Developing & Implementing Alternative Evidence-Based Psychotherapy (EBP) Training Models

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Original VA EBP Training Model

- Mental Health Services (MHS) sponsors and provides program oversight to 15 different EBP training programs
- The original training model involved two key components designed to promote skill mastery, local implementation, and sustainability
  - Attendance at an in-person, experientially-based workshop, followed by
  - Weekly expert consultation on actual therapy cases for six months
    - Most involve review of audio-taped psychotherapy sessions and fidelity ratings
Current Model Challenges

- **Training Access and Costs**
  - Limited number of available training slots
  - Estimated $6k spent per participant on EBP training (varied by program); more if you examined how many completed consultation
  - 50% Budget cut: Had to focus on what was essential to training (43% of EBP budget was travel and conference costs)

- **Travel**
  - Travel not feasible for some clinicians and results in longer time away from clinic duties; is subject to a variety of processes not under the control of MHS
  - This resulted in many conferences being cancelled from what was planned/budgeted for at the beginning of several Fiscal Years (FYs). Therefore field needs were not met.
EBP Alternative Training Project
Road Map 1

- **Formed EBP Alternative Training Team**
  - Hired full-time Project Manager, Kristin Lester Williams, Veterans Integrated Service Network 6 (VISN 6) Mental Illness Research, Education, and Clinical Center (MIRECC)
  - Detailed Implementation Scientist, Sara J. Landes, National Center for Posttraumatic Stress Disorder (NC-PTSD) Palo Alto (now V16 MIRECC)

- **Set Goals for EBP alternative training**

- **Reviewed research literature** to evaluate models of implementation and training
  - Joined the VISN Mental Health (MH) Liaison Decentralized EBP Training Workgroup
Surveyed key stakeholders
- Conducting qualitative interviews with EBP Training Programs about key aspects of training
- Conducted a survey of all VISN MH Liaisons, Mental Health Chiefs, Psychology Training Directors, Local EBP Coordinators & follow-up calls with those who expressed interest

Talked with non-VA psychotherapy training leaders
- Center for Deployment Psychology (CDP)
  - Largely moved to Second Life and online training
- Beck Institute
- Reviewed online training for Dialectical Behavior Therapy (DBT) and Interpersonal Psychotherapy (IPT)
EBP Alternative Training Project
Road Map 3

- **Blended Learning Model (BLM)**
  - Hybrid or mixed mode: when a portion of the training is through delivery of content and instruction via digital and online media with some element of learner control over time, place, path, or pace.

- **Regional Training**
  - Train the trainer model: National program trains local trainers who train local staff
Blended Learning

Blended Learning Model

Preparative Reading

Online Didactic Course

Experiential Role Play through Adobe Connect

Consultation Phase
Primary Goals for Developing Alternative Training Methods

- Expand Veteran access to these treatments
- Improve availability of these trainings to field staff
- Improve the timeliness of training in these treatments
- Maintain the high quality of current EBP training
- Improve cost-effectiveness
Research Literature
Training

- Printed education materials (e.g., treatment manuals) have minimal effect on therapist or patient outcomes (Farmer et al., 2008; Grimshaw et al., 2001; Giguere et al., 2012)
- Growing literature shows that workshops alone have minimal impact on trainee behavior (e.g., therapy skill) or patient outcome (Beidas & Kendall 2010; Grimshaw et al., 2001; Rakovshik & McManus 2010)
  - However, workshops do change knowledge and attitudes toward EBPs
Online Training

- Online or web-based training may be an alternative to in-person training or serve as an adjunct (i.e., blended learning)
- Data suggest that online training may be equivalent to in-person training and in some instances more effective at increasing knowledge (Beidas et al., 2009; Dimeff et al., 2009; Gega et al., 2007)
- Online training with VA providers is feasible and has been found to increase skill demonstrated in standardized patient interviews (Ruzek et al., in preparation)
- Online training has been found to be more efficient than in-person training (Gega et al., 2007)
Research Literature – Consultation

- Number of consultation hours significantly predicted higher therapist adherence and skill
  - *Each hour of consultation improved adherence* by .4 point and *skill* by .3 point on a 7 point Likert scale, suggesting a good return on investment (Beidas et al., 2012)

- Consultation and/or feedback increased proficiency, which was maintained at follow up (Miller et al., 2004)

- Link between consultant adherence to a consultation protocol and therapist treatment fidelity and client outcomes (Schoenwald et al., 2004)
Consultation Core Functions

