Practical Guide for Orienting New Providers to CBT+

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Highlights from the SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues. January 24, 2013:

"Pre-service education and continuing education and training of the workforce have been found wanting, as evidenced by the long delays in adoption of evidence-based practices, under-utilization of technology, and lack of skills in critical thinking (SAMHSA, 2007). "

"Staff turnover is costly in monetary terms with regard to replacement expenses and also disruptive to the therapeutic relationship. SAMHSA's workforce studies (2007, 2006, 2006a) all found high turnover rates reported in the literature at those times. Recent studies corroborate those earlier findings. … rates are substantially higher when compared to primary care physicians in managed care organizations who had a median turnover rate of approximately

"This survey also found that salaries for positions in behavioral health care were much lower than reference professions both in other service areas within the health care industry and outside health care."

Rationale for the Practical Guide

The work force issues referenced in the SAMHSA Report to Congress are very familiar to public mental health organizations. Newly hired providers come from a variety of educational backgrounds and frequently have not had pre-service training that is consistent or comparable across disciplines. Training in evidence-based principles and specific practices is still very minimal. Few new hires come with the knowledge and expertise to deliver EBPs. Mental health workers are paid less than other comparable professions and less than professionals with the same professional degrees who work in other settings such as medical or the government. Working conditions are often stressful and lead to burnout. Turnover rates are high, probably around 20% per year.

Organizations that have embraced EBP and that offer a range of evidence-based models are faced with significant challenges in creating and sustaining a work force that can deliver EBPs.

Organizations now recognize that there are both organizational and training steps that are necessary to create evidence-based organizations and an evidence-based work force. Organizational considerations include leadership endorsement of EBP as the practice model, support for training the workforce in EBP, ongoing EBP supervision, and some form of QA and/or fidelity monitoring to insure that the practices are being delivered as intended. In terms of the basic EBP training, it is well recognized that training should include both in-person learning sessions that emphasize skill acquisition and follow-up expert consultation in applying in the models with clients.

The WA State CBT+ Initiative, supported by the Division of Behavioral Health and Recovery Services supports a statewide training in the four evidence-based models that are subsumed within CBT+ (CBT for anxiety, CBT for depression, Trauma-Focused CBT for trauma-specific impact, and Behavioral Parent Training for behavior problems). This training uses a modified learning collaborative method that includes an in-person learning session followed by 6 months of bi-weekly expert case consultation. The Initiative also supports other activities designed to sustain the CBT+ interventions including monthly supervisor calls, an annual supervisors learning session, an annual advanced training and other special projects.

This Guide focuses on practical suggestions for mental health organizations that will hire new providers over the course of a year. The new hires typically will not have the basic training in the four interventions and may not even have the foundational training in EBP principles and practices. They cannot wait for the opportunity to attend a formal external training before beginning to see clients. Even with internal supervisors who are qualified to provide the formal

training, it is not feasible to offer the full 3 day learning session every time a new provider is hired. Yet at the same time, organizations must be able to get these new hires up to speed so that they can begin practicing immediately within the practice model of the organizations. It will be less and less acceptable to consumers seeking care at an organization that offers EBPs to be assigned to a provider who is not practicing EBP.

Hiring and Orientation

Hiring Practices:

One way to facilitate getting providers up to speed quickly is to have a hiring preference for providers who have experience delivering EBPs or formal training in EBP in other settings because they are most likely to hit the ground running. A hiring preference should also extend to those with pre-service training that was favorably inclined toward EBP and included classes in EBP, or pre-service training that included internships where the providers learned to actually deliver an EBP under supervision. A background or foundational training in the basic principles and practices of CBT and PMT is highly desirable.

Orientation to EBP:

It is critical that new providers be oriented immediately to the CBT+ way of doing business. New providers need to understand that in CBT+ treatment is active, change oriented, collaborative, transparent, structured, and focused on a specific clinical target. Clinical targets are measured at baseline and then periodically in order to assess progress or adjust treatment. Teaching clients skills to think and behave differently in real life is the main activity of therapy; clients are

expected to practice the new skills in-between sessions. The CBT+ treatment ends when the clinical target is resolved or when maximum benefit is achieved. The CBT+ interventions can be the only service that a client needs, or the CBT+ interventions can be embedded within the context of other ongoing services, but explicitly distinguished as a program of treatment that has a beginning and an end.

Another key element of CBT+ practice is the importance of provider responsibility to make every effort to engage clients and enhance motivation for participation in active treatment. This is especially critical for caregivers when the presenting clinical problem is behavior problems. New providers need to learn the specific steps for engagement.

Pre-Service Requirements:

New providers are expected to:

- Take the on-line TF-CBT web course.
- Read Treating Trauma and Traumatic Grief in Children and Adolescents by Cohen, Mannarino, and Deblinger.
- Read at least one book on PMT by authors such as Forehand, Barkley, Patterson, or the Off Road Parenting book.
- Become familiar with the CBT+ Flow Chart, CBT+ Notebook, all CBT+ cheat sheets and N2K sheets.

Use of Standardized Measures:

Supervisors will teach new providers:

- What measures are being used; how to administer a trauma screen as a clinical encounter; and how to administer, interpret and give clinical feedback on the results of a specific measure of the clinical target.

