Cognitive component (know the rules)
    b. Emotional regulation component (self-control procedures)
    c. Adult supervision
    d. Decreases activities that might be sexually stimulating to child
    e. A, C, and D
    f. All of the above
    g. I don't know

17. Clinicians should not have joint sessions when:
    a. Parent is negative and critical of the child
    b. Parent is supportive of the child but still tears up when listening to the narrative (even with preparation)
    c. Child is adamantly opposed
    d. A and B
    e. A and C
    f. All of the above
    g. I don't know

4. Implementation Climate Scale

Implementation Climate Scale (ICS)

This 18-item measure assesses the degree to which there is a strategic organizational climate supportive of evidence-based practice implementation. Implementation climate is defined as employees' shared perceptions of the policies, practices, procedures, and behaviors that are rewarded, supported, and expected in order to facilitate effective EBP implementation.

Note: This measure can be adapted to study climate for evidence-based practice implementation for teams/work groups or entire organizations. Please choose a single referent point for all of the items (e.g., team or agency).

Instructions: Please indicate the extent to which you agree with each statement.

	Not at All	Slight Extent	Moderate Extent	Great Extent	Very Great Extent
Focus on Evidence-Based Practice					
1. One of this team/agency's main goals is to use evidence-based practices effectively	☐	☐	☐	☐	☐
2. People in this team/agency think that the implementation of evidence-based practices is important	☐	☐	☐	☐	☐
3. Using evidence-based practices is a top priority in this team/agency	☐	☐	☐	☐	☐
Educational Support for Evidence-Based Practice					
4. This team/agency provides conferences, workshops, or seminars focusing on evidence-based practices	☐	☐	☐	☐	☐
5. This team/agency provides evidence-based practice trainings or in-services	☐	☐	☐	☐	☐
6. This team/agency provides evidence-based practice training materials, journals, etc.	☐	☐	☐	☐	☐
Recognition for Evidence-Based Practice					
7. Providers in this team/agency who use evidence-based practices are seen as experts	☐	☐	☐	☐	☐
8. Providers who use evidence-based practices are held in high esteem in this team/agency	☐	☐	☐	☐	☐
9. Providers in this team/agency who use evidence-based practices are more likely to be promoted	☐	☐	☐	☐	☐
10. This team/agency provides financial incentives for the use of evidence-based practices	☐	☐	☐	☐	☐
11. The better you are at using evidence-based practices, the more likely you are to get a bonus or raise	☐	☐	☐	☐	☐

12. This team/agency provides the ability to accumulate compensated time for the use of evidence-based practices	☐	☐	☐	☐	☐
Selection for Evidence-Based Practice					
13. This team/agency selects staff who have previously used evidence-based practice	☐	☐	☐	☐	☐
14. This team/agency selects staff who have had formal education supporting evidence-based practice	☐	☐	☐	☐	☐
15. This team/agency selects staff who value evidence-based practice	☐	☐	☐	☐	☐
Selection for Openness					
16. This team/agency selects staff who are adaptable	☐	☐	☐	☐	☐
17. This team/agency selects staff who are flexible	☐	☐	☐	☐	☐
18. This team/agency selects staff open to new types of interventions	☐	☐	☐	☐	☐

5. Implementation Leadership Scale

Implementation Leadership Scale (ICS) – Staff Version

Please indicate the extent to which you agree with each statement.

	Not at All	Slight Extent	Moderate Extent	Great Extent	Very Great Extent
Proactive					
19. [Name of supervisor] has developed a plan to facilitate implementation of evidence-based practice	☐	☐	☐	☐	☐
20. [Name of supervisor] has removed obstacles to the implementation of evidence-based practice	☐	☐	☐	☐	☐
21. [Name of supervisor] has established clear department standards for the implementation of evidence-based practice	☐	☐	☐	☐	☐
Knowledgeable					
22. [Name of supervisor] is knowledgeable about evidence-based practice	☐	☐	☐	☐	☐
23. [Name of supervisor] is able to answer my questions about evidence-based practice	☐	☐	☐	☐	☐
24. [Name of supervisor] knows what he or she is talking about when it comes to evidence-based practice	☐	☐	☐	☐	☐
Supportive					
25. [Name of supervisor] recognizes and appreciates employee efforts toward successful implementation of evidence-based practice	☐	☐	☐	☐	☐
26. [Name of supervisor] supports employee efforts to learn more about evidence-based practice	☐	☐	☐	☐	☐
27. [Name of supervisor] supports employee efforts to use evidence-based practice	☐	☐	☐	☐	☐
Perseverant					
28. [Name of supervisor] perseveres through the ups and downs of implementing evidence-based practice	☐	☐	☐	☐	☐
29. [Name of supervisor] carriers on through the challenges of implementing evidence-based practice	☐	☐	☐	☐	☐
30. [Name of supervisor] reacts to critical issues regarding the implementation of evidence-based practice by openly and effectively addressing the problem(s)	☐	☐	☐	☐	☐

Implementation Leadership Scale – Supervisor Version

Please indicate the extent to which you agree with each statement.

	Not at All	Slight Extent	Moderate Extent	Great Extent	Very Great Extent
Proactive					
1. I have developed a plan to facilitate implementation of evidence-based practice	☐	☐	☐	☐	☐
2. I have removed obstacles to the implementation of evidence-based practice	☐	☐	☐	☐	☐
3. I have established clear department standards for the implementation of evidence-based practice	☐	☐	☐	☐	☐
Knowledgeable					
4. I am knowledgeable about evidence-based practice	☐	☐	☐	☐	☐
5. I am able to answer staff's questions about evidence-based practice	☐	☐	☐	☐	☐
6. I know what I am talking about when it comes to evidence-based practice	☐	☐	☐	☐	☐
Supportive					
7. I recognize and appreciates employee efforts toward successful implementation of evidence-based practice	☐	☐	☐	☐	☐
8. I support employee efforts to learn more about evidence-based practice	☐	☐	☐	☐	☐
9. I support employee efforts to use evidence-based practice	☐	☐	☐	☐	☐
Perseverant					
10. I persevere through the ups and downs of implementing evidence-based practice	☐	☐	☐	☐	☐
11. I carry on through the challenges of implementing evidence-based practice	☐	☐	☐	☐	☐
12. I react to critical issues regarding the implementation of evidence-based practice by openly and effectively addressing the problem(s)	☐	☐	☐	☐	☐

6. Consultation Feedback Form

Consultation Feedback Form (CFF)

(Adapted from the Consultation Feedback Form used by Edmunds 2013)

Please provide your responses to the following questions.

1. How would you rate the overall quality of the consultation you have received?

0	**1**	**2**	**3**	**4**	**5**
Poor	Mediocre	Satisfactory	Good	Excellent	N/A

If **N/A**, please explain:_____

2. Please rate your experience using technology (e.g., conferencing line) during consultation calls.

0	**1**	**2**	**3**	**4**	**5**
Poor	Mediocre	Satisfactory	Good	Excellent	N/A

If **N/A**, please explain:_____

3. At this point, how comfortable would you say you are in applying TF-CBT with youth?

0	**1**	**2**	**3**	**4**	**5**
Not at all	A Little	Moderately	Very	Extremely	N/A

If **N/A**, please explain:_____

4. How comfortable do you feel applying what you have discussed in consultation to your client sessions?

0	**1**	**2**	**3**	**4**	**5**
Not at all	A Little	Moderately	Very	Extremely	N/A

If **N/A**, please explain:_____

Please rate the extent to which you agree with each of the following statements.

