OUTCOME-INFORMED TRAUMA TREATMENT RESULTS OF THE CRC FUNDED PAA INTERVENTION

August 2020

PAA's Wood Buffalo Region Psychological Trauma Treatment Program: Outcomes of Services as measured by the ORS

This report represents final treatment results from the 2017-2020 Wood Buffalo Wildfires Psychological Trauma Treatment Program delivered by the Psychologists' Association of Alberta & funded by the Canadian Red Cross.

Outcome-informed Trauma Treatment results of the CRC funded PAA intervention

PAA'S WOOD BUFFALO REGION PSYCHOLOGICAL TRAUMA TREATMENT PROGRAM: OUTCOMES OF SERVICES AS MEASURED BY THE ORS

BACKGROUND & DESCRIPTION

The Canadian Red Cross (CRC) approved funding to the Psychologists' Association of Alberta (PAA) on 01 April 2017 under their Alberta Wildfires 2016: Community Organization Partnership Program. This funding was used to directly fund psychological trauma assessment & treatment for those impacted by the 2016 Wood Buffalo region wildfires. Originally set for two years, funding was extended to 3 years to accommodate identified ongoing needs.

PAA operates a short-term Disaster Response Network (DRN) which was activated immediately after the 2016 wildfire. Given the scale of this disaster, & the limited pro-bono interventions provided by the DRN, it was determined that a more formalized intervention was warranted. The CRC funded the Wood Buffalo Region Psychological Trauma Treatment Program with the intent of providing more robust psychological trauma assessment & treatment by psychologists with trauma expertise.

PAA partnered with individual psychologists (specialists in trauma treatment) & with the Wood Buffalo Regional Collaborative Service Delivery (WBRCSD) to provide fully funded trauma assessment & treatment by registered psychologists to those individuals, families, & first responders impacted by the 2016 Wood Buffalo Region Wildfires. All contracted providers were psychologists (or provisionally registered) with trauma expertise as evidenced by certification or trauma training including: Prolonged Exposure (PE) Therapy, Eye Movement Desensitization & Reprocessing (EMDR), Cognitive Processing Therapy (CPT), Present Centered Therapy, and/or Stress Inoculation Training.

Clients approved for funding must have resided in Alberta and/or had previously resided in the region between 01 April 2016 through 01 April 2017. This included migrant or temporary workers employed in the area during 01 April 2016 – 01 October 2016 & first responders who were actively employed between 01 April 2016- 01 April 2017. This included the children, spouses, & family members.

The responsibilities of the PAA include management of the program & financial reimbursement of services provided. The responsibility of all contracted providers is to provide trauma-informed psychological assessments & trauma-informed psychological treatment, to ensure eligibility criteria are met for all service recipients, & to collect required outcome informed measures (using the Outcome Rating Scale (ORS) & other measures as needed).

Clients originally self-referred but in the last year were predominantly identified by frontline CRC staff and referred for ongoing significant psychological distress.

Outcome Informed Practices

Outcome informed practices (OIP), or the use of progress monitoring techniques in clinical practice, empirically validate treatment response. OIP aligns with PAA's mandate of advancing the science-based profession of psychology. PAA promotes the use of progress monitoring tools which have demonstrated benefit in: increasing clinician expertise, highlighting biases in clinical judgement, increasing service quality, decreasing no-show & cancellation rates, increasing retention rates, & identifying high-risk clients most effectively (Kowalyk et al., 2013).

Specific scales, such as the Outcome Rating Scale (ORS), can evaluate the overall effectiveness & compare outcomes of individuals & programs, strengthen therapeutic relationships, aid clinical decision-making, & give insight to treatment plan modifications (Bringhurst, Watson, Miller & Duncan, 2004; Fitzpatrick, 2012; Miller, 2012).

The Outcome Rating Scale (ORS) evaluates overall treatment effectiveness & compares outcomes of individuals & programs for cost savings, stronger therapeutic relationships, better clinical decision-making, & treatment plan modifications

ORS

The ORS provides clients & clinicians with an outcome measurement tool that is easily implemented on a routine basis within everyday clinical practice. This four-item visual analogue scale demonstrates strong reliability estimates & provides rapid & valid information about patient functioning & wellbeing.

Respondents rate how they are feeling about their general wellbeing, personal wellbeing, family relationships, & social relationships allowing the ORS to measure the four domains of individual, interpersonal, social, & overall functioning (Campbell & Hemsley, 2009).

