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Early assessment of implementing evidence-based brief therapy interventions among secondary service psychiatric therapists☆

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ABSTRACT

This implementation study was part of the Ostrobothnia Depression Study, in Finland, which covered implementation of motivational interviewing (MI) and behavioral activation (BA) within regional public psychiatric secondary care. It aimed to evaluate the mid-term progress of implementation and related factors. Altogether, 80 therapists had been educated through the implementation program by the point of the mid-term evaluation. Eligible information for evaluation was gathered using two questionnaires (q1, q2) with a one-year interval.

A total of 45 of the 80 therapists completed q1, 30 completed q2, and 24 completed both questionnaires. Professional education was the only background factor associated with adopting the interventions (q1: $p = 0.059$, q2: $p = 0.023$), with higher education indicating greater activity. On the basis of trends such as changes in overall usefulness score from q1 to q2, the most involved therapists were slightly more likely to adopt MI/BA. Our experience so far suggests that encouraging staff to begin using new interventions during education is very important. The Consolidated Framework for Implementation Research was found to be a useful tool for constructing the evaluation.

1. Introduction

More systematic use of evidence-based, time-limited psychosocial interventions in psychiatric care would achieve more prompt and sufficient symptom relief for a significant proportion of patients compared with typical treatment or long-term psychotherapies (Cuijpers, Anderson, Donker, & van Straten, 2011; Knekt et al., 2011). Increased use of evidence-based, time-limited psychosocial interventions could also lead to smoother patient flow management. However, the implementation of new psychosocial interventions has proven challenging, and, in general, some estimates indicate that approximately 40% of organizational efforts for implementing new methods in health care yield satisfying results (Damschroder et al., 2009). The obstacles for implementation can emerge at different levels: the healthcare system, the practice environment, the educational environment, the social environment, the political environment, the practitioners, and patient-related levels (Damschroder et al., 2009; Haines, Kuruvilla, & Borchert, 2004). The crucial facilitating or inhibitory factors that have been identified at organizational level are support from the leaders and attitudes of the workers about their own need for training and the training program (Anderson, 2009; Brunette et al., 2008; Haines et al., 2004; Moser, DeLuca, Bond, & Rollins, 2004; Steinfeld, Coffman, & Keyes, 2009). There are earlier studies and reviews about the influence of work experience or the level of therapy training on adopting new psychosocial interventions, and the results show that therapists with more previous supervision are less prone to change (Beidas & Kendall, 2010). Having worked for longer seems to have some negative effects on openness to change (Anderson, 2009; Beidas & Kendall, 2010). The different findings from studies of implementation of evidence-based practices are generally due to differences between study or program designs and outcome variables used. These include, for example, varied outcomes in preserving acquired therapeutic skills and lack of consensus about how therapist-related variables influence the adoption of new practices (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). An integrated view of the antecedents influencing implementation is best reached by taking account of a wide

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range of system-contextual factors, such as therapist- and client-related variables, organizational support, and quality of the training program (Beidas & Kendall, 2010; Herschell et al., 2010). There is still a need for studies on the implementation of psychotherapy interventions that take into account professional training background and perceived needs for training (Beidas & Kendall, 2010; Herschell et al., 2010; Prytys, Garety, Jolley, Onwumere, & Craig, 2011). Damschroder et al. (2009) introduced an integrative implementation theory known as the Consolidated Framework for Implementation Research (CFIR). The CFIR is a synthesis of many previous implementation theories and it can be used to plan implementation processes or to assess the level of success of a committed implementation by providing a range of system-contextual viewpoints for evaluating its results.

The aims of this study were 1. to explore staff-related factors (professional background, level of experience in applying previous training, perceived need for new methods) associated with participating in a work development program, 2. to evaluate the perceived usefulness of the implemented brief therapy interventions during the early stages of a treatment developing ODS program within public secondary psychiatric services (specialized care provided by district hospitals), and 3. to test the psychometric properties of a questionnaire developed for this study to assess implementation usefulness.

2. Methods

This implementation study was part of the Ostrobothnia Depression Study (ODS). The population of the catchment area is 200,000, and the aim of the ODS is to develop a systematic model of assessment and treatment of depression and other non-psychotic disorders with regional coverage. The goals of the ODS program are rapidly identifying and treating mood and anxiety disorders, as well as complicating alcohol disorders, quickly recognizing complicated cases, and diminishing the number of extended treatments to facilitate patient flow. Depressed patients were used as a benchmarking group, with the goal of recruiting 200 study patients in total, including 100 patients with co-morbid substance use disorders. The program interventions chosen were behavioral activation (BA) for treatment of depression and motivational interviews (MI) for substance misuse. These interventions were used because there is evidence of their effectiveness on a meta-analytic level (Cuijpers, van Straten, & Warmerdam, 2007; Lundahl & Burke, 2009), and they are also time-limited. We also considered that both interventions could be taught to a large number of therapists in a reasonable time. Running the developing ODS program was managed and supported by psychiatric secondary care unit administrative staff. The implementation branch of the study aimed to evaluate the success in coverage of application of the implemented evidence-based interventions. According to the policy activities that constitute research in the South Ostrobothnia Hospital District, this work met the criteria for operational improvement activities exempt from ethics review.

2.1. Setting and sample

Employees in five selected units of the local hospital district were invited to participate in the study, and individual employees made the final decision about their participation. Four of the selected units were outpatient care units, and one was an 18-bed acute inpatient ward (one of the five acute wards for adults in the hospital district). The outpatient care units included in the study cover a population of 124,000 (62% of the population of Southern Ostrobothnia).

From spring 2009 to spring 2012, 80 therapists were educated to participate in the ODS. The elements included in this education are presented in Inline Supplementary Table 1. The majority of the staff receiving this education were registered psychiatric nurses, but the participating staff also included psychiatric practical nurses, psychologists, and doctors. The present study excluded doctors because they focused on diagnosis and drug treatment in the ODS program and did not participate in the practice of psychosocial intervention.

The implementation study plan was introduced to staff in participating units through an invitation letter. This was emailed personally to all intended participants at the beginning of the recruitment phase of the clinical study. The study survey collection was indicated in the agenda of the refresher seminars. The questionnaires were collected anonymously, with a personal study number saved for each respondent. A prompt letter including the questionnaire forms was sent to seminar non-attenders via the research nurse after each survey.

2.2. Questionnaire and data collection

Beginning nearly one year after beginning of the educational ODS program described above, the staff members participating in the ODS program were asked to complete a questionnaire (q1). These staff members were asked to complete the same questionnaire following a one-year interval (q2). The questionnaire assessed the participating therapists' background information (level of education, working years, and previous training in psychotherapy) as well as their level of practice using psychotherapy skills acquired through previous training and perceived need for new working methods (as indicators of employees' attitudes). The therapists' activity in using the treatment methods covered in the ODS program was assessed using the number of the patients they reported had been treated with BA and MI. The perceived usefulness of these methods was assessed with a separate 7-item questionnaire developed for this study (included questions are presented in Inline Supplementary Table 2). In this questionnaire, questions 1 and 2 evaluated the therapists' experiences with learning the methods and their adaptability, which form the basis of implementation (Damschroder et al., 2009). Question 3 was originally included based on the knowledge that an individual's attitude and prediction of future behavior are linked (Kraus, 1995). A reassessment of question 3 aimed at following the changes over time in the therapists' attitudes toward the future use of the new interventions. Questions 4–7 were included based on common factors of psychotherapy that have been found to be associated with therapy outcome (Baldwin, Wampold, & Imel, 2007; Lambert, 2005; Snyder, 1995).

2.3. Participants' characteristics

The vocational education of the participants of this implementation study is presented in Table 1.

The work experience of the participants was <2 years for three, 2–5 years for six, 5–10 years for nine, and >10 years for 27 of the respondents. For analysis, these groups were dichotomized, as work experience ≤ 10 years and >10 years. The sample included nine people who had additional psychotherapist training (or were currently on a training course lasting at least 2 years), and six were family therapists. The majority of non-psychotherapists had previously participated in shorter education programs on psychosocial interventions.

2.4. Statistical methods

The number of patients treated using BA or MI was used as a variable gauging therapist activity. The separate items, the sum of scores for q1 and q2, and the change in scores from the first to