5. Participating in consultation calls has helped me to feel more comfortable applying TF-CBT with youth.

0	**1**	**2**	**3**	**4**	**5**
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

6. Consultation call topics are relevant to my work with clients who are receiving TF-CBT.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

7. The amount of time spent in group consultation is adequate.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

8. I like the structure of consultation calls.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

9. Consultation calls provide a useful additional training experience, above and beyond the training workshops.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

10. I have enjoyed receiving additional training and/or support in TF-CBT provided by the consultation calls.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

11. I believe the consultation calls are a good use of my time.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

12. Consultation calls are just as good as face-to-face meetings.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

13. It is difficult for me to attend consultation calls due to conflicts with my schedule.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

14. My agency's requirements (e.g., time, productivity requirements) make it difficult for me to participate in consultation calls.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

15. It is difficult for me to attend consultation calls because C-START does not allow any flexibility with the consultation call schedule.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

16. I am motivated to participate in consultation calls in part because it is required for TF-CBT certification.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

17. Participating in consultation calls allows me opportunities to collaborate with others (e.g., providers, brokers, leaders, etc.) in the community.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

18. The consultation calls provide important information and support that I would otherwise not receive as a part of supervision at my agency.

0	1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A

19. Please let us know anything else about consultation calls you believe would be important for us to know:

7. Working Alliance Inventory – Consultation – Clinician Version

Working Alliance Inventory – Consultation- Clinician Version

(Adapted from the Supervisory Working Alliance Inventory Trainee Form by Efstation et al 1990)

Instructions: Please indicate the frequency with which the behavior described in each of the following items seems characteristic of the consultant leading your consultation calls.

1. I feel comfortable working with the consultant during consultation calls.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

2. The consultant welcomes my thoughts and ideas about cases and treatment.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

3. The consultant makes an effort to understand me.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

4. The consultant encourages me to discuss my work with clients in ways that are comfortable for me.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

5. The consultant is tactful when commenting about my performance.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

6. The consultant encourages me to formulate my own session plans with each client.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

7. The consultant helps me talk freely during consultation.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

8. The consultant stays in tune with me during consultation.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

9. I understand client behavior and treatment techniques similar to the way the consultant does.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

10. I feel free to mention to the consultant any troublesome feelings I might have about him/her.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

11. The consultant treats me like a colleague during consultation calls.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

12. On consultation calls, I am more curious than anxious when discussing my difficulties with clients.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

13. During consultation, the consultant places a high priority on our understanding the client's perspective.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

14. The consultant encourages me to take time to understand what the client is saying and doing.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

15. The consultant carefully considers questions and concerns I bring to consultation.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

16. When offering support on cases, the consultant offers alternative ways of working with that client.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

17. The consultant helps me to work within a specific treatment plan with my clients.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

18. The consultant helps me stay on track during consultation calls.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

19. During consultation calls, the consultant works on specific goals.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

20. The consultant stays on track during consultation calls.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

21. The consultant is respectful of my time during consultation calls.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

22. I feel free to mention to the consultant any troublesome feelings I might have about consultation.

1	2	3	4	5	6	7
Almost Never			Sometimes			Almost Always

8. Consultation Coding Manual

Consultation Coding Manual – Providers

General Guidelines

- Timing includes whole minutes such that minute 1 is 0-60 seconds, minute 2 is 61-120 seconds, minute 3 is 121-180 seconds, and so on.
- A computer timer that beeps each minute should be used to keep the official time during minute-to-minute live coding. Please use the computer timer created by UM IT. The "current code min" box within the timer indicates the minute to code on your code sheet.
- At least one person needs to keep time during the call to indicate the duration of the call from start to finish.
- Begin timing immediately when consultant indicates or verbalizes that the call will begin; end timing when it is indicated that the call is adjourned.
- For each of these codes, mark if the code is present within each one-minute sample on the coding sheets.
- If content overlaps across minutes, count it as occurring within *both* minutes.
- Only double-code a verbalization if specifically indicated in the manual
- Pay attention to instructions to use one code over another "when in doubt"
- General rules for coding:
    - Content Codes should only be used to code verbalizations by providers (2 exceptions: Trauma Narrative, Other – technology issues)
    - Method Codes should only be used to code verbalizations by consultants
- If available, RA's should be asked to take notes during all calls
- If coders and note-takers are not in the same room during consultation call coding, use this world clock to sync help sync timers at the start of the call: http://www.time.gov/
    - Using the world clock, push start on the coding timer when the world clock hits the hour XX:00:00.
    - After the call, Ashley will decide when the call "officially" began and will ask coders to cross out any of the beginning minutes before the official start time of the call.
    - Master timekeeper should also note the official start time of the call, using a world clock.
- Reserve 30-60 minutes after each call for consensus coding

Minute to Minute Codes

A. Content Codes

1) Case Discussion/Case conceptualization/Case appropriateness/Case identification/Ongoing Tx Planning

General notes:

- This code should be used when reference is made to a specific case, and not "youth in general"
- This could refer to a real case or a hypothetical case

Discussion related to the initial assessment.

- This could include discussion about whether an initial assessment was administered
- What were the scores on measures that were administered?
- How the decision was made to register the case as a training case?

Discussion of appropriateness of cases for TF-CBT, as well as any discussion regarding appropriateness of cases as training cases. This could include revisiting appropriateness as treatment progresses.

- Case summary information
    - Case history or background information, problem list, school performance, treatment history
- Case identification or selection for a treatment or treatment planning
- Exclusionary criteria
- Appropriateness of cases for TF-CBT
    - E.g., Discussion of good "training cases" (age, trauma history, trauma-related symptoms; Importance of caregiver involvement)

Discussion of a case to help with ongoing treatment planning

- Case updates, discussion of a specific case, treatment planning

- *Examples*:
    - "I have a child whose level of abuse is very severe and I'm wondering if TF-CBT can help."
    - "This new case is a 5 year old female. Is it still an option to try parts of TF-CBT with her?"
    - *Do not code* statements such as: "I have two cases to discuss on today's call" (unless followed by more substantial case updates).

- Do not code if this comes up in the context of a didactic. Only use if a *real* case is discussed.
    - *Example*: After providing a *vignette*, consultant says: "What are some things you'd want to do with this kid?" Therapist responds by saying "You'd want to separate the kid from her parents." (do not code)

- Do not code if the consultant is checking in to see who has cases to discuss, and the response is "no/yes."
  - *Example*: Consultant says, "Hank do you have any cases to discuss today?" Provider responds, "No" or "Yes" or "I just have one, it's that 14 year-old girl."
  - In these cases, *only code* if the provider goes on to present or discuss the case, or provides more substantial detail.
    - *Example*: "I have one case. It's the girl who is 14. She had a really tough time with the TN last week and I wanted to talk about how to approach session this week."

- Double-count if verbalization is also about Engagement
  - "I met with a potential client and they seem like a good fit for TF-CBT, but the caregiver told me they don't think they can make it to session on a weekly basis so I'm wondering if I should take them on as a training case?"

- Note about "kids in general" vs. a specific case: If verbalization is asking a question about "kids in general" or "kids who have XXX symptom" or "When kids are having trouble with XXX, what should I do?", and *if the verbalization is not about a specific case*, then do not code as Case Discussion. Instead, use one of the secondary codes below (e.g., How To, Flexibility, Engagement).

2) General TF-CBT Model/Components – "WHY"

Discussion or review of general components underlying the model, questions about TF-CBT in general, or verbalizations that indicate a misunderstanding of TF-CBT.

