NWX-OS-OGC-RKVL (US)

Moderator: Jaclyn Ruiz

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1:30 pm CT

Coordinator: Excuse me, this is the operator. I'd like to inform all participants that today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I'd like to turn the conference over to Ms. Jaclyn Ruiz. Thank you, ma'am, you may begin.

Jaclyn Ruiz: Thank you. Today we'll be interviewing Dr. Mary Jane Rotheram-Borus as part of our developer interview series. The Office of Adolescent Health will be hosting a series of interviews with developers of those programs identified by the Department of Health and Human Services, teen pregnancy prevention, evidence review as having shown effectiveness in reducing teen pregnancy, sexually-transmitted infections or sexual risk behaviors.

The goal of these interviews is to ask developers some of the most frequently-asked questions by OAH grantees. The Webinar series was developed as a technical assistance product for use with OAH grant programs to provide additional guidance on selecting, planning and implementing an evidence-based program for teen pregnancy prevention.

The Webinar should not be used on its own but as a complement to various other resources available online. Additional resources are identified later in this PowerPoint presentation. Inclusion on the HHS teen pregnancy prevention evidence review does not indicate HHS or OAH endorsement of a program model.

As I mentioned we are interviewing Dr. Mary Jane Rotheram-Borus. She's a Professor of Clinical Psychology and Director of the Global Center for Children and Families and the Center for HIV Identification, Prevention and Treatment Services at the Semel Institute for Neuroscience and Human Behavior at UCLA.

Her research interests include HIV/AIDS prevention with adolescents, children and family wellness assessment and modification of children's social skills, suicide among adolescents and homeless youth.

Dr. Rotheram-Borus has spent the past 30 years developing, evaluating and disseminating evidence-based intervention for children and families. She has directed and implemented several landmark intervention studies that have demonstrated the benefits of providing behavior-change programs and support of families in risky situations.

Several of these programs have received national and international recognition. She mounted and evaluated multiple interventions which have been selected and reviewed by the Substance Abuse and Mental Services Administration, the Center for Disease Control and Prevention and the American Psychological Association as (efficacious) program.

Welcome, Mary Jane. Sorry, that was a lot of words. Can you please briefly describe the program Project Talk?

Mary Jane Rotheram-Borus: Yes, Project Talk was developed initially for families with AIDS who had a terminal illness and were expected to die in a year and but now it's also been both designed and evaluated for families with a chronic disease. AIDS is seen as a prototype because whenever families have an ill parent, that illness decreases their ability to parent well and stress especially mental health symptoms radiate throughout the family to all the children.

So that interventions for families with either a terminal or chronic illness first want to develop better social skills for coping with these stresses in daily life and the skills are common across all evidence-based interventions, problem solving, goal setting, coping with feeling anxious, angry, depressed.

The second would be that we want to set expectations because most of diseases have a specific course. That's certainly true in HIV and the course has changed from our first study that we evaluated in 1993 to '96 and that from 2005 to today.

And finally what families are going to need to do is to establish daily routines that optimize their health so our goals in these programs to decrease emotional distress, to help families have fewer behavior problems like being truant from school for the adolescents, getting involved with drugs, doing a criminal act, threatening or being aggressive with others.

And in particular for the Office of Adolescent Health to reduce the number of sex partners which our programs did do, increase protected sex but where the real money outcome is is to have fewer and later babies, not become teenage pregnant.

Our programs have targeted low-income ethnic minority parents and our typical delivery formats have been small groups where parents meet alone, kids meet alone and then they meet together but we've expanded those delivery formats in more recent years to home visiting, to soccer, to clinical and hospital visits.

Jaclyn Ruiz: And I don't know if you want to maybe wait until another slide to talk a little bit about the key components. It sounds like we might talk about it when we get to adaptations, is that correct?

Mary Jane Rotheram-Borus: I think so, yes.

Jaclyn Ruiz: Okay, so I'll hold off on that question. Can you describe some of the previous evaluation results?

Mary Jane Rotheram-Borus: So our first study was in New York City with parents most of whom were injecting drug users and whose lives had been immersed in drug abuse cultures. More than half have been in jail.

Their partners were injectors and these parents over a period we evaluated them for two years, they respond to it - I'm sorry, we evaluated them for six years - but by the first evaluation which was two years later, parents are using substantially and significantly fewer drugs, on fewer days a month, less severe drugs.

They moved from heroin, injecting heroin down to using marijuana. They were significantly less depressed and they were better parents. Youth had fewer and later babies, youth used less alcohol and drugs. They were less emotionally distressed.

And it was not only compared to a compare group of other young adolescents who had parents with HIV but also compared to other kids in their neighborhoods without a male parent and they were more likely to finish to school.

Our second study was in Los Angeles also with low-income Latino and African-American families and their adolescents but these were more stable, non-drug-involved families and now our primary outcomes were on depression and the third study which we conducted was with home visits.

We're now in the fifth year of evaluation and these were with other adolescents, they were parents with younger children and we found substantial a 50% improvement in the tasks for preventing maternal to child transmission, less emotional distress on the parents, longer and better breastfeeding of any children that occurs. At three years we had significantly less depressed parents and those outcomes are currently being evaluated at age 5 for children.

Jaclyn Ruiz: Can you talk a little bit more about the valuated populations and especially discussed a little bit about what population do you think would be applicable for this program?

Mary Jane Rotheram-Borus: We focused on low income who were African-American, Latino, Caucasian, some Asian but very few in numbers. Our interventions were with their parents and adolescent children but we've now expanded that to pregnant women and to families with children that have much younger children from birth to adolescents as well.

We've included extended families that included grandparents in China, grandparents and nieces, nephews, aunts and uncles. What we find is with HIV certainly but other chronic and terminal diseases as well, there's always

substantial discrimination and stigma in the community and parents are very aware of it as are their children.

Almost all the adolescents know about the disease and when parents have had a huge risk history, it's a window of opportunity to help them basically get their lives together especially when they fear death.

And we've evaluated both when HIV was a chronic illness as well as when it was a terminal illness but on the next slide we've evaluated these in settings which are community settings. Many parents don't want us to go and have any meeting in their own community for the fear of stigmatization and discrimination.

They're willing to take a bus in order to have it not in my backyard. We've done programs at hospitals and clinics and home visits. It's a program that's always been delivered by para-professionals. Parents from the neighborhood who have similar backgrounds who we train to deliver the program.

And across all adaptations in Thailand, Zimbabwe, Haiti, South Africa as well as two spots in the United States, the same principles, elements and processes were involved in every program.

As you can see if you go to the next slide, our theory is always the same and while it's only one sentence, it takes a long time to train. Families change slowly over time in relationships taking small steps with opportunities and rewards. While it's only one sentence, to train a para-professional, what does that mean when what you want to do is help somebody feel less depressed every day?

How do people get less depressed? It's not going to be I'm depressed today and not - depressed today - and not depressed tomorrow. You're going to feel a little better every day as you make small behavioral changes and when we train people how to make that behavior change, we've found that 80% in a review of more than 900 manuals of evidence-based interventions, all of those currently available for children and adolescents that 80% of those manuals use the same skills.

So we train para-professionals on those skills, goal setting, problem solving, relaxation, praising, social rewards, being more assertive and a few others and that across all evidence-based interventions especially those that are HIV when we again rate the manuals.

There are embedded some principles, habits of daily living which work whatever your family issue is. Be prepared, act on what you know, not on what you feel. Be internally directed by yourself, not to please your peers. Choose to limit your own freedom. You could have 50 sexual partners but you choose not to.

And then these common principles are again always addressed with five different aspects of whatever the content area is, whether it's being an adolescent, whether it's having a parent with AIDS or cancer, whether it's that you're a depressed person or an anxious person, that you frame the issue.

There is a limited amount of information but not too much but that you have to apply to the person's life. You have to build skills, those are those 14 practice elements. Everybody needs to be better able to set goals and problem solve. You need to eliminate environmental barriers.

If it's for HIV, you need to have access to HIV testing, (kits) and you need to build an ongoing way of social support. Our manual has all of these practice elements, principles and common factors and it gives you one example of how to put those together.

For families in New York we have one manual. For families in L.A. we have another. We have four other demonstrations but you're going to need to culturally tailor the scripts, what you do for the ethnicity, the language, the incoming or the education of who you want to address needs to be adapted by you who knows the population better.

And our manual is only one example of how to give the skills, the principles and to deal with those common factors for a terminal and a chronic illness. On the next slide our potential adaptations are for probably any institutional or community setting, it is our manuals always anticipate that there's stigma and discrimination for families with an ill or terminally-ill or chronically-ill parent.

We want you to do it in the local language. We want you to adapt it and there are other examples of adaptation of our program in Thailand, China, Haiti and Zimbabwe.

Jaclyn Ruiz: And so Mary Jane can I actually just interrupt real quick because I have a couple of questions that I thought of as you've been explaining the program so just really quickly back to the target population. I know we've said parent with a chronic illness and I just want to clarify that it's a parent with a chronic illness and a child who has a parent with a chronic illness so it's both the child and parent together, right?

Mary Jane Rotheram-Borus: Yes, although they meet separately as well as together.

Jaclyn Ruiz: And so I was also hoping you could maybe talk a little bit about sort the length of the program. I might have missed it when you were talking about what you did when you did the evaluation of it so I know you said it was over the course of six years. Was the intervention occurring over that course of six years and was it any difference between the New York City one versus the L.A.?

Mary Jane Rotheram-Borus: So in our original evaluation it was 16 sessions while the parent was alive and the parent was and we put it in modules so the first module was for parents only and for those parents it was for them to cope with their illness, to get links to medical peer and adhere to their medical regimens on an ongoing basis for eight sessions.

We did two sessions a day and so families would come on a Saturday and have a session in the morning, a session in the afternoon and build their social networks during lunch. For the second eight sessions it was about parenting better for the parents and for the adolescents coping with your parents' illness, again eight sessions, four Saturdays, one in the morning, on in the afternoon.

And for the 50% whose parents died, we had another eight sessions, four Saturdays, one in the morning, one in the afternoon about with your new caregiver and the adolescent.

In Los Angeles by that time HIV had become a chronic illness and so it was reduced to 16 sessions and again that was only eight times that the families got together and the first evaluation of families in New York City lasted six years and the evaluation period for the families in Los Angeles lasted 18 months.

Jaclyn Ruiz: Thank you, sorry, I really wanted to sort of clarify that because I know I was sort of wondering if I was thinking about implementing the program like how did you guys do it in terms of length and I think providing sort of the number of sessions and understanding that there was a difference between what was happening in New York with HIV at the time versus the L.A. and how that might show when grantees go on your Website and look at the different manuals that are available so thank you for that clarification.

Mary Jane Rotheram-Borus: Because we want to extend this to families with other terminal and chronic illnesses, we think that the program should be offered in the clinical sites and drop-in groups whenever the parent comes for one of their medical appointments and that's how we evaluated it in one of the adaptations in South Africa.

Jaclyn Ruiz: Oh, that's a great idea, thank you for that information. I also just wanted to know at least for Slide 10 as we talk about adaptation just a little bit of some Office of Adolescent Health disclaimer language that if any potential grantees or current grantees are thinking about making adaptations to this program that they also need to make sure to talk to their project officer whoever that is about the adaptation to ensure that they're getting OAH prior approval for that.

And of course we make sure to work closely with the developer to ensure that that's, you know, appropriate for the program as well. I'm going to turn it back over to you, sorry Mary Jane for the interruption of any sort of training consider, I mean, staffing considerations. I know you've already talked about that a little bit more but I know you have some great bullets on the slide and then training considerations for grantees.

Mary Jane Rotheram-Borus: Okay, we always have two para-professionals in a group, one to manage the content presentation and one to manage the group process. We give our groups an advantage, a structural advantage, distributing, we have every group member we give them 20 tokens in the beginning of the group.

These tokens aren't turned-in for anything. It doesn't buy you anything. They can be poker chips. We used one color of poker chips and every time you want to say something, appreciate another group member or note catch them being good in a way that somebody does something you like, you give them a token and say something to them as you give them that token.

It's a huge advantage in eliciting in a supportive group environment. When you select parents, some of many of our group leaders have no more than a 10th-grade education but we select what's called positive peer deviance, people who are positive role models in their communities.

They're good problem solvers. Their homes tended to be organized. Their kids tend to be doing well but all kids can get in trouble. They are parents themselves and we train them in those basic cognitive behavioral change strategies, the theory, the principles and the practice elements that we mentioned on the page before.

In the last 10 years we always give a mobile phone. We ask only three questions but every single contact whether it's an individual family in a home visit, a telephone contact or a small group meeting, the para-professionals, leaders, each of them reports what did they cover, what content area?

It's a checklist from the multiple choices. What skill did you focus on and did you think you had any impact? We allow drop-in services. We link to other services. If you can get a parent to come one time, we find that parents will

then attend 75% of sessions. We do know though that across globally we've found people don't want to go to meetings in their own backyard.

They want to be anonymous when they go to these meetings and they prefer to take a bus than to meet at their local church. Any questions?

Jaclyn Ruiz: No, I was actually I think that might be a great segue for talking about challenges when you were implementing this program and sort of any strategies that you believe would have worked or may have worked in overcoming those challenges.

Mary Jane Rotheram-Borus: So we train in the common principles on practices and factors only for about a week to begin with and we train on the manual but we find that participant-professionals especially people without a lot of education they get all this new knowledge about a disease and about how to cope with making healthy family routines and they want to dump their new knowledge on people all the time.

That's not going to be useful and it's not going to change people's behavior so we have to stop them from giving that knowledge and focus on how to help families change what they're doing. Iterative quality improvement over time is what we expect. We don't expect fidelity to be scripts and the sequenced set of activities in our manual.

We expect that the content areas and the topics are going to be highly relevant in the manual but that the leader has to be able to problem solve how is each person in that group and it's you have to help use of problem solving, are they going to improve the habits of daily living?

We use the tokens as I mentioned above among all group members noticing the good feelings they have towards others and we've even extended moving our interventions from clinics or community settings and having group meetings to having the (men) who are living with HIV play soccer three days a week and the intervention was delivered by their coaches.

That's an ongoing evaluation but our first prime pilot of that for six months we found dramatic reductions in drug abuse among young men who were living with HIV when we organized the soccer program for them.

We are planning some curriculum revisions and have supplemental manuals on our Websites about the foundational skills, the practice elements and the principles that we think are common to all evidence-based interventions.

Jaclyn Ruiz: And Mary Jane I have a question. In terms of the training of the para-professionals that you mentioned, is that something that a site if an organization wants to implement this should think about getting somewhere else or is that something that they could contact you and you guys can help them develop the trainings that the para-professionals would need? How would that work?

Mary Jane Rotheram-Borus: We can both help them and we can refer them to people in their local community. The most critical training piece is to train a para - are two-fold - to train strongly with a lot of role-playing, maybe 200 at least different role plays about applying cognitive behavioral change theories to people's everyday problems.

The second is to monitoring what para-professionals are doing every single time on an ongoing basis so that supervisors have data that informs them how to help this para-professional improve their skills.

What we've found in our data over the last 20 years is that in the beginning para-professionals only focus on building a relationship and being trusted. Trust is critical, is essential but not enough and to move para-professionals from only building their trusted relationship to actually helping somebody problem solve, set a goal, problem solve and change their behavior is a far more sophisticated skill and we estimate that it takes nine months of improving over time based on supervision and feedback from the mobile phone-based ratings to get highly skilled para-professionals.

They're implementing the program over that nine months but they're getting better at it over time.

Jaclyn Ruiz: So it seems as if for staffing purposes in addition to para-professionals, whoever is the supervisor of the para-professionals should themselves be highly trained in cognitive behavioral theory?

Mary Jane Rotheram-Borus: That's right.

Jaclyn Ruiz: Okay, that's very helpful to know.

Mary Jane Rotheram-Borus: And there are local resources in every community for this. They can come to us and we can provide the expertise about how to combine cognitive behavioral for terminally-ill or chronically-ill parent especially those with HIV but anybody who's going to implement, there is not an adolescent intervention program that is not based on cognitive behavioral skills theory.

Jaclyn Ruiz: Right, no, that's very important to know so I just wanted to refer our listeners to Slide 14 that has additional information on Project Talk and that these resources in conjunction with today's Webinar we're hoping will provide

anybody with a more comprehensive understanding of this evidence-based teen pregnancy prevention and will assist you in making not only an informed decision on which evidence-based program to select for your community but how to best prepare for and implement this program.

Mary Jane do you have any final words? I think this has been incredibly helpful I should know especially for myself to get to know a little bit more about Project Talk but is there anything else you'd like to add?

Mary Jane Rotheram-Borus: We'd just like to thank the government because the more evidence-based programs we've been now nationally, the healthier our teens are going to be.

Jaclyn Ruiz: Well, thank you again and for everybody on the call, Slide 15 or everybody listening I should say, on Slide 15 you'll find contact information for Dr. Rotheram-Borus. As she mentioned, you know, you can definitely contact her if you have questions about the program, training or resources that she may be able to refer you to in your community if you want to know how to be able to implement this program so thank you again.

Mary Jane Rotheram-Borus: Thank you.

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