- Continued training
- Problem-solving implementation barriers
- Provider engagement
- Case support
- Accountability

- Mastery skill-building
- Appropriate treatment adaptation
- Planning for sustainability

(Nadeem, 2013)
Survey of Key Stakeholders
Stakeholder Groups

- VISN MH Leads, N=15
- Local EBP Coordinators, N=64
- MH Chiefs, N=35
- MH Training Directors, N=45
Percentage endorsing original EBP training components as effective

- Workshops: Local EBP Coordinators > MH Chiefs > MH Training Directors
- Consultation: Local EBP Coordinators > MH Chiefs > MH Training Directors
- Rating of tapes: Local EBP Coordinators > MH Chiefs > MH Training Directors
- Req. completed cases: Local EBP Coordinators > MH Chiefs > MH Training Directors
- Central management: Local EBP Coordinators > MH Chiefs > MH Training Directors
- Selection process: Local EBP Coordinators > MH Chiefs > MH Training Directors
- Other: Local EBP Coordinators > MH Chiefs > MH Training Directors
- Nothing: Local EBP Coordinators > MH Chiefs > MH Training Directors
Acceptable alternatives for EBP training and/or feasibility testing

- MH Leads
- Local EBP Coordinators
- MH Chiefs
- MH Train Directors

Options:
- Online Training (Self-Paced)
- Online Meeting (Real Time)
- Online Training w/ small group breakouts
- Blended Learning
- Video Teleconferencing
- Regional Trainings
- Other
Have you used regional trainers or consultants to meet your training needs?

<table>
<thead>
<tr>
<th>Regional EBP</th>
<th>MH Leads</th>
<th>Local EBP Coordinators</th>
<th>MH Chiefs</th>
<th>MH Train Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>100%</td>
<td>72%</td>
<td>83%</td>
<td>61%</td>
</tr>
<tr>
<td>No</td>
<td>0%</td>
<td>28%</td>
<td>17%</td>
<td>39%</td>
</tr>
</tbody>
</table>
Piloting & Implementation Plan
Piloting & Implementation

- Two programs had existing online courses so they were tasked with the piloting blended learning in FY14.
- Remaining EBP programs were to develop alternative training plans based on the goals that were set.
- Created a blended learning seminar which was presented to all the training program coordinators over a several month period.
- Kevin Holloway (CDP): Lecture on how to engage online learners (since CDP is doing so much of this they have developed lessons learned materials).
- Set up a schedule for piloting these alternatives and then implementing alternatives.
- We asked programs to continue their program evaluation efforts using the same measures so we could compare therapist and Veteran training outcomes to in-person conferences.
Blended Learning Pilots

- SST
- PST
- PE
- IPT
- CBT-I
- CBT-D Group
- CBT-D Indiv

To Date

EOY
Regional Training

- SST: Has been using a regional mode for several years
- MI/MET
- CPT: Has been using a regional mode for several years
- CBT-SUD
- CBT-CP
- ACT

Legend:
- To Date
- EOY
Pilot Results
CBT-D Training Program

**Traditional Workshop Training**

2 Components:
- 3-day in-person workshop (large group)
- 6-month follow-up consultation call (small group)

**Blended Learning Training**

3 Components:
- 8-hour web-based training course (individual)
- 6 Experiential and Independent Study training calls (small group)
- 4-month follow up consultation calls (small group)
CBT-D BLM Pilot: Qualitative

What I liked most about these components of the training?

- Web based training
- CBT-D Manual and its availability on SharePoint
- Role Playing
- Small Workgroup
- Supportive Group
- Training Consultant

What I liked least about these components of the training?

- Web based training
- Not being able to see my fellow trainees
- Would like a copy of the slides for review
- Could not hear the demonstration video on call; I had to watch it on own time
- Role plays difficult over the phone
### BLM vs. Traditional CBT-D: POST-TRAINING

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>B (95% CI) for blended model*</th>
<th>Effect Size</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT specific skills self-efficacy</td>
<td>0.46 (0.21-0.72)</td>
<td>0.51</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>General therapy skills self-efficacy</td>
<td>0.42 (0.19-0.66)</td>
<td>0.58</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Attitudes towards CBT</td>
<td>0.08 (-0.08-0.24)</td>
<td>0.16</td>
<td>0.35</td>
</tr>
</tbody>
</table>

*Effect estimates were adjusted for baseline values of the dependent variable, gender, and training level (doctoral vs. masters degree).
### BLM vs. Traditional CBT-D: POST-TRAINING

<table>
<thead>
<tr>
<th>Dependent Variable (By post-consultation)</th>
<th>B for blended model*</th>
<th>Effect Size</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT specific skills self-efficacy</td>
<td>0.28</td>
<td>0.31</td>
<td>0.051</td>
</tr>
<tr>
<td>General therapy skills self-efficacy</td>
<td>0.26</td>
<td>0.35</td>
<td>0.031</td>
</tr>
</tbody>
</table>

*Effect estimates were adjusted for baseline values of the dependent variable.