- Verbalizations or questions about TF-CBT in general
  - Why use TF-CBT? Questions about TF-CBT that suggest a misunderstanding or lack of knowledge about the treatment.
  - *Example*: "I don't think my client needs a TN." (in the sense of 'I don't get why I need to do the TN with my client') = code as WHY and double code as TN.
- Verbalization regarding the Cognitive, Behavioral, or Family Principles of TF-CBT
- Verbalization/discussion regarding rationale for TF-CBT PRACTICE components.
- Rationale for why a specific component or the model is important.
- Discussion about TF-CBT in general, or the PRACTICE components in general
- Rationale for WHY we use certain components (e.g., Trauma Narrative)
  - Psychoeducation/information provision and sharing
  - Parenting/behavior management
  - Relaxation
  - Affective identification/modulation/Expression
  - Cognitive Coping
  - Trauma Narrative and TN processing

  - In vivo mastery
  - Conjoint sharing of TN
  - Enhancing Safety
- Discussion about agenda setting for a case within session and why it is important
- WHY homework is important
- Broader reference to "why" TF-CBT/PRACTICE components

- *Examples*:
  - "Do we have to talk about the agenda with our clients at the start of each session? Or is it enough just to have the agenda set in our mind?"
  - "I don't understand why we want our clients to share their TN with others." (double-count as TN)
  - "I don't think my client needs a TN." (in the sense of 'I don't get why I need to do the TN with my client') = code as WHY and double code as TN.
    - However, if example of "I don't think my client needs a TN," is about wanting to do the TN in a different way, then code as Flexibility/Adaptation and double code as TN.

- Double-count if verbalization is also about Trauma Narrative

3) Specific TF-CBT Components – "HOW TO"

Discussion of any specific TF-CBT techniques or HOW TO implement specific PRACTICE components/techniques or specific sessions from the manual. This includes questions about "how to" administer or use the assessment measures or "how to" use the information from the assessment. This also includes a clinician response when discussing "how to" do something related to treatment. Use this code if the therapist is wondering about next steps for treatment.

- This code should be used when clinicians ask "how to" do something (*vs*. how they can adapt or change treatment, which would be coded as Flexibility)
- Code "How To" if the therapist asks how to do something in general or for a "group" of youth and/or for a specific case.
  - *Example*: "I was wondering how to know when it's okay to start the TN for kids who are older?"

- *Examples*: Use of handouts for Psychoeducation; instruction in Time-Out for Parenting; controlled breathing or PMR for Relaxation; feelings charades for Affective Expression; Cognitive Triangle for Cognitive Component; creation of a book for TN; use of responsibility pie for TN processing; development of a hierarchy for in vivo mastery; preparation of caregiver for Conjoint; safety plan development for Enhancing Safety
  - Includes assignment and/or review of Homework
  - Includes agenda setting and "how to" set an agenda

  - ONLY code a COW if the verbalization is specifically about "how to" apply a specific technique to address a COW

    - When in doubt: Code as Flexibility
        - "How can I use affective expression techniques to reframe [child's major problem of the week]"
        - "How can I apply [name of any skill] when the caregiver/child only wants to discuss the COW?"

- *Examples:*
    - "Are there any supplemental educational handouts we can give caregivers when we're teaching youth how to do PMR?"
    - "I'm still not sure how to best introduce the TN in a way that makes sense to clients." (double-count as TN)
    - "Setting the agenda in session feels a little awkward, do you have any ideas on ways to make it feel more natural?"
    - "Can we role play how to do an imaginal exposure [or insert any other PRACTICE component name here]?" This kind of verbalization would indicate a question about how to do one of the components.
    - "What do I do next?" (Provider asking a question about how to proceed with treatment)
    - Clinician asks what to do next in treatment. Consultant asks clinician how he/she would design a treatment strategy. Clinician says, "Maybe we could do [this] for the next exposure."

- Double-count if verbalization is also about Trauma Narrative
- Double count if verbalization also refers to "Provider Level Barrier"
    - "I'm really struggling with how to develop the TN and was wondering if we could talk about how to do that for kids who have a lot of anxiety about talking about the trauma." (Double count as Provider Level Barrier and TN)

- When in doubt: Code Flexibility/Adaptation/Fidelity over "How To"

4) Trauma Narrative

Any discussion relating to the Trauma Narrative. Code this any time you hear providers say the words "Trauma Narrative." (only providers)

- Use this code *only* when providers bring up the TN
- TN might be referred to as the narrative, book, story, pictures, etc., so also be on the lookout for words that might be used to describe the TN

- *Examples:*
    - "I'm still not sure how to introduce the TN in a way that makes sense to my younger clients." (double-count as TN and "how to")

- Double-count if verbalization is also appropriate for other codes. Most common would be: (1) General TF-CBT Model/Components ("why"), (2) Specific TF-CBT Techniques ("how to"), (3) Flexibility/Adaptation/Fidelity, (4) Engagement, but you should count TN + any other appropriate code any time TN is brought up.

5) Flexibility/Adaptation/Fidelity

Discussion about adapting or flexibly applying TF-CBT (e.g., teaching topics in different ways, using TF-CBT with different populations). This includes discussion about adapting or flexibly implementing treatment and individualization for specific child or family needs.

- This code should only be used when talking about cases that are ongoing. Do not use in the context of identifying appropriate cases for TF-CBT.
    - Do not code – *Example*: "So I have one potential new case but they would only be able to come in for session every other week." (ID'ing appropriate case)
    - Code this: "My client is only able to come in every other week, so how can I structure sessions to make sure the youth gets the treatment?" (vs. ongoing/current case)

    - Do not code: "Can I use TF-CBT for kids with autism?"
    - Code these: "*How can* I use this protocol for kids with autism?" (asking specifically about how to adapt TF-CBT) or "Is it possible to use TF-CBT with kids who have pervasive developmental disorder?"

- This code can be used to code comments/verbalizations/discussion about adapting a treatment for a population in general
    - "So how could we do that if the child has PDD or is cognitively not at the same point as other kids?"

- Do not code general clinical skills used to adapt to expected fluctuations within a session
    - *Examples*: Stomachache during session and needing to end early (Flexibility) vs. forgetting homework (potentially expected, do not code as Flexibility unless there is additional information that would lead you to use the code).

- Discussion of adaptations needed to address family circumstances (e.g., crises, logistical barriers to treatment) or treatment setting.
    - *Examples*:
    - "The family experienced a crisis and I need to figure out how to address the crisis while still continuing with treatment as planned."
    - "The child is in a residential treatment facility; should I see her more than 1/week?"
    - How to condense treatment into fewer sessions because the family needs to end treatment early.

- Code discussion about general cultural or family factors that may be related to the need to adapt the treatment, or cultural/family factors that are a barrier to treatment

- Code any discussion or question related to doing "parts" of a treatment component or treatment manual instead of the "whole" treatment component/manual

- Code COWs if therapist brings up any general issue about a COW and how to modify sessions/adapt sessions
- When in doubt about COWs: Code as Flexibility
    - "So if our client comes in with a COW, how should we go about addressing the COW while balancing getting through the session content?"
    - "If our client comes into session with a COW can we just deal with it the way we normally would?"
    - "How are we supposed to handle COWs?"
    - Includes how to manage crises (COWs) using TF-CBT techniques
        - NOTE: If verbalization is a general comment about "managing COWs using a specific TF-CBT technique" then code as "how to"

- *Examples*:
    - Adapting the treatment to be more developmentally appropriate
    - "Even though my client is 7 years old, he is developmentally at a 5 year-old level and is having some difficulty with parts of TF-CBT. Can we talk about what I can do to change things up a little so it makes more sense to him?"
    - Adapting the treatment to better fit differences in client presentations or concerns
    - "My client has a lot of behavior problems and her caregiver was wondering if I could help them more with managing behavior at home?"
    - Adapting the treatment to better fit a family's cultural background
    - "One of the caregivers I'm working with doesn't believe in Time Out, is there something else I can try instead?"
    - Tailoring exposure tasks/Trauma Narrative to be more appropriate for individuals
    - "If our clients don't want to share their TN with others, is there something else we can do instead?" (double-count as TN) or "One of my clients really doesn't want to share her TN with others. Does she have to do it?" (double-count as TN)
    - "Can my clients do the TN without writing it down? Can they color it instead or make a song or something like that?" (double-count as TN)

- Double-count if verbalization is also about Engagement (i.e., if someone is adapting protocol to help to meet family where they are in terms of engagement)
- Double-count if verbalization is also about Trauma Narrative

- When in doubt: Coding Flexibility/Adaptation/Fidelity trumps coding "How To" (see examples below)

- *Examples*:
  - "I'm having trouble getting through everything in a 50 min session. Are there things that I can cut?"
  - "What happens if you have a kid who isn't convinced that telling their story will help them? Then what do you do?"

