Practical Guide for Orienting New Providers to Evidence-Based Practice and CBT+

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Rationale for the Evidence-Based Practical Guide

A major work force challenge in public mental health is turnover. Turnover rates are high, perhaps over 20% per year. Turnover can negatively affect clients because it disrupts continuity of care and may reduce access to care while positions are vacant. It imposes burdens on organizations that must recruit, orient and train new providers as quickly as possible to reduce impact on clients and organizational culture and functioning.

These pressures are heightened in the contemporary context where increasingly there are expectations that providers be trained and qualified to deliver evidence-based interventions. Newly hired providers typically 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 highly variable. Many new hires do not come with the knowledge and expertise to deliver EBPs.

Washington State has set a policy expectation that EBPs be preferred in child welfare, juvenile justice and public mental health. In 2012 the legislature passed HB 2536: Concerning the use of evidence-based practices for the delivery of services to children and juveniles. This bill directed the Washington State Institute for Public Policy (WSIPP) in collaboration with the Evidence Based Practice Institute (EBPI) at the University of Washington to create an Inventory of Research/Evidence-Based and Promising Practices. It was most recently updated in the fall of 2017 http://www.wsipp.wa.gov/ReportFile/1673/Wsipp_Updated-Inventory-of-Evidence-Based-

Research-Based-and-Promising-Practices-For-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems_Inventory.pdf. The law set bench marks for the percentage of sessions that must be research/evidence-based.

The mechanism for documenting whether sessions are research/evidence-based relies on the use of an EBP modifier code that is attached to individual, family and group sessions. They are known as EBP SERI codes and they map onto research/evidence-based interventions listed on the WSIPP Inventory. More recently the UW EBPI has produced the EBP Reporting Guide (2017) that outlines the documentation that must be present in order for an EBP SERI code to be used. One criterion is that the provider must show that they have received approved training in the EBP. The other criteria address the documentation of Essential and Allowed Clinical Elements in treatment plans and progress notes.

Many mental health provider organizations in WA have embraced EBP and offer a range of evidence-based models. One of the approved evidence-based trainings in WA is the CBT+ Learning Collaborative. 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. Providers are trained in four evidence-based models that encompass the most common childhood mental health conditions and provide coverage for approximately 80% of all children in public mental health (CBT for anxiety, CBT for depression, Trauma-Focused CBT for trauma-specific impact, and CBT/Behavioral Parent Training for behavior problems). Successful completion of a CBT+ Learning Collaborative means that the provider has attended the 3 day in-person learning session, participated in at least 9 of 12 consultation calls, and delivered one of the EBPs to at least two cases. This modified learning collaborative approach

documents that providers have learned and delivered the EBPs with adherence. Providers who meet these criteria receive a CBT+ Certificate.

The CBT+ Initiative is supported by the Youth and Family Behavioral Health Division of the Health Care Authority (formerly Division of Behavioral Health and Recovery Services, DHSH). It partially subsidizes the cost to provider organizations for their participants. However, the five regional trainings are only offered once a year. This creates a situation where organizations will be hiring, orienting and training providers to deliver EBPs before they have the opportunity to receive formal approved training. The new hires typically will not have had formal training or documentation of competence to deliver the four CBT+ interventions. They may not even have foundational training in EBP principles and practices. Organizations cannot have newly hired providers wait for the opportunity to attend a formal external training before beginning to see clients and delivering effective treatment. For example, it would be highly disruptive and potentially harmful for a client to switch from a trained provider who is delivering an evidence-based intervention to one who is not trained. Organizations must be able to get new hires up to speed so that they can begin practicing immediately within the practice model of the organization. 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.

This Guide focuses on practical suggestions for mental health organizations that will hire new providers over the course of a year. CBT+ trained supervisors are qualified to orient new providers to the basic principles and skills so that they can begin practicing CBT before they have opportunity to attend a formal approved training. Although they will not be able to use

the EBP SERI codes until they have successfully completed an approved training they will have had the opportunity to learn and deliver the models. In addition, they will be oriented to the EBP Reporting Guides as the standard of practice.

Hiring and Orientation

Organizational Climate:

The research on implementation and sustainment of EBPs in organizations converges on the importance of the organizational climate regarding EBPs. An EBP supportive organizational climate makes explicitly clear from the top that using EBPs is a priority for the organization. Materials and communications in the community prominently mention the availability of evidence-based programming. Clinical administrators and supervisors emphasize evidence based practice and provide opportunities for supervision and training. Providers who use evidence-based practices as routine part of their practice are considered expert clinicians and are held in high esteem. These characteristics within an organization are associated with implementation and sustainment of evidence-based practice.

