



Training Substance Use Disorder Counselors in Cognitive Behavioral Therapy for Depression: Development and Initial Exploration of an Online Training Program



Geoffrey M. Curran, Ph.D.^{a,e,*}, Stephanie M. Woo, Ph.D.^b, Kimberly A. Hepner, Ph.D.^c, Wen Pin Lai, M.S.^d, Teresa L. Kramer, Ph.D.^e, Karen L. Drummond, Ph.D.^{a,e}, Ken Weingardt, Ph.D.^d

^a Central Arkansas Veterans Healthcare System, 2200 Fort Roots Drive, North Little Rock, AR 72144, USA

^b Department of Psychology, Pepperdine University, Graduate School of Education and Psychology, 24255 Pacific Coast Highway, Malibu, CA 90263, USA

^c RAND Corporation, 1776 Main St., Santa Monica, CA 90401, USA

^d VA Palo Alto Healthcare System, 795 Willow Road (152-MPD), Menlo Park, CA 94025, USA

^e Department of Psychiatry, University of Arkansas for Medical Sciences, 4301 West Markham Ave., Little Rock, AR 772205, USA

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ABSTRACT

Introduction: Evidence based psychotherapies (EBPs) remain underutilized. Models for EBP training and implementation that are cost-effective, minimally disruptive, and sufficiently flexible are needed. Internet-based technology is a promising platform, but questions remain about how this technology can address the barriers to implementation. We developed and examined the implementation of an online training for the Building Recovery by Improving Goals, Habits, and Thoughts (BRIGHT) intervention—a manualized, sixteen-session group depression treatment for individuals with substance use disorders (SUDs). We explored the feasibility of replacing in-person BRIGHT training with a self-paced, online training.

Methods: A highly partnered and iterative process was followed to translate the written BRIGHT manual and associated didactic training materials into a media rich, interactive, and detailed (12–16 h) online training. Subsequently, 8 volunteer counselors across 7 Veterans' Affairs SUD programs completed the training. Semi-structured interviews focused on the counselors' experiences and their plans for implementing BRIGHT groups. A template approach, using a mixture of deductive and inductive coding, was used for data analyses.

Findings: The most important barrier to completing training was a lack of protected time. Most counselors were not afforded protected time and reported a sometimes frustrating and fragmented training experience. Many used personal time at work and at home to complete the work. Facilitators to completing the training included positive reactions/attitudes towards the training modules, supervisor support, counselor dedication, and strong beliefs supporting providing services for depression. Many counselors were also concerned about the feasibility of fitting 16 group sessions (2 h each) into their program's clinical schedule, but many had devised potential solutions or "work-arounds" to accommodate or approximate the recommended treatment course (e.g., using lunch times, reducing some content/exercises).

Conclusion: This work contributes to the literature on implementation of complex EBPs and addresses the strengths and limitations of web-based technologies in supporting the implementation of EBPs.

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1. Introduction

Evidence based psychotherapies (EBPs) are available for a wide range of mental health disorders, yet remain underutilized in routine clinical practice (Jameson, Chambless, & Blank, 2009; Shafran et al., 2009; Young, Klap, Sherbourne, & Wells, 2001). Although pressure to

use EBPs has come from many arenas, including clinical care guidelines and policy statements of professional organizations and government entities (American Psychological Association, 2005; NICE, 2009), third party payers (Sanderson, 2003), and even legislated mandates (Biegel et al., 2003; Chorpita et al., 2002; Rieckmann, Kovas, Fussell, & Stettler, 2009), significant organizational and practitioner barriers to EBP implementation remain (Gotham, 2006).

Among the organizational hurdles to be crossed are convincing administrators and other key stakeholders of the advantages of EBP adoption (e.g., improved client outcomes, consistency of care) and addressing concerns about how training and implementation can fit within existing organizational practices (Gunter & Whittal, 2010; Rogers, 2002; Stirman, Crits-Christoph, & DeRubeis, 2004; Woo et al.,

* Corresponding author at: Department of Psychiatry, University of Arkansas for Medical Sciences, 4301 West Markham Ave., Little Rock, AR 772205, USA. Tel.: +1 501 686 7601; fax: +1 501 296 1168.

E-mail addresses: currangeoffrey@uams.edu (G.M. Curran), stephanie.woo@pepperdine.edu (S.M. Woo), hepner@rand.org (K.A. Hepner), wenpin.lai@va.gov (W.P. Lai), kramerteresal@uams.edu (T.L. Kramer), kldrummond@uams.edu (K.L. Drummond), ken.weingardt@va.gov (K. Weingardt).

2013). A recent survey of front-line service providers and other employees from 55 primarily community-based and residential treatment programs found that EBP adoption was associated with considerable organizational stress, including employee perceptions of increased stress, decreased work engagement, and difficulties receiving help and cooperation from co-workers (Patterson-Silver Wolf, Dulmus, & Maguin, 2012).

If adoption of an EBP is highly complex, costly, or time consuming, implementation will be difficult even if providers are interested in learning the intervention. Although Sholomskas et al. (2005) found that clinicians who completed a 3-day in-person didactic seminar and post-training supervision were superior in implementing Cognitive Behavioral Therapy (CBT) compared to those who only read a treatment manual, several clinicians could not initially be randomized to the seminar plus supervision group because they could not attend the training (e.g., could not obtain permission from their employers to miss work). Understanding the culture and structure of an organization and allowing for flexibility in how EBPs are implemented have been highlighted as under-recognized but critical components of successful EBP dissemination (Foa, Gillihan, & Bryant, 2013). It is therefore important to explore how adaptations of usual training methods can enhance the transportability of EBPs (Gotham, 2006).