6) Client and Family Engagement

Did the provider bring up issues related to caregiver involvement, reconceptualizing caregivers' view of treatment, or outreach to caregivers? This can also include engagement of children in treatment. Strategies or compliance.

- Use this code for both general *and* specific engagement issues
- Tip: Use this code to capture anything related issues that are brought up related to variables like compliance or engagement issues and how these would impact ability to participate in treatment. Do not code if the discussion is just related to the child's background or story.
- Do not code: "It's hard for me to get him to do stuff." Or "He seems really withdrawn." (this would be related to a case that hasn't started)
- Includes any relevant background information relevant to engagement issues, only if it is noted that these background issues are getting in the way
  - *Example*: "I been picking up on the fact that mom's anxiety is getting in the way of treatment… because she's worried about exposures."
  - *Example*: "Mom is making the child's anxiety worse because she's so anxious, and it's making it hard to complete homework."
  - *Example*: "One of my kids is trying to reunite with his father, but the father is out of state."
  - *Do not code*: "Mom is anxious" or "The child doesn't have any parents." Unless followed by more detailed information about how/why it's getting in the way.

- *Examples*:
  - Discussing client motivation/engagement
    - Attendance
    - Treatment compliance
    - Homework
  - Identifying strategies for facilitating patient engagement
  - Description of the nature/background of the engagement issues
  - Discussion of *how* to involve a caregiver in the treatment or *how to talk to caregiver about involvement*
    - *Example:* "I'm wondering how to talk to mom about this since she's pretty intrusive with her daughter a lot of the time and worries her daughter is not telling the whole story in session."
  - Discussion about *who to involve in treatment* and identifying appropriate caregivers
  - Questions related to "how to engage" specific populations such as youth who have Selective Mutism

- Double-count if verbalization is also about Case Identification/Conceptualization
  - "I met with a potential client and they seem like a good fit for TF-CBT, but the caregiver told me they don't think they can make it to session on a weekly basis so I'm wondering if I should take them on as a training case?"
- Double-count if verbalization is also about Trauma Narrative
- Double-count if verbalization is also about Flexibility (i.e., if someone is adapting protocol to help to meet family where they are in terms of engagement)
- If the Provider says, "I feel stuck because the client doesn't seem to be getting the material." (Double code: Provider Level Barrier and Engagement)
- Do not code: If the verbalization is related to a past case only.
  - *Example*: "I had this kid once who had Selective Mutism and was hard to engage. Can we talk about how to use this treatment with kids who have SM?" (Code this as Flexibility b/c of the second part of the verbalization. Do not code as Engagement because it references a past case only).

- Only code positively valenced verbalizations if it is related to a strategy the therapist is using to engage clients/families.:
  - Code: "I had to talk to mom more to give her some more psychoed, and afterwards she was on board."
- Do not code: "Mom is very supportive of treatment, so I'm really pleased about that."
  - Code this as Satisfaction/Success
- "(discussion re: should both parents be included in txt, as a backstory) I mean the mother has given up her parenting in a way, and she also is being excluded in many ways. So there are a couple of things going on with her. (39 min) And I'm not exactly sure, but she does want to be included and I want to include her in this, as well." → Code first part (min 38) as Engagement, but do not code min 39 as engagement.

7) Provider-Level Barriers

Discussion related to personal obstacles faced by clinicians when implementing TF-CBT, participating in the CBLC, attending calls, etc.

- *Examples*:
  - Lack of confidence in delivering treatment
  - Lack of knowledge regarding how to deal with certain situations or clients
  - Lack of knowledge about how to implement something with regards to a case
  - Doubt that treatment will help
- *Note*: This code would be used anytime a clinician reports a clinician-level barrier, or anytime clinician-level barriers are discussed in general.

- *Examples*:

- "I still don't feel comfortable doing the Trauma Narrative with my clients."
- "I don't like to push kids."
- "In my experience, kids will talk about the trauma when they're ready to."
- "I don't want to re-traumatize my client."
- "I don't really know what to do with this case right now."
- "I'm able to use TF-CBT competently without attending consultation calls."
- "I know we went to the training but I'm confused with the format of this treatment and how we implement the components, or like, what order we need to go in." (Double-code as "How To" and Provider-Level Barrier)
- Consultant says, "Ok so what do you think you are going to do next?" and then Provider says, "I don't know." Or "I don't know where to go from here." Or "I feel stuck."
- IF the Provider says, "I feel stuck because the client doesn't seem to be getting the material." (Double code: Provider Level Barrier and Engagement)
- "It felt a little awkward for me to do relaxation with her."
- "It was hard for me to get a sense of how the client was feeling."
- "I just switched agencies so I'm on the hunt for new cases."

- Double-count if verbalization is also about an Organizational-Level Barrier
  - "I can't afford to buy any of those books about trauma to use with my clients and my agency doesn't give me any money for that stuff."
  - *Note*: Only double-count if the verbalization explicitly includes language that indicates both a provider-level and organizational-level barrier. Do not make any inferences about what the consultee "might mean". For example, "I can't afford to buy those books about trauma" would just be coded as a provider-level barrier, even if the provider might be meaning to indicate that he/she can't buy books because the organization doesn't provide funds for such materials.
- Double count if verbalization also refers to "How To"
  - "I'm really struggling with how to develop the TN and was wondering if we could talk about how to do that for kids who have a lot of anxiety about talking about the trauma."
  - Note: Double code these if the provider indicates that they are struggling with or are having difficulty with doing or implementing a component vs. if they indicate that they are wondering "how to" do something
  - Do not code: "I was looking through materials not sure how to structure TN sessions. Can we go over how to do that?" (code this as "how to" only)

8) Organizational-Level Barriers

Discussion related to obstacles clinicians are facing or anticipate facing in their organizations or settings when implementing TF-CBT.

- Use this code to capture provider perceived barriers in their agency/setting

- *Examples*:
  - Difficulty delivering TF-CBT due to time constraints imposed by setting
    - E.g., Can only do 50 minute sessions; can't see the caregiver on the same day as the child)
  - Insurance won't cover treatment
    - E.g., Insurance won't cover time spent with caregiver or any conjoint child/caregiver session)
  - Organizational barriers
    - Includes discussion about lack of organizational support, lack of leadership support, or lack of support from other clinicians
    - "We have so many other requirements at my organization so it's hard to make these training cases a priority."
    - "We aren't allowed to see offenders and this mom was physically abusive, so how can I include her in treatment?"
    - "Who's supposed to watch the child while the caregiver is being seen?"
    - "Our clinic is only open M-F, 8-5pm."
    - "My supervisor doesn't see the point of me learning TF-CBT."
    - "We don't see a lot of kids with trauma histories at my agency."
  - No appropriate clients in setting (e.g., cannot get any cases because agency doesn't see children)
  - Other setting barriers
    - E.g., School settings – "How can we do TF-CBT if the child has to go back to class?"
- Other clinic procedures/issues:
  - "Our intake procedures are a little backed up."
  - "We are not an outpatient clinic."
  - "Finances have made things harder for everyone."
  - "My agency is crazy right now."