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METHODOLOGY

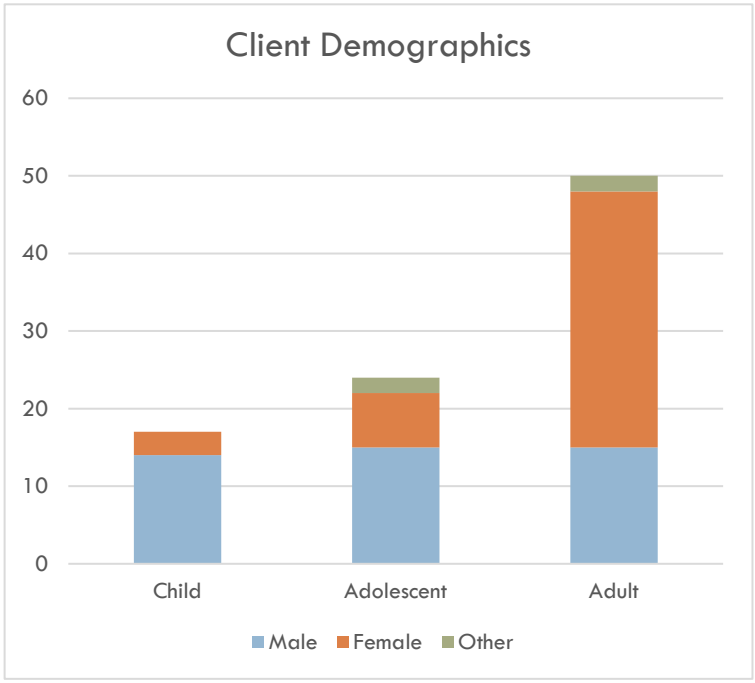
16 approved psychologists provided trauma-informed psychological services (three directly in the Wood Buffalo Region and one who travelled to the community to provide service).

At the intake session (session 1) clients consent included information about the ORS, program intent, & confidentiality (protected through de-aggregating ORS data using letter codes).

Clients completed the ORS at five-session intervals. The ORS data collected in this report is scored on a 1-10 scale.

Participants

There were 349 clients served individually, in group, or as families. Usable data was collected from 91 or 26% of clients served (a representative sample) individually.



The participant sample included children (n=17), adolescents (n=24), & adults (n=50). Of those participants, clients were female (48%), male (48%), or unspecified (4%).

Of the 43 female clients, 7% were children (n=3), 16% represented adolescents (n=7) & 77% were adults (n=33).

Of the 44 male clients, 32% were children (n=14), 34% were adolescents (n=15) & adults represented 34% (n=15).

Of the unassigned or unknown genders, two were adults & two were adolescents.

Both the clients & the providers in this report have been de-identified to protect their personal identities during data analysis via assigned letter coding per person

RESULTS

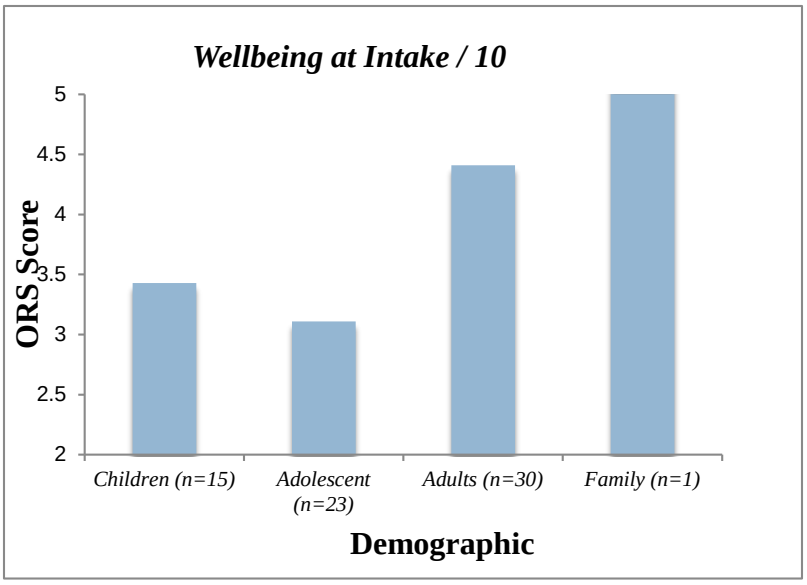
Study data was collected over a period of 56 weeks. Client ORS information was entered into Excel 2011, & basic statistical analyses were carried out with average & sum calculations for grouped data.

Data analysis included focus on the overall category of functioning as included in the ORS form. The statistical analysis was intended to determine the effects of trauma treatment over time.

Functioning & Wellbeing at Intake

All clients completed the ORS at intake to provide a baseline of functioning & wellbeing.

The best possible functioning & wellbeing scores at intake would be 10.



82% of participants rated at 5/10 or lower at intake indicating low levels of functioning. 74% of adults, 100% of adolescents, and 82% of children had low levels of functioning at intake.

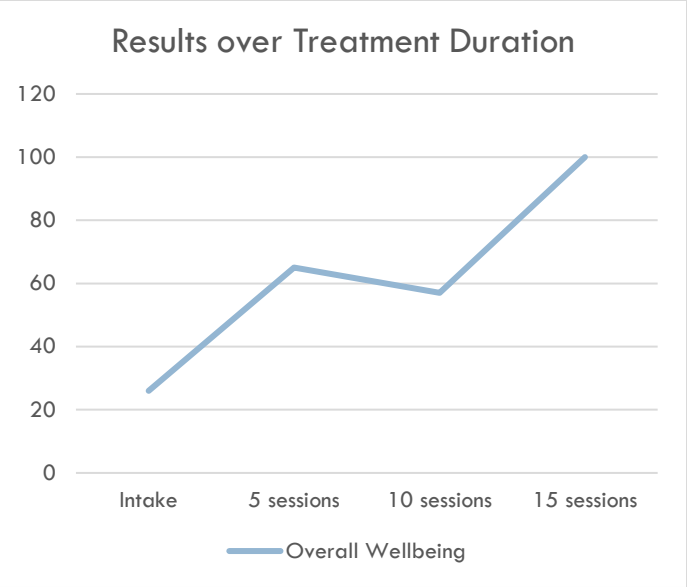
100% of adults and adolescents of non-specified gender reported low functioning at intake.