ABCs of CBT+

CBT triangle: The thought-feeling-behavior connection, and the idea that thoughts cause feelings in one of the central principles of CBT. Inaccurate and more importantly unhelpful thoughts are what lead to feelings that are highly distressing or are too intense for the situation. Knowing this is empowering for clients because it shows a pathway to feeling better by changing thoughts.

Supervisors will teach new providers:

- How to do a CBT triangle with clients.

Functional Behavior Analysis: The second key principle is that all behavior occurs for a reason (gets something wanted or gets out of something unwanted). The function of the behavior is typically legitimate; it is the method that causes problems. Negative or unhelpful behaviors persist because they are working.

Learning how to apply FBA to the range of unhelpful behaviors associated with each of the four CBT+ clinical conditions is critical in changing contingencies to interrupt the status of "it's working" and create incentives for more constructive behaviors. Since children may not be motivated to change without a change in external rewards/consequences, involvement of caregivers or the caregiving environment is usually necessary to achieve improvement.

Examples of unhelpful behaviors associated with each clinical condition are: avoidance in anxiety temporarily reduces anxiety; withdrawal in depression reduces the likelihood of being unsuccessful or failing; in behavior problems, throwing tantrums delays chores; and aggression gets others to go along.

Supervisors will teach new providers:

- How to do an FBA for a problem behavior.

Cognitive restructuring using Socratic methods:

Unless untrue or unhelpful thoughts change, emotions that are distressing or too strong will persist and lead to ineffective or negative behaviors. There are two basic strategies for changing thoughts: Psychoeducation (giving information) and cognitive restructuring. Psychoeducation is a common and familiar strategy that most providers already know. New information will change certain types of untrue or unhelpful thoughts. But many unhelpful thoughts are entrenched and do not respond to new information. Cognitive restructuring is used when untrue/unhelpful thoughts are "stuck". Socratic methods are intended help clients change their own thoughts through evaluation, examination, and consideration of alternatives.

Supervisors will teach new providers:

- Common thoughts associated with each clinical condition and basic cognitive restructuring techniques.

Clinical Target Specific Strategies

Behavioral Activation for depression: Behavioral activation involves creating a very specific plan to spend time on activities that create a positive mood, to develop a step by step plan to achieve an achievable goal, or learn the steps of problem solving and try out a potential solution. Behavioral activation leads to change in depression cognitions and mood.

Supervisors will teach new providers:

- Pleasant activity scheduling
- Goal planning
- Problem solving

In vivo exposure for anxiety: In vivo exposure involves specifying the unrealistic fear that is interfering with functioning and creating a step by step process for facing up to the feared, but not dangerous situation and learning it can be managed. Finding out that the feared situation can be tolerated and is not dangerous will change anxiety cognitions and the emotional state of anxiety and worry.

Supervisors will teach new providers:

- How to do a fear ladder.

Trauma Narrative (TN) for trauma-specific impact: The TN consists of two parts, facing up to what really happened (exposure) and creating a helpful narrative ("the story you tell yourself"). The key is being able to think about the trauma without significant distress and coming up with a way of understanding the event(s) that is helpful and allows the trauma to be put in the past.

Supervisors will teach new providers:

- How to explain the rationale; introduce the TN component of treatment, and basic methods of constructing a TN.

Positive parenting for behavior: All EBPs for behavior problems begin with strategies to prevent misbehavior by increasing closeness and warmth between the child and caregiver. Techniques to manage misbehavior are taught after the prevention approaches.

BPT start with the positives and then moves to managing misbehavior: 1) One on one time: structuring several times a week of unstructured child/youth led activities. 2) Acknowledging: praising or some other family congruent method of acknowledging any and all behaviors that the caregiver would like to see more of until they take hold. 3) Active Ignoring: explicitly ignoring minor irritating, negative attention seeking behaviors. 4) Giving effective instructions: providing basic guidance such as one at a time, eye contact, very specific. 5) Time out and rewards and consequences for misbehavior.

Supervisors will teach new providers:

- How to teach these basic positive parenting skills to parents.
- How to practice parenting skills in session.
- How to give homework on parenting skills.

Methods for Orientation

Use the "Say, See, Do" approach.

Say:

Directly discuss organizational expectations, EBP as the practice model and orientation to EBP in terms of how treatment is delivered and expectations for providers. Review the readings and help the new hires connect the information to the ABCs of CBT+ and the clinical target specific skills.

See:

- Have new hires attend EBP group supervision to hear how more experienced providers manage cases.
- Model the key skills during orientation activities.
- Pair new hires up with experienced providers to observe assessments with administration of standardized measures and clinical sessions. Whenever possible have audio or video tapes of sessions available for review by new hires.

Do:

- New providers are accompanied by an experienced provider or supervisor during initial delivery of sessions with immediate discussion and feedback after the sessions.
- Supervisors observe, listen to or review tapes of clinical sessions. Sessions are reviewed and discussed with the new hires and positive, specific, and corrective feedback is provided.
- "Supervise the heck outta" of the first few cases to make sure the provider is really learning and applying the key skills.
- Closely monitor progress notes for initial cases.