Blended model participants reported 0.26 points greater increase in general therapy skills self-efficacy between pre- and post-didactic training (Cohen’s d = 0.35; p = 0.031).
CBT-D BLM Pilot Final Results

- Component 1: 27/28 completed
- Component 2: 25/28
- Retention for Case Consultation (Component 3)
  - 4 therapists dropped out
  - Participant enrolled 1 patient, but delayed in sending tapes. Lengthy extension requested (3+ months) but program denied. Program dropped/withdrew participant.
  - Early difficulties in recruiting patients. Did not send tapes until mid-point of consultation. He dropped/withdrew.
  - Participant withdrew due to not being able to recruit patients. No patients enrolled.
  - Missed at least 4 calls during consultation. Did not enroll any patients nor return requests for updates from program. Program dropped for not completing requirements.
Retention of Therapists

- **CBT-D Blended Learning Model**
  - 84% (21/25) of therapists who started training completed Components 1, 2, and 3 and received a “Record of Completion”

- **CBT-D “Traditional” Model (Workshop)**
  - 86% (730/844) who attended workshop training-completed consultation and received a “Record of Completion”
**CBT-D BLM vs. Traditional Model: Cognitive Therapy Rating Scale (CTRS)**

<table>
<thead>
<tr>
<th>CBT-D Model</th>
<th>Mean (SD) CTRS Scores</th>
<th>Improvement</th>
<th>95% CI</th>
<th>Cohen’s D</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional Learning</strong></td>
<td>37.3 (7.7) to 44.1 (7.1)</td>
<td>6.8 Points</td>
<td>6.2 to 7.4</td>
<td>0.88</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>(cohorts 1-27) n = 747</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blended Learning</strong></td>
<td>40.5 (6.5) to 44.6 (10.5)</td>
<td>4.1 Points</td>
<td>-0.7 to 9.0</td>
<td>0.63</td>
<td>0.091</td>
</tr>
<tr>
<td><strong>n = 19</strong></td>
<td></td>
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</table>

BLM cohort started at a higher level on the CTRS; both cohorts ended at similar level (difference of ½ a point).
CBT-D BLM: Lessons Learned

1. Offer CEUs for Experiential Training (ET) to improve motivation to complete the ET.
2. Require attendance at an orientation session to clarify expectations.
3. Increase the availability of Training Consultants in ET and formalize consultant training (more instruction on technology).
4. Ask providers to establish EBP clinics for 2-3 patients upon acceptance to program and begin recruitment.
CBT-D BLM: Lessons Learned

5. To improve the application of CBT-D skills, increase focus on role plays and group discussion rather than on didactic instruction.

6. Produce a new, full-session CBT-D video used for “practice” ratings and consensus discussion.

7. To improve group cohesion and connectedness, use interactive video for therapists and consultants or have participants upload photos.
PE Pilot
### Blended Pilot Program Evaluation

<table>
<thead>
<tr>
<th>Category</th>
<th>Training years before FY15</th>
<th>FY15 In Person Trainings</th>
<th>FY15 Blended Pilot</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>67%</td>
<td>74%</td>
<td>64%</td>
<td>NS</td>
</tr>
<tr>
<td>Psychologist</td>
<td>57%</td>
<td>61%</td>
<td>51%</td>
<td>NS</td>
</tr>
<tr>
<td>Clinic Type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT</td>
<td>37%</td>
<td>36%</td>
<td>13%</td>
<td>0.071</td>
</tr>
<tr>
<td>MHC</td>
<td>31%</td>
<td>36%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>32%</td>
<td>27%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Full time staff member</td>
<td>88%</td>
<td>86%</td>
<td>95%</td>
<td>NS</td>
</tr>
<tr>
<td>Almost all individual</td>
<td>26%</td>
<td>29%</td>
<td>31%</td>
<td>NS</td>
</tr>
<tr>
<td>CBT Orientation</td>
<td>65%</td>
<td>69%</td>
<td>56%</td>
<td>NS</td>
</tr>
<tr>
<td>Trained in PE before</td>
<td>26%</td>
<td>22%</td>
<td>26%</td>
<td>NS</td>
</tr>
<tr>
<td>Asked to be nominated</td>
<td>84%</td>
<td>89%</td>
<td>95%</td>
<td>NS</td>
</tr>
</tbody>
</table>
Blended Pilot Program Evaluation

Current Panel Size or Caseload ($p = .030$)

- Training years before FY15: 90.5
- FY15 In Person Trainings: 76.5
- FY15 Blended Pilot: 124.0
Blended Pilot Program Evaluation

Current Number of PTSD Patients ($p = .029)$

- Training years before FY15: 4.4
- FY15 In Person Trainings: 4.3
- FY15 Blended Pilot: 3.5
PE Blended Pilot: Population Differences

- Blended Pilot participants were different from typical PE trainees on the following indicators:
  - Higher percentage in Outpatient MHC
  - Higher percentage requested nomination
    - But Pilot trainees report slightly lower motivation to participate in PE training
  - Pilot trainees have larger overall caseloads
  - Pilot trainees have seen fewer PTSD patients in the past six months and are currently seeing fewer PTSD patients
Blended Pilot Program Evaluation

Attrition

- Number of Trainees: N=40
- First Live Webinar (5/26)
- PE Web Certificate Due (5/19 5pm PST)
- Last Live Webinar (6/10)
- Independent Study
- Background Survey Sent (4/13)
- N=28
PE Blended Learning Pilot

Attrition

Blended Attrition = 30%
In Person Attrition = 7.5%
PE Blended Pilot: Attrition

1. Illness or family issues
2. No response to queries about training or evaluation requirements
3. Lack of management support for blocked time
4. Course too time consuming/unforseen work demands
5. Leaving VA
PE Blended Pilot Program Evaluation

Median Time to Complete Each PEWeb Module (in minutes)
PEWeb

- Liked PEWeb: 45%
- Liked PEWeb with changes or caveats: 44%
- Did not like PEWeb: 11%
PE Blended Pilot

- Blended learning trainees showed positive gains in PE knowledge from pre- to post-training similar to in person trainees.
- No relationship between the median time to complete PEWeb modules and increases in PE knowledge pre- to post-training.
- Other factors that may have contributed to increases in PE knowledge during independent study:
  - Supplemental materials
  - Material or PEWeb review during survey completion.
Recommendations

- Recruitment & Retention
  - Hold a kick-off meeting prior to independent study
  - Create and launch email listserv prior to training
  - Shorten the overall length of training by several weeks
  - Revisit inclusion criteria

- Materials & Paperwork
  - Go over administrative requirements at kick off meeting
  - Better coordinate pre-training emails
  - Make better use of SharePoint to store documents, checklists
  - Eliminate interim surveys
Recommendations

- Blocking Clinic Time
  - Use blended learning theory but allow for flexibility based on clinic realities and different learning styles
    - Add explicit language that, while trainees can spread learning out over several weeks, they can also choose to complete independent learning in 2 days if that works better for them
    - Ask clinic managers to support whatever will work for trainees
    - Allow for trainees to take AA and complete course from alternative distraction-free environments
Recommendations

- Course Content & Experiential Sessions
  - Provide Adobe Connect training at kick off meeting
  - Restructure course from five 2-hour sessions to longer sessions on fewer days (similar to Department of Defense)
  - Add content about challenging cases & PE modifications
  - Allow more time for Q&A to address questions and concerns
  - Provide separate trainer training on Adobe connect and distance learning, as well as ways to engage participants using this modality

- Other
  - Work with EES to ensure that participants can obtain CEUs
Where are we now and where will we go?
Future Plan

- For each EBP, continue to:
  - Pilot
  - Evaluate
  - Adapt
  - Implement
Resources Needed

- If these methods are successful, fewer trainers will be needed, travel costs greatly reduced, but MORE consultants will be needed (due to more staff being trained)
- If we continue to use regional trainers and consultants, how do we ensure they have time to fulfill these duties?
  - Reimburse sites for time but ensure backfilling?
- Conversely should there be national dedicated consultants that are centrally paid and provide consultation across the system?