This indicates a very low level of functioning & perceived wellbeing amongst clients but more so for children. Adolescents reported the lowest levels of functioning at intake.

At intake, wellbeing was reported at less than 50% of potential with the worst outcomes for adolescents & children & for those with non-disclosed gender status

Overall Treatment Results

Scores were compared over the treatment period, generally, with outcomes at intake, the end of assessment (typically session 5), & at the end of the first treatment period (typically session 10). 29% participants received 5 or more sessions.



For those participants receiving at least 5 treatment sessions, 65% demonstrated clinically significant improvements in overall wellbeing. For those participants receiving at least 10 treatment sessions, 57% demonstrated clinically significant improvements in overall wellbeing. And, for those participants receiving at least 15 treatment sessions, 100% demonstrated clinically significant improvements in overall wellbeing.

Results indicate that overall average functioning & well-being increased over the treatment period with the greatest benefits after 15 sessions.

Adult participant self-report ratings indicated the most significant benefits in overall functioning after 15 sessions of treatment

CLINICIANS' FEEDBACK

In addition to the OSR data collected from clients, the PAA sought feedback about the program from participating clinicians involved in the program. Overall, clinicians had a mixed view of the program's success. In addition to their concerns regarding treatment delays, clinicians noted a number of challenges including: 1) not having access to an appropriate, confidential counselling space; 2) receiving a significant number of inappropriate, non-traumatic referrals from the CRC; 3) inability to offer consistent weekly counselling sessions to clients; 4) pre-existing client mental health issues that greatly exacerbated the emotional impact of the disaster; 5) clients' ongoing financial distress in relation to the CRC that became a chronic stressor throughout the course of treatment; and 6) having to terminate treatment prematurely due to loss of funding.

Treatment was hindered by the treatment conditions, referral suitability, & funding

SUMMARY

At the completion of this project, 349 clients were served by 16 psychologists under this wildfire psychological trauma treatment program and a representative sample of 91 (26%) provided data for this analysis.

Approximately 92% of the sample clients who participated in the PAA Wood Buffalo Trauma Treatment Program did not receive counselling until 18 – 24 months after the disaster. This extensive treatment delay is noteworthy as the evidence suggests that early intervention after trauma exposure leads to positive long-term clinical outcomes (Litz, 2015; Oosterbaan, et al., 2019).

Assessments at intake indicated that, regardless of age or gender, clients participating in the program were self-reporting very low levels of functioning & wellbeing.

Further, while 33% of adult females showed improvement as a result of participating in the program, none of the female adolescents or children demonstrated improvements in wellbeing. Rather, they presented with either no change or a decline in their overall level of wellbeing. This finding is alarming as it is well established that women and girls present with higher levels of general psychological distress, depression and anxiety than men and boys (Van Droogenbroeck, Spruyt, & Keppens, 2018).

Finally, while 13% of the 44 male clients did report clinical improvements, overall they received significantly fewer treatment hours compared to females. Indeed, none of the 26 male adolescents and children appear to have achieved the minimal 5 session benchmark set in order to acquire comparative data on their clinical progress. This finding reaffirms well-established data in the clinical literature on the many barriers faced by males seeking treatment for mental health issues (Lynch, Long, Moorhead, 2016; Perlick & Manning, 2007).

Outcome measures can enhance therapeutic outcome even for those who do not improve as expected. In trauma treatment, what could be interpreted as not appearing effective may represent the response (often from trauma assessment) of uncovering trauma necessary for psychological growth & resiliency. Often, more time is required for the client to respond positively & a continuation of the current treatment plan is the appropriate clinical decision (Hatfield, 2006).

Treatment made a significant difference for clients who received sufficient treatment, but referrals were delayed, and many participants received few sessions

RECOMMENDATIONS

Based on the data emerging from this program, the PAA is making the following five key recommendations:

1) Albertans must be provided with timely access to trauma assessments and counselling in the face of all future natural disasters.

2) Clinical screening of clients seeking trauma recovery services must be conducted by trauma-informed professionals.

3) Special consideration must be given to the unique needs of children and youth who are exceptionally vulnerable to the long-term effects of trauma exposure.

4) Existing barriers to men's access to mental health treatment must be identified and ameliorated.

5) To ensure treatment efficacy, participating clients in future trauma recovery projects must be appropriately funded for no less than 15 counselling sessions with efforts to remove barriers to service access.

Post-disaster, treatment must be timely, trauma-informed, tailored to the developmental stage and gender of the client, and treatment conditions (including funding) must be sufficient to support success

ACKNOWLEDGEMENTS

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