Hiring Practices:

An organization can facilitate the process of getting providers up to speed quickly by having 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 can 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 deliver an EBP under supervision. A background or foundational training in the basic

principles and practices of CBT and Parent Management Training (PMT)/Behavioral Parent Training (BPT) is highly desirable since many evidence-based programs are based on cognitive behavioral theory and contain common elements.

Orientation to EBP:

It is critical that new providers be oriented immediately to the evidence-based practice framework. New providers who will be delivering CBT based interventions should learn right away that in CBT treatment is active, structured and change oriented. It is delivered in a collaborative and transparent way where the provider and the client agree on a clinical target. Creativity and flexibility are encouraged and supported, as long as the treatment is consistent with an evidence-based framework; it is sometimes called "flexibility within fidelity". 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 CBT therapy. Clients are expected to practice the new skills in-between sessions. Treatment ends when the clinical target is resolved or when maximum benefit is achieved. EBP interventions can be the only service that a client needs, or can be embedded within the context of other ongoing services. But EBPs are explicitly distinguished as a program of treatment that has a beginning and an end.

CBT+ is explained to new providers as a widely used training model in WA for four CBT-based EBPs that cover the most common childhood conditions. All clinical providers will be treating children and families with anxiety, depression, posttraumatic stress or disruptive behavior disorders and should therefore be prepared to deliver effective interventions for children who

have these diagnoses. Expertise in treating children with the common conditions should be a part of the standard repertoire. CBT+ uses generic versions for anxiety, depression and behavior problems, but providers who are trained in other models for the common conditions may use a brand version for which they have received training (e.g., PCIT, Coping Cat, etc.).

Pre- or Early Service CBT Basics:

- Take the on-line TF-CBT web course. https://tfcbt2.musc.edu/
- Read Treating Trauma and Traumatic Grief in Children and Adolescents (2cd edition) by Cohen, Mannarino, and Deblinger.
- Read at least one book on PMT. Examples: Rex Forehand (Parenting the Strong Willed Child), Russell Barkley (Defiant Children), Alan Kazdin (The Kazdin Method for Parenting the Defiant Child), Scott Sells (Treating the Tough Adolescent), Gerald Patterson (Families). Off Road Parenting book.
- Read one book on CBT for anxiety. Examples: Elizabeth McCauley et al Behavioral Activation with Adolescents; Bruce Chorpita et al Modular CBT for Childhood Anxiety Disorders.
- Read one book on CBT for depression. Example: Williams and Crandal Modular CBT for Children and Adolescents with Depression.
- Read John Weisz and Bruce Chorpita MATCH-ADTC. This is a transdiagnostic manual that covers the four CBT+ clinical targets.
- Become familiar with the CBT+ by checking out the CBT+ Notebook for the CBT+ Flow Chart, cheat sheets, N2Ks, resources, handouts. http://depts.washington.edu/hcsats/PDF/TF-%20CBT/CBT_Plus_NB.html

Importance of Engagement:

Many clients or caregivers of children are hesitant or unsure about participating in therapy or terminate therapy prematurely. There are many reasons why clients may not actively

participate in treatment (e.g., attitudes toward therapy, prior negative experiences with therapy, practical barriers, ambivalence about the effort required to change the status quo, coercive context). These concerns may be based on legitimate concerns and must be proactively addressed. It is the providers' responsibility to identify potential barriers, take steps to solve them and engage and motivate clients.

Supervisors teach new providers:

- Specific strategies to enhance engagement.
- Specific strategies to address ambivalence.

Use of Standardized Measures:

Baseline measurement and routine progress monitoring is a core aspect of EBP. Using standard measures in a clinically meaningful way is often a novel skill for providers. Most have not had any specific training in administering a standard measure and giving helpful feedback to clients and their families. Giving feedback should be part of using standard measures and should be done as soon as possible after the measure is completed. Organizations differ in what standard measures are required for clients at Intake or early in therapy. Providers should be oriented to measures used in the organization with primary attention paid to how to deliver feedback on scores (both normal and clinical) as a clinical encounter. See the Measures Cheat Sheet on the CBT+ Notebook for CBT+ measures. http://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/3%20Assessment/Standardized%20Measures/CBT+-Cheat-Sheet-Measure.pdf

CBT+ is trauma-informed. This means that all clients are explicitly screened for trauma exposure whether trauma is part of the presenting concern or not. CBT+ uses the Child and Adolescent

Screen for Trauma (CATS). http://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/assessment.html. Most children do not spontaneously report trauma experiences so many children with PTSD are missed in counseling programs. There is no evidence that children are distressed by screening and it can be done at intake as long as there is acknowledgement and feedback. Many children are exposed to events that are potentially traumatic and do not develop PTSD. But all children exposed to trauma benefit by acknowledgement, validation and normalization. Without systematic screening, trauma histories are often not discovered and nor PTSD identified.

Systematically measuring progress during therapy is a core aspect of EBP. Standard measures of the clinical target can be administered with as much frequency as every session or two. The key for progress monitoring to be helpful is that it is done frequently and that feedback about the results is discussed with the client as soon as possible. This helps clients see whether they are getting better or not and gives the provider key information about how the therapy is going. If clients are not improving it is important to attend to this sooner rather than later so clients do not become discouraged that therapy is not helping. Results can be used to celebrate progress, problem solve challenges, tweak strategies or even change the model.

Measurement does not need to be a standard instrument. Identifying a personal goal in client voice and frequently assessing whether progress is being made is considered very helpful by clients. Examples of personal goals are: “feel less stressed out in social situations”, “sleep better”, “memories not bother me so much”, “get along better in my family”, “and make a friend”.

Progress on personal goals can be measured in a variety of ways. The simplest way so to simply rate how much progress has happened since the last visit on a scale of 1 to 10.

Supervisors teach new providers:

- What measures are being used in the organization and what they measure.
- How to administer a trauma screen as a clinical encounter.
- 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 is a central principle of CBT. Inaccurate and 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 their own thoughts.

Supervisors teach new providers:

- How to do a CBT triangle with clients.

Functional Behavior Analysis: Then other key principle is that behavior occurs for a reason (gets something wanted or gets out of something unwanted). The function of the behavior is typically legitimate (get attention, get out of punishment); it is the method that causes problems. Negative or unhelpful behaviors persist because they lead to the desired outcome. Getting attention even if it is negative. Getting out of an unwanted consequence

for misbehavior by wearing down the caregiver.

Learning how to apply FBA to the range of unhelpful behaviors associated with each of the four CBT+ clinical conditions is critical to interrupt the status quo where the unhelpful behavior is "working" and to 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:

Anxiety and PTSD: Avoidance temporarily reduces anxiety.

Depression: Withdrawal reduces the likelihood of being unsuccessful or failing.

Behavior problems: Throwing tantrums leads to parental acquiescence; aggression gets others to comply.

Supervisors teach new providers:

- How to do an FBA for a problem behavior.

<u>Cognitive restructuring using Socratic methods:</u>

Untrue or unhelpful thoughts need to change or 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 teach new providers:

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

Clinical Target Specific Behavior 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 to learn the steps of problem solving and try out a potential solution. Behavioral activation leads to change in depression cognitions and mood.

Supervisors teach new providers:

- Pleasant activity scheduling.
- Goal planning.
- Problem solving.

In vivo exposure for anxiety and PTSD (trauma reminders): In vivo exposure involves specifying the situation, object or worry that causes 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, object or worry can be tolerated and is not dangerous will change anxiety cognitions and the emotional state of anxiety and worry.

Supervisors teach new providers:

- How to do a fear ladder.

Imaginal exposure for anxiety and PTSD (trauma memories): Imaginal exposure involves thinking about the feared memory or a feared situation, object or worry and learning it can be handled. For traumatic memories imaginal is the exposure strategy. For anxiety disorders, imaginal exposure should only be used when in vivo cannot be.

Supervisors teach new providers:

- How to do imaginal exposure.

Trauma Narrative (TN) for trauma-specific impact: The TN consists of two parts, facing up to the traumatic memories of what happened (imaginal exposure) and creating a helpful narrative about why it happened and what it means (cognitive restructuring/processing or "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 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.

Start with the positives and then move 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: one at a time, eye contact, very specific. 5) Time out and rewards and consequences for misbehavior.

Supervisors 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.

Teaching Methods

Use the "Say, See, Do" approach. Teaching providers new skills is a parallel process to providers teaching clients new skills. Supervisors should explain this as central to helping clients to make changes.

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.