- <u>Double-count</u> verbalization if it is also a <u>Provider-Level Barrier</u>
  - "I can't afford to buy any of those books about trauma to use with my clients and my agency doesn't give me any money for that stuff."
  - *Note*: Only double-count if the verbalization explicitly includes language that indicates both a provider-level and organizational-level barrier. Do not make any inferences about what the consultee "might mean". For example, "My agency doesn't give me money buy those books about trauma" would just be coded as an organizational-level barrier, even if the provider might be meaning to indicate that he/she also can't buy books because he/she personally doesn't have funds to do so.
- <u>Do not code</u> if it's unclear why there might be a barrier: E.g., There wasn't enough time in the session

9) C-START Issues

Discussion about *barriers* related to C-START requirements.

- *Examples*:

- Barriers related to attendance on calls
- Barriers related to registering cases
  - *Example*: Not understanding how to register cases, forgetting process for registering cases
- Call agenda setting
  - Difficulty working consultation calls into schedule
  - No flexibility in weekly schedule for consultation calls
- Call logistics
  - Code if clinician mentions that the call time is difficult to attend, etc.
  - *Example*: "I'm going to have to leave this call early to see a client."
- Too many cases to discuss on a single consultation call\
  - *Example*: "Can I email you to get some feedback on one of my cases?" (If no more time on the call)
- Too much paperwork (e.g., weekly/monthly metrics; registering cases; doing the pre/post child assessments)
  - "I'm having difficulty completing the required paperwork because C-START requires so much for each client."
- Learning Collaborative / C-START issues
- Brief updates on the status of C-START

- Completion of 12 required consultation calls
  - Code this: "How many calls do I have so far? How many more do I need?"
  - "When is our next call?"

10) Satisfaction / Successes / Appreciation / Facilitators

Use this to code instances when providers bring up facilitators or satisfaction or successes with TF-CBT, C-START, consultation calls, etc.

Client-level facilitators / successes

- Use this code to capture any mention of client-level facilitators or successes/improvements, including facilitators or success with client engagement, progress in treatment, etc.
- *Examples*:
  - "My client's foster mother has been really dedicated to treatment."
  - "The foster mom has been sitting down and helping with homework."
  - "My client has really been doing a lot better since we started talking about affective expression."
  - "My client is very insightful."

Provider-level facilitators / successes

- Use this code to capture any provider-level facilitators or successes, such as indicating understanding of the treatment, TF-CBT certification, etc.
  - "I really like using TF-CBT because I see my clients getting better."
  - "She's very creative, artistic. I'm looking forward to narrative so we can get creative with that." (clinician enthusiasm and buy-in to the treatment)

- "I feel really comfortable using TF-CBT."
- "When I use TF-CBT I really feel like I'm helping make a difference in my clients' lives."
- "TF-CBT makes a lot of sense to me and is consistent with my orientation."
- "I like that we can get national certification when we complete this training."
- "I enjoy getting additional training to help me with my practice."
- "I see so many clients with trauma and it's been nice to learn a treatment that will really help these kids."

Organizational-level facilitators / successes

- Use this code to capture any organizational-level facilitators or successes, such as agency support, agency positive attitudes, agency flexibility, etc.
  - "My organization is really supportive of me learning TF-CBT."
  - "My supervisors have really encouraged me to be a part of C-START."
  - "A lot of people at my agency think TF-CBT is really effective."
  - "My agency gave me paid time off to be able to attend the learning sessions."
  - "My coworkers are also really excited about learning TF-CBT."
  - "Things are going well. At my agency we've had no problem getting referrals in."
- Subtle facilitators should be coded:
  - "My site does allow school visits and sessions in the schools."
  - "I have an interpreter coming in who can talk to the parents about treatment."

C-START facilitators / successes

- Use this code to capture any C-START facilitators or success, such as providing opportunities to network, consultation call schedules, etc.
  - "The info from the learning sessions was really helpful."
  - "It's nice to be able to network with others in the community."
  - "I'm glad C-START was able to schedule these calls on Thursdays."

- This code can also be used if a consultee verbalizes agreeing with someone else's praise.
  - *Example*: Consultant says, "Great, I really liked how you explained that, Wayne." Consultee says, "I agree!" (this indicates support/agreement of praise).

- Do not code: "Thank you" or other short verbalizations or "canned responses" that are lacking content (e.g., "That makes sense" or "Ok that's a good idea"), in response to something the consultant or another consultee says.
  - *Example*: "That's wonderful."
- Only code if the verbalization is followed by a more substantial comment, e.g., "Thank you *for that helpful suggestion*."
- Note: You may code phrases that are borderline if they are extremely emphatic and indicate clear excitement or satisfaction.

- Double-count if verbalization is also appropriate for other codes: e.g., Collaboration, Other (C-START materials)

- Think: Labeled vs. Unlabeled Praise

11) Collaboration (Positive, Negative, and Neutral)

Any discussion relating to collaboration between clinicians, brokers, supervisors, administrators, etc., both within and across agencies and in the community. This includes things that are "working" or "going well" in terms of collaboration, "not working" or "not going well," or neutral comments.

- Any discussion related to "working with" others in the community (e.g., related to assessment, referral, treatment or case monitoring)
- Mention of collaboration with others through C-START

- *Examples*:
  - "Since this whole thing started I've been able to network with people from so many other agencies."
  - "Even with this CBLC, it just doesn't feel like we're working together any better in Miami."
  - "I still don't understand what [agency name] role is, so that's why I didn't follow up with them."
  - "So I followed up with the case manager about that and she wasn't sure."
  - "Is this a case where we should involve the case manager?"

- Double-count if verbalization is also about Satisfaction/Successes
- Do not code: If the provider mentions that they spoke to their agency supervisor about a case

12) Peer Consultation

Use this code when providers provide their own thoughts/ideas about another provider's case or a question posed by another provider

- *Note*: This code may be preceded by a prompt from the consultant asking for the input of others, such as the following: (do NOT code these unless the provider responds)
  - Consultant says: "What I would do in that case is XXX, but does anyone else have any other ideas?"
  - Consultant says: "What does everyone else think?"
  - Consultant says: "What are some other ways you might handle that kind of situation?"

- *Examples*: CODE THESE
  - Provider says to another provider: "Well, maybe you could try starting with relaxation at the start of each session so your client gets some practice and also feels more calm before you continue with the TN."
  - Provider says to another provider: "I've also had trouble ending sessions on time when doing the TN. A trick I've starting using is that

I no longer ask my clients about their week, and instead ask them 'over the past week, how have your symptoms been?' I've noticed that it keeps the check-in brief, and then gives me a nice lead-in to continue with the TN." (this would also be double-counted as TN)

13) Technology Issues

Code all Technological issues (Note: RAs should note if there is a technical issue that arises on a call. E.g., Call is disconnected)

- This includes technical issues brought up by *both* consultees and consultants
    - Consultant says: "I can't hear you, do you think you're on mute?"
    - Clinician says: "Sorry I was late; I had trouble connecting and getting onto the call."
    - Any dropped calls
    - Any static or feedback on the line that makes content inaudible or extremely difficult to hear or understand (do not code if it's just minor static)
    - Any time an attendee forgets to unmute themselves and begins to speak while on mute, and then upon rejoining the call notes that he/she forgot to unmute.
- Includes any discussion about using the conference call system, if related to helping with technology issues (e.g., muting your line if you aren't speaking).

14) Other – only check if you can't use any other codes

Did the clinicians and supervisors discuss other issues relevant to the treatments or supervision/sustainability not covered above?

