Training community clinicians in the use of CBT for psychosis within an Early Invention in Psychosis service

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CBT FOR PSYCHOSIS TRAINING MODEL

•Cognitive Behavioral Therapy for psychosis (CBTp) has been widely recommended as a treatment, adjunctive to medication management, for individuals experiencing psychosis (Dixon et al., 2010; NICE., 2014) and in early psychosis care (Bertolote and McGorry, 2005)

•CBTp was included as one of several evidence-based interventions for early psychosis in the development of a community-academic Early Intervention in psychosis service in Northern California, USA

•CBTp training and supervision was implemented to support community-based clinicians in acquiring competence in this approach to ensure clients presenting with a recent-onset of psychosis in the community received gold standard care

CBT FOR PSYCHOSIS TRAINING MODEL

1.To develop a CBTp training and supervision model that could be implemented within a community-based service

2.To train community-based, predominantly Master's Level, clinicians in CBTp to competence

3.To develop a 'train the trainer' model to allow for sustainability in program growth

CBT FOR PSYCHOSIS TRAINING MODEL

1.Can community clinicians be trained to competence in CBTp following a 20 hour didactic training package, weekly group supervision and monthly tape review?

2.Can clinicians trained to competence be supported to become internal CBTp trainers and consultants?

CBT FOR PSYCHOSIS TRAINING MODEL

- 20-hour CBTp didactic developed based upon existing CBTp manuals (Kingdon & Turkington, 2008; French and Morrison, 2004)
- Training provided at roughly 9 monthly intervals between May 2010 and September 2014
- Initial training provided by PI from the academic side of the partnership previously trained in formulation-based CBTp
- All clinical staff providing therapy and case management across five EIP sites engaged in training
- Program Managers from each site also participated in training and consultation to ensure on-site engagement and implementation
- Training followed up by weekly group consultation and monthly tape review
- Taped clinical sessions reviewed for competence using Cognitive Therapy Scale-Revised (Blackburn et al. 2000)
- Clinician considered to be competent in CBTp upon submission of three consