



Increasing psychotherapists' adoption and implementation of the evidence-based practice of progress monitoring



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ABSTRACT

Evidence-based practices (EBPs) reach consumers slowly because practitioners are slow to adopt and implement them. We hypothesized that giving psychotherapists a tool + training intervention that was designed to help the therapist integrate the EBP of progress monitoring into his or her usual way of working would be associated with adoption and sustained implementation of the particular progress monitoring tool we trained them to use (the Depression Anxiety Stress Scales on our Online Progress Tracking tool) and would generalize to all types of progress monitoring measures. To test these hypotheses, we developed an online progress monitoring tool and a course that trained psychotherapists to use it, and we assessed progress monitoring behavior in 26 psychotherapists before, during, immediately after, and 12 months after they received the tool and training. Immediately after receiving the tool + training intervention, participants showed statistically significant increases in use of the online tool and of all types of progress monitoring measures. Twelve months later, participants showed sustained use of any type of progress monitoring measure but not the online tool.

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The burden of mental illness in our country is high, in part because clinicians are slow to adopt and implement evidence-based practices (EBPs). Seventeen years typically elapse before a research finding is translated to patient care (Weingarten, Garb, Blumenthal, Boren, & Brown, 2000). Even when they do adopt new EBPs, clinicians often fail to implement them persistently over time (Stirman et al., 2012) or to generalize their use of the EBP to domains outside the one in which they were trained (Rosen & Pronovost, 2014).

The implementation science literature tells us that in order to increase adoption and implementation of an EBP, it is essential to provide implementation support that addresses clinicians' barriers to adopting and implementing a new EBP (Baker et al., 2010; Damschroder et al., 2009). That is, trainers cannot simply present

the details of the EBP, but must carefully design an EBP that is not too complex or difficult, and must actively help the clinician overcome impediments to using the EBP in his or her daily workflow.

Several types of data support this notion. Clinicians report that they are more willing to adopt a new EBP if they can integrate it into what they are already doing without changing other aspects of their practice (Cook, Schnurr, Biyanova, & Coyne, 2009; Stewart, Chambless, & Baron, 2012). Borntreger, Chorpita, Higa-McMillan, and Weisz (2009) showed that psychotherapists are more receptive to adopting modules than whole treatments, presumably at least in part because it is easier to integrate a module than an entire treatment into what the therapist is already doing. Casper (2007) showed that clinicians are more likely to adopt a new skill if they are given a chance to report reservations about the skill and impediments to using it to the trainer, who adapts the training to address those reservations and impediments. Other strategies for helping the clinician integrate the skill into his or her workflow include teaching the skill one step at a time in a way that provides the clinician with opportunities to practice and get feedback about performance at each step (Pronovost, Berenholtz, & Needham, 2008), and encouraging clinicians to reflect after a training

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workshop on what they learned in the workshop and how they can use it in their practice (Bennett-Levy & Padesky, 2014). A final strategy involves providing reminders and accountability mechanisms in the work environment. Pronovost et al. (2006) (see also Gawande (2007)) developed and studied a multi-faceted intervention to increase physicians' use of the evidence-based procedures for installing a catheter in a hospital intensive care unit. The intervention included using a checklist to monitor and verify physicians' implementation of the evidence-based procedures, and stopping the provider when the procedures were not being followed. The intervention led to large decreases in hospital infection rates. All these pieces of evidence support the notion that increasing clinicians' use of EBPs requires more than just teaching the EBP; it also requires explicit and systematic efforts to help the clinician integrate the EBP into his or her daily workflow.

Thus, factors that promote adoption and implementation of an EBP include that the EBP is one that the clinician can adopt without modifying other aspects of his or her practice, and the training to use the EBP explicitly and actively helps the clinician integrate the practice into his or her daily workflow. We addressed both these factors as we selected an EBP and carried out a multi-faceted intervention to train psychotherapists to use it.

We selected the EBP of progress monitoring, which we defined as: Using a written or online tool at the beginning of every session to monitor changes in a patient's symptoms or functioning and using that information to inform the treatment. We selected progress monitoring because it is a relatively straightforward evidence-based practice (see reviews by Carlier et al. (2012) and Goodman, McKay, and DePhilippis (2013)) that the clinician can add to any type of psychotherapy he or she is doing without requiring changes in that psychotherapy.