- Use this code to capture any other clinically-relevant talk, questions, or concerns
- This includes:
    - Speaking about clinical content of a case that does not fit into the other categories. Clinical content not directly related to conceptualization of a case. Not directly related to treatment or treatment plan.
        - *Examples*: Discussion about SI or risk assessment, intelligence testing for school (unless this is related to ability to receive services)
        - *Examples*: Prepping a kid to testify.
        - Logistics that don't fit into other categories
            - Court dates, reunification, other legal issues
    - Crisis/emergency issues:
        - Hospitalization (not just COW)
        - Police, criminal situation (new situation); new abuse or neglect report
    - Discussion about supervision that is not related to C-START (i.e., Supervision with agency supervisor)
    - Mention of use of materials from the training sessions (which is other clinically-oriented discussion not covered by above codes)
        - *Example*: Provider is asking consultant about the PRACTICE components and which order to go in during sessions. Consultant

reminds them about the order of the components. Provider response is, "Ok so I should probably go back to the handouts from the training."

- Any mention of other relevant materials, such as the "Triangle of Life" app.
- DO NOT CODE: Any time a situation like this comes up = Consultant says, "Ok so go ahead and tell me your name, agency, and how many cases you have." Then Provider responds, "Hi this is Al and I have three cases." Don't code Provider response.

Examples:

- "Well, I mean, I don't hate using TF-CBT."

15) Off-task

Includes any off-task discussion.

- *Examples*: Weather, sports, chit chat, catch-up
- *Examples*: Name clarification
  - C: "Banana, is that what you said?" Liana: "Oh no, it's Liana, L-I-A-N-A."
  - C: "Maria Luisa?" ML: "Oh, it's Maria Luisa, but you can call me Vicky."

General Notes and Decisions

DO NOT CODE:

- Do NOT code verbalizations related to joining the consultation call
  - *Example*: "Hi this is Henry, I just joined the call!"
  - *Example*: "Hi this is Margot from Agency Name XXX."

- Any time a clinician responds to a question posed by a consultant, this should not get coded unless there is additional follow-up.
  - *Do not code if this is a hypothetical case*: Consultant says, "What do you think that diagnosis could be?" and then clinician says, "Well, it sounds like social anxiety." (If this is referring to a new case then code the Provider response)

B. Method Codes

16) Case Presentation / Case Discussion / Facilitating Case Identification or Conceptualization / Case Updates

Consultant presents an actual or hypothetical case example for discussion or to illustrate a point.

- Only use this code in reference to specific cases, *not* general examples (code is meant to capture actual case discussion vs. didactics)
- Do not use this code if the consultant is asking providers if they have cases to discuss
    - *Example*: "Bethany, do you have any cases to discuss today?"
- Use this code if the consultant prompts consultees to think about cases that could be appropriate for TF-CBT
    - *Example*: "Ok so for our next call I want everyone to think about any cases that might be a good fit for TF-CBT and to come prepared to the call to discuss your thoughts about these cases."

- *Examples*:
    - If a consultant brings up a real or personal case example, a hypothetical case example, or discusses another clinician's case
    - This does not count if the discussion is about general types of cases, only code when a specific case is discussed (discussion of general experiences with clients should be coded as Didactics/Informing)
        - General (do not code as Case Presentation/Case Discussion, code as Didactics/Informing): E.g., "When my clients have a lot of anxiety, I typically like to…"
        - Specific (code this): E.g., "That's a pretty common concern. I had a client who also expressed apprehension about the TN, and what I did was…"
    - Code if the consultant is helping to facilitate case conceptualization
    - Code if the consultant makes any reference to a specific real or hypothetical case
        - E.g., "In the role play with Jessica (Jessica is the name of the client in the role play), we'd want to try something new." Or "In Jessica's case…"
    - Code this if a consultant is providing or describing a case vignette
    - Code if the consultant prompts a clinician to discuss a specific case
        - *Example*: "Okay, so [clinician's name] why don't you go ahead and start, and you can tell us a little bit about the case you're thinking about implementing treatment with."
        - *Example*: "Victoria, please give us your case updates."
        - *Example*: "Jamie will you please present a case on our next call?"

    - *Note*: Only count if a case is being discussed, do not count if a case is being role-played or modeled

- Double-count if verbalization is also relevant to Didactics/Informing
  - "In cases like the one you are describing when a child is also experiencing [description of presentation], the client might not do as well with TF-CBT so we should probably try to find a different training case for you."
  - Provider states that he is concerned about the stability of a client. Consultant responds by saying, "Sometimes we aim for them to be stably unstable. If we wait we won't get anywhere." Note, in this case it's not certain whether the consultant's reply is in regard to kids like this in general, or to the specific case, so double-code as Didactics and Case Presentation
- Double count if verbalization is also appropriate for Behavioral Rehearsal/Role Play
  - *Example*: (Consultant is setting up a role play) "So in this role play we'll say that we have Jessica who is a 9 year-old female…"
- When in doubt: If you're unsure whether to use this code, err on the side of using it (vs. not using it)
  - *Example*: Consultant says: "Alright Frank, tell me about your [agency/clinical] setting." (said in the context of asking whether the provider is getting referrals or has cases)
- Do not code a statement like this: "C: Victoria, how many cases do you have registered and what component in each, and have you sent in assessment material?" (Code as Questioning and Other – Agenda setting)

17) Didactics / Informing

This code includes any teaching, information sharing, or instruction, as well as feedback and suggestions, provided by the consultant to clinicians.

- This includes when a consultant shares knowledge with clinicians, describing a treatment, research findings, general experiences working with clients, teaching clinicians about the treatment, or informing clinicians of other relevant information
- In general, this includes any time a consultant teaches/informs/instructs clinicians about issues related to treatment or their cases, gives clinical feedback or suggestions, etc.
  - This includes anytime the consultant is giving a consultee feedback on a role play
    - Consultant interrupts a role-play to give feedback and says, "So I generally wouldn't say that with a 9-year old. Remember with a 9-year old you'd want to call it something so she could understand what you mean."
  - *Do not code* if feedback is praise only. E.g., "I like how you described that."
- Do not count if discussion is *restricted* to case discussion

- *Examples*:

  - "Sometimes younger kids have a hard time with the cognitive aspects, so you could start by explaining the concepts the way we discussed and drawing a picture to help illustrate what you're talking about."
  - "It's sometimes a good idea to check-in with kids to see if what you're saying makes sense to them."
  - "[Discussing a specific case] So it sounds like you're getting ready for him to be discharged and it sounds like he has some anxiety leaving because it sounds like he's done some really great work with you over this past year. So does it sound like you could implement some of those strategies we talked about?

- When deciding if a verbalization is Didactics/Informing or Other Consultant Strategy, use this as a general rule:
  - Didactics/Informing should be used for clinically-oriented discussion
  - Other Consultant Strategy should be used for administrative/logistics/agenda-setting/validation, etc.
  - *Example*: "What I'd like to do today is have everyone introduce themselves and then tell me a little bit about how you're doing in terms of getting cases." (Double-code as Other Consultant Strategy and Questioning/Prompting)

- Double-count if verbalization is also relevant to Case Identification
  - "In cases like the one you are describing when a child is also experiencing [description of presentation], the client might not do as well with TF-CBT so we should probably try to find a different training case for you."

18) Questioning/Prompting

Use this code any time the consultant poses a question or prompts the group using a question or statement as a prompt.

- You can also use this code when a consultant poses a question to providers, such as when a consultant might elicit peer consultation (see examples under Content Codes – Peer Consultation)
  - *Example*: "What does everyone else think?"
  - "How would you all handle that kind of situation?"
- *Examples*:
  - "[Consultee's name], do you have any cases to discuss today?"
  - "Gerry, give us updates on your case" (Double-count as Case Presentation)
  - "What are some other things you might do if that comes up?"
  - "Who remembers one of the tricks we discussed to help you introduce the TN?"
  - "Please jump in and interrupt me at any times if you have any questions or want to add anything."

- Do not count if it is within the context of technical issues

  - E.g., Call audio goes out and consultant says "Can anyone hear me?" (Code this as Technology Issues – Content Code)

-
- Do not count if it is within the context of modeling or role play
  - E.g., (consultant modeling) "So you might need to ask kids 'What do you remember from that day?"

- Do not count if it is a rhetorical question or statement
  - *Example*: Consultant is responding to potential questions from providers and says, "You may be wondering things like, 'Where do I start?' or 'Do I have to go in the exact order of the PRACTICE components?' but don't worry too much about that now because we'll address that in the coming weeks."

- Double count if verbalization takes place within the context of Didactics
  - [Consultant explaining a concept…] "Does that make sense to everyone? Any questions?"
  - Context is a therapist asking for advice about next session, and then consultant replies with some options for what to do, then says: "Does that feel like it's going to be too repetitive, or do you think that sounds ok for your next session?"
- Double count if verbalization is also about Case Presentation
  - "Jan, will you please give us some updates on your case?"
  - "Gerry, give us updates on your cases."

19) Modeling

This includes any time the consultant demonstrates a skill in the role of a clinician to teach or show how to deliver a skill. This also includes times when a clinician demonstrates or models a skill for another clinician.

- This includes ACTIVE modeling only. Any "set up" or prep work is coded under "Other Consultant Strategy."
- This can include times when a consultant demonstrates a brief phrase or sentence, such as instances when a consultant provides an example of a phrase he/she commonly uses with clients

- Include *both* clinically-oriented and non-clinically-oriented modeling
  - *Example*: Consultant says, "That was great how you introduced yourself and that's exactly how I want people to say that each week. So something like, 'This is Michael and I have two cases to discuss today. With the first I'm trying to figure out if they are a good fit for TF-CBT. With the second case we are just wrapping up psychoeducation.'"

- Decision Rule: Only code in cases when the provider would be able to take what the consultant says and apply it verbatim, either in clinically-oriented or non-clinically-oriented situations.

20) Behavioral Rehearsal / Role Play

This includes any time a clinician demonstrates or role-plays a skill as a clinician to practice a skill.

- This includes ACTIVE role play only. Setting up a role play is coded under "Other Consultant Strategy."
- DO NOT count if the consultant is playing the role of a clinician. This code is only used when a clinician is playing the role of clinician to practice a skill.
- This will usually involve two people. However, it can also involve a single person if the clinician is practicing a skill in front of others (in cases when a skill is being practiced, but *not* when a skill is being modeled to teach others)

- Double count if verbalization is also appropriate for Case Presentation
    - Example: (Consultant is setting up a role play) "So in this role play we'll say that we have Jessica who is a 9 year-old female…"

21) Other Consultant Strategies

Did the consultant use other strategic methods to respond to providers not covered above?

- This may include:
    - Agenda setting
        - *Example*: "Today we're going to do some didactics and then we'll move into some role plays."
        - *Example*: Consultant says to a provider, "Maria, tell me about yourself and which agency you're from."
        - *Example*: Use when the consultant asks for providers to tell about themselves or whether they have cases, if this is clear from previous context. "Alright, Karl" (Double-code as Questioning/Prompting)
        - *Example*: "Kenny, how many cases have you registered?"
        - *Example*: "Edgar, tell me how many cases you have."
        - *Example*: "Jenny do you have any cases to discuss?"
        - *NOTE*: If the consultant is setting the agenda and poses a question, code it as Questioning over Other Consultant Strategy.
            - *Example*: "Who has something to add to the agenda?"
    - Praising providers for doing something well or for work on a case. Also use when a consultant expresses enthusiasm. Can use this code when enthusiasm is expressed about a case.
        - *Example*: "That was great!" or "I really liked how you explained how you used relaxation in that case."

- "Okay, so thus far you've been doing relaxation with your client and *have been doing a really good job with that*. However, now let's move onto something new."
- "I'm really excited to be able to work with all of you and to get to know more about your experiences and cases."
- Decision Rule: If you're not sure whether to use this code, err on the side of using it (vs. not using it).
    - Example: Provider says, "I was assigned a couple of siblings from the court and the court requested TF-CBT." Consultant says, "That's great." (Double-code as Content: Collaboration)

- "Public shaming" should be coded as Other Consultant Strategy
    - *Example*: "Are you all still on the call…and awake?" (In cases when the consultant prompts consultees to participate and nobody says anything)
- Offering support, assistance, validation, or empathy to providers
    - *Example*: "Yes, that's frustrating." or "I've felt that way myself."
- Wrap-up (usually at end)
    - *Example*: "Okay, thank you everyone for your participation today. I'll see you next week!"
- Any other consultant strategy or response not covered by the above method codes
- Reminder: If consultant brings up a technology issue, that should be coded under "Other" in the Content Codes, do not code it here

- Use this code when a consultant is sharing information about himself/herself
    - *Example*: "I've been a TF-CBT trainer for seven years now and I love doing these calls."
- Use this code if a consultant is setting up a situation where he/she will model what to do
    - "What I am going to do now is model that for everyone so you can see how it might sound."
    - "I am going to model that kind of situation now, so listen carefully to what I say."
- Use this code if a consultant is setting up a role play
    - "What I thought we could do today is a bit of role playing, so let's get started."
    - "So if we have any brave volunteers somebody could play the therapist and someone could play the child and I could help critique some things."
    - "Let me give you a background of the case vignette."
    - (Setting up a role play) "[Child's name for role-play] is a 9-year old female and she experienced abuse by a close family member."
    - "Can someone else volunteer to be the child for this one?"
- When deciding if a verbalization is Didactics/Informing or Other Consultant Strategy, use this as a general rule:

- Didactics/Informing should be used for clinically-oriented discussion
- Other Consultant Strategy should be used for administrative/logistics/agenda-setting/validation, etc.
- *Example*: "What I'd like to do today is have everyone introduce themselves and then tell me a little bit about how you're doing in terms of getting cases." (Double-code as Other Consultant Strategy and Questioning/Prompting)

22) Off-task

Use this code to capture any off-task discussion.

- *Examples*: Weather, sports, chit-chat, catch-up
  - "How's everyone doing today"
  - "I heard there's a heat wave down there in Miami."
- *Examples*: Name clarification
  - C: "Banana, is that what you said?" Liana: "Oh no, it's Liana, L-I-A-N-A." C: "Ok oops sorry, got it, Liana."
  - C: "Maria?" Maria: "Oh, it's Maria, but you can call me Penny." C: "Ok, I've noted that, thanks Penny."