While visible organizational support is key in encouraging adoption of EBPs (Sanders & Turner, 2005; Woo et al., 2013), additional barriers at the individual clinician level can also hamper dissemination efforts. Like their administrative counterparts, busy practitioners also have concerns about the time and expense associated with EBP training (Lewis & Simons, 2011; Riley et al., 2007; Stewart, Stirman, & Chambless, 2012). Surveys further indicate that clinicians are more likely to base treatment decisions on past clinical experiences than on approaches supported by literature (Riley et al., 2007; Stewart & Chambless, 2007). Clinicians are often wary of EBPs (especially manualized treatments) out of concern they will detract from client–therapist rapport, will be less effective with clients seen in real-world settings, and will remove therapist experience from clinical decision making (Lewis & Simons, 2011; Shafran et al., 2009; Stewart et al., 2012). Providing clinicians with research-based evidence that supports EBP effectiveness and dispels common “myths” may be helpful (Sanders & Turner, 2005). However, additional strategies are equally important, such as demonstrating respect for clinicians’ expertise and experience (e.g., seeking their input on training and implementation efforts), examining ways to flexibly integrate EBPs within clinicians’ existing practices (e.g., noting similarities between EBPs and usual approaches), and highlighting the EBP relevance through application to actual clinical examples in training (Gunter & Whittal, 2010; Lewis & Simons, 2011; Sanders & Turner, 2005; Stewart et al., 2012; Stirman et al., 2004; Woo et al., 2013).

Researchers thus face a major challenge in developing models for EBP training and implementation that are cost-effective, minimally disruptive to an organization’s daily practices, address clinician concerns, and are sufficiently flexible and engaging so that learning the EBP does not seem overly burdensome. While this is a tall order to fill, internet-based technology is a promising platform from which to launch efforts to address some of the dissemination barriers. In contrast to traditional in-person training, web-based training is more flexible because practitioners can access it at their convenience. This may address one of the most common practitioner barriers to EBP implementation: lack of time to learn the intervention. Web-based training can also be spaced (facilitating absorption, reflection, and practice of information) and graded (e.g., repeated for therapists slower to develop competence), which may enhance learning (Rakovshik & McManus, 2010). Use of embedded videos and interactive formats can replicate elements of in-person training that have been recommended in the literature (Woo et al., 2013). Preliminary investigation of this type of multimedia online training indicates high user satisfaction ratings (Kobak, Craske, Rose, & Wolitsky-Taylor, 2013). Supervision or consultation can also be provided via synchronous online formats (web conferencing) or

teleconferencing which can address the problem of not having an on-site EBP expert available to provide ongoing support and answer clinicians’ questions (Lewis & Simons, 2011). Both online training and supervision have the further advantage of being highly scalable, meaning that once materials are developed, it is relatively easy to rapidly increase the number of trainees without significant increases in training resources (Weingardt, Cucciare, Bellotti, & Lai, 2009).

Weingardt et al. (2009) studied a “blended” learning approach combining self-paced online training modules and live supervision via web conferencing in a group of substance abuse counselors learning CBT. Participants were randomly assigned to one of two conditions that varied the degree of structure placed upon clinicians when completing the online training and supervision. Clinicians in both conditions demonstrated significant increases in CBT knowledge and self-efficacy in delivering the intervention. These findings suggest that different types of online training and supervision can be flexibly combined to improve clinician knowledge of and comfort with EBPs. Kobak et al. (2013) similarly found that clinician knowledge of CBT significantly increased following completion of a self-paced, interactive online tutorial on CBT for anxiety disorders and 3 individual videoconference training sessions. Importantly, blind ratings indicated significant improvement in the application of CBT skills as observed from the first to last video training session (in which clinicians conducted a mock-CBT session with a clinical supervisor).

Although training approaches utilizing the internet and other forms of technology hold promise for greatly expanding training opportunities for clinicians to learn EBPs, to what extent such strategies can address the many significant barriers to implementation that have been reviewed remains an empirical question. The present study examined the development and implementation of a web-based, interactive training program plus weekly telephone consultation/supervision for the Building Recovery by Improving Goals, Habits, and Thoughts intervention (Hepner, Hunter, Paddock, Zhou, & Watkins, 2011). BRIGHT is a manualized, 16-session CBT group depression treatment for individuals with Substance Use Disorders (SUDs). Hepner et al. (2011) found that addiction counselors with little or no prior mental health experience could be effectively trained to deliver BRIGHT after undergoing a 2-day in-person training and receiving weekly clinical group supervision with a CBT therapist. We were interested in exploring the feasibility of replacing the in-person BRIGHT training with a self-paced, online training program and utilizing distance consultation. Data are presented here from clinicians at 7 Veterans Administration (VA) sites who volunteered to participate in the study. The goals of the overall study were to assess the feasibility of the training and subsequent implementation of the BRIGHT groups, to evaluate satisfaction of the counselors and programs with the training and implementation of the groups supported by distance supervision, and to better understand barriers to routine implementation and sustainability of the online trainings accompanied by distance supervision. The current manuscript focuses on the development of the online trainings, the counselors’ experiences in completing the trainings, and their expectations for implementation. A subsequent manuscript will focus on the implementation of the BRIGHT groups by the counselors and possible barriers/facilitators to uptake and sustainability on a large scale. This work contributes to the literature on implementation of EBPs for the type of complex clinical presentations often encountered in community practice and addresses the strengths and limitations of web-based and distance training technologies in supporting the implementation of EBPs.

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