Our intervention had two parts. It consisted of (1) an online progress monitoring tool that allowed clients to go online to complete the Depression Anxiety Stress Scales (DASS; (Lovibond & Lovibond, 1995)), and (2) a series of four online classes that trained clinicians to use the online tool. We expected each of the two parts of intervention (the tool and the training) to promote participants' use of progress monitoring in different ways. The online tool was designed to overcome many obstacles that our pilot work had identified as impediments to clinicians' use of progress monitoring. It overcame the obstacles of selecting a measure by providing a measure (the Depression Anxiety Stress Subscales; DASS) that assessed symptoms that are common in most adult patients seeking psychotherapy. The online tool also overcame obstacles of obtaining a measure, getting it to the patient, scoring and plotting it, interpreting the scores via reference to clinical norms, and addressed clinicians' reluctance to spend time in the session administering the measure (clients completed the measure online before the session). The classes taught the clinician ways to overcome obstacles of forgetting to assign the measure, patient noncompliance, and uncertainty about how to use the data in the session. The four-session series of classes allowed trainers to break the skill down into steps and teach them one at a time (e.g., introduce the measure to the client, ask the client to complete the measure), and give clinicians practice using the skill during class and between classes, so they could get feedback and help improving their performance and overcoming obstacles. Many of these skills were applicable to progress monitoring tools of all sorts, not just the online tool, and thus promoted generalization of the skill of using the online progress monitoring tool to the larger domain of using all types of progress monitoring measures.

Based on the literature reviewed above, we hypothesized that giving psychotherapists a tool + training intervention that emphasized helping them integrate the EBP of progress monitoring into their daily workflow would be associated with adoption and

increased implementation of the EBP. To test these hypotheses, we developed an online progress monitoring tool and a training intervention to help psychotherapists do progress monitoring, and we collected data from psychotherapists before, during, immediately after, and 3, 6, and 12 months after they received the tool + training intervention. Our online progress monitoring tool was a tool that allowed clients to go online to complete the Depression Anxiety Stress Scales (DASS). We predicted that psychotherapists' use of the online tool would increase immediately after they received the online tool and again after they received training in progress monitoring, and that similar increases would occur in use of all types of progress monitoring measures, reflecting generalization of training in the online tool to all types of progress monitoring. We predicted that the therapists' increased use of progress monitoring would persist during the 12 months after the intervention. Because use of any type of progress monitoring measure requires fewer changes to the clinician's practice (no need to use a computer, no need to adopt a new measure, the DASS), we predicted that use of any type of progress monitoring measure would show more sustained implementation than use of the online tool.

1. Method

1.1. Participants

We recruited practitioner participants by advertising on professional e-mail distribution lists (e.g., Association for Advancement of Behavioral and Cognitive Therapies, Society of Clinical Psychology (Division 12) of the American Psychological Association) and in the co-principal investigators' (J. B. P. and K. K.) professional networks.

We invited participants who met the following criteria: living in the USA; treating at least five adult patients weekly in outpatient psychotherapy; able to participate in research without needing permission from any administrative authority or able to get such permission quickly; able to attend all sessions of the progress monitoring training; having access to a computer and internet connection in the office where seeing clients; conducting therapy in English; and not regularly using the online tool's main assessment scale (the Depression Anxiety Stress Scales; DASS).

Twenty-six clinicians responded to our recruitment efforts and participated in the study. Most participants were female (65.4%) and Caucasian (96.2%). Most were Ph.D. psychologists (53.8%); the remaining were masters' level providers. Participants' mean age was 45.8 years ($SD = 9.8$). The majority (69.2%) worked in a private practice setting; 19.1% worked in a mental health clinic, and 11.5% worked in another setting. Participants had practiced psychotherapy for a mean of 12.7 years ($SD = 8.8$), and spent 22.6 h/week ($SD = 11.2$) providing psychotherapy.

Of the 26 psychotherapists who agreed to participate, four dropped out (two due to work and family stressors, one because our online tool was not compatible with his ipad, and one for unknown reasons). Twenty-two completed the training and provided at least some data after the training. Two of these twenty-two participants were lost to follow-up during the post-training follow-up period.

1.2. Intervention

The intervention we delivered had two parts: (1) an online tool and (2) training to use the online tool and all types of progress monitoring.

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