9. Minute-to-Minute Coding Sheets

Coder Name: _____

Call Date/Time:_____,_____:00_____AM____PM____

Call Group ID:_____

Consultant ID: _____

 # Present on Call/# Expected on Call:_____/_____

Total Call Time:_____

Call start time:_____ (to be recorded by master timekeeper)

Notes:

Minute-to-Minute Coding Sheets

	Call Minute															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	*TOTALS*
Content Codes: Consultee Talking																
1) **Case Conceptualization** - Initial ax, appropriateness of case	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
2) **General TF-CBT Model/Components - "WHY"** - Rationale why we use specific TF-CBT components or in general	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
3) **Specific TF-CBT Components - "HOW TO"** - "How to" implement PRACTICE components or assessment, "*how to* " re: using components to address COWs	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
4) **Trauma Narrative** (any mention by Providers)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
5) **Flexibility/Adaptation/Fidelity** - Adapting or flexibly implementing tx, changing tx to fit needs of child/family, general COWs	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
6) **Client/Family Engagement** (General/specific; NOT clt background) - Issues/barriers/strategies, attendance, compliance, homework	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
7) **Provider-Level Barriers** (Provider personal obstacles)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
8) **Organizational-Level Barriers** - Perceived or actual obstacles in organization/setting	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
9) **C-START Issues** - Administrative barriers / C-START requirements / # calls left - Attendance, call logistics, paperwork, registering cases	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
10) **Satisfaction / Success / Appreciation (including client successes)** - Any positive discussion/remarks, facilitators, satisfaction	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
11) **Collaboration** (Positive, Negative, Neutral) - "Working with" others in agency/community - Within agencies, community, or C-START	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
12) **Peer Consultation** - Providers share ideas re: other's case/share experiences/thoughts	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
13) **Technology Issues** (Call disconnect, can't hear, significant static)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
14) **Other** (Issues re: txt, supervision, txt materials, sustainability)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
15) **Off-task** (Weather, sports, chit-chat)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Method Codes: Consultant Talking																
16) **Case Presentation or Discussion/Facilitate ID Case/Conceptualize** - Specific actual or hypothetical case	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
17) **Didactics/Informing** (Clinically-oriented) - Teaching, instruction, feedback, share knowledge	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
18) **Questioning / Prompting**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
19) **Modeling** (Clinically-oriented and non-clinically oriented) - Consultant demonstrates skill in role of clinician (active)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
20) **Behavioral Rehearsal/Role Play** - Provider demos/role-plays skill as a provider (active)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
21) **Other Consultant Strategy** (Set agenda, praise, set up role play)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
22) **Off-task** (Weather, sports, chit-chat)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	

Minute-to-Minute Coding Sheets

	Call Minute															
REMEMBER to do AFFECT RATINGS!	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	***TOTALS***
Content Codes: Consultee Talking																
1) **Case Conceptualization** - Initial ax, appropriateness of case	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
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3) **Specific TF-CBT Components - "HOW TO"** - "How to" implement PRACTICE components or assessment, "*how to* " re: using components to address COWs	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
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10) **Satisfaction / Success / Appreciation (including client successes)** - Any positive discussion/remarks, facilitators, satisfaction	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
11) **Collaboration** (Positive, Negative, Neutral) - "Working with" others in agency/community - Within agencies, community, or C-START	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
12) **Peer Consultation** - Providers share ideas re: other's case/share experiences/thoughts	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
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Minute-to-Minute Coding Sheets — **Call Minute**

REMEMBER to do AFFECT RATINGS!	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	*TOTALS*
Content Codes: Consultee Talking																
1) **Case Conceptualization** - Initial ax, appropriateness of case	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	
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Method Codes: Consultant Talking																
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21) **Other Consultant Strategy** (Set agenda, praise, set up role play)	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	
22) **Off-task** (Weather, sports, chit-chat)	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	

Minute-to-Minute Coding Sheets

	Call Minute															
REMEMBER to do AFFECT RATINGS!	**46**	**47**	**48**	**49**	**50**	**51**	**52**	**53**	**54**	**55**	**56**	**57**	**58**	**59**	**60**	***TOTALS***
Content Codes: Consultee Talking																
1) **Case Conceptualization** - Initial ax, appropriateness of case	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
2) **General TF-CBT Model/Components - "WHY"** - Rationale why we use specific TF-CBT components or in general	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
3) **Specific TF-CBT Components - "HOW TO"** - "How to" implement PRACTICE components or assessment, "*how to* " re: using components to address COWs	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
4) **Trauma Narrative** (any mention by Providers)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
5) **Flexibility/Adaptation/Fidelity** - Adapting or flexibly implementing tx, changing tx to fit needs of child/family, general COWs	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
6) **Client/Family Engagement** (General/specific; NOT clt background) - Issues/barriers/strategies, attendance, compliance, homework	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
7) **Provider-Level Barriers** (Provider personal obstacles)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
8) **Organizational-Level Barriers** - Perceived or actual obstacles in organization/setting	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
9) **C-START Issues** - Administrative barriers / C-START requirements / # calls left - Attendance, call logistics, paperwork, registering cases	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
10) **Satisfaction / Success / Appreciation (including client successes)** - Any positive discussion/remarks, facilitators, satisfaction	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
11) **Collaboration** (Positive, Negative, Neutral) - "Working with" others in agency/community - Within agencies, community, or C-START	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
12) **Peer Consultation** - Providers share ideas re: other's case/share experiences/thoughts	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
13) **Technology Issues** (Call disconnect, can't hear, significant static)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
14) **Other** (Issues re: txt, supervision, txt materials, sustainability)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
15) **Off-task** (Weather, sports, chit-chat)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
Method Codes: Consultant Talking																
16) **Case Presentation or Discussion/Facilitate ID Case/Conceptualize** - Specific actual or hypothetical case	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
17) **Didactics/Informing** (Clinically-oriented) - Teaching, instruction, feedback, share knowledge	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
18) **Questioning / Prompting**	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
19) **Modeling** (Clinically-oriented and non-clinically oriented) - Consultant demonstrates skill in role of clinician (active)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
20) **Behavioral Rehearsal/Role Play** - Provider demos/role-plays skill as a provider (active)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
21) **Other Consultant Strategy** (Set agenda, praise, set up role play)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
22) **Off-task** (Weather, sports, chit-chat)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	

Minute-to-Minute Coding Sheets

	Call Minute															
REMEMBER to do AFFECT RATINGS!	**61**	**62**	**63**	**64**	**65**	**66**	**67**	**68**	**69**	**70**	**71**	**72**	**73**	**74**	**75**	***TOTALS***
Content Codes: Consultee Talking																
1) **Case Conceptualization** - Initial ax, appropriateness of case	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
2) **General TF-CBT Model/Components - "WHY"** - Rationale why we use specific TF-CBT components or in general	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
3) **Specific TF-CBT Components - "HOW TO"** - "How to" implement PRACTICE components or assessment, "*how to* " re: using components to address COWs	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
4) **Trauma Narrative** (any mention by Providers)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
5) **Flexibility/Adaptation/Fidelity** - Adapting or flexibly implementing tx, changing tx to fit needs of child/family, general COWs	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
6) **Client/Family Engagement** (General/specific; NOT clt background) - Issues/barriers/strategies, attendance, compliance, homework	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
7) **Provider-Level Barriers** (Provider personal obstacles)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
8) **Organizational-Level Barriers** - Perceived or actual obstacles in organization/setting	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
9) **C-START Issues** - Administrative barriers / C-START requirements / # calls left - Attendance, call logistics, paperwork, registering cases	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
10) **Satisfaction / Success / Appreciation (including client successes)** - Any positive discussion/remarks, facilitators, satisfaction	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
11) **Collaboration** (Positive, Negative, Neutral) - "Working with" others in agency/community - Within agencies, community, or C-START	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
12) **Peer Consultation** - Providers share ideas re: other's case/share experiences/thoughts	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
13) **Technology Issues** (Call disconnect, can't hear, significant static)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
14) **Other** (Issues re: txt, supervision, txt materials, sustainability)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
15) **Off-task** (Weather, sports, chit-chat)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
Method Codes: Consultant Talking																
16) **Case Presentation or Discussion/Facilitate ID Case/Conceptualize** - Specific actual or hypothetical case	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
17) **Didactics/Informing** (Clinically-oriented) - Teaching, instruction, feedback, share knowledge	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
18) **Questioning / Prompting**	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
19) **Modeling** (Clinically-oriented and non-clinically oriented) - Consultant demonstrates skill in role of clinician (active)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
20) **Behavioral Rehearsal/Role Play** - Provider demos/role-plays skill as a provider (active)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
21) **Other Consultant Strategy** (Set agenda, praise, set up role play)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	
22) **Off-task** (Weather, sports, chit-chat)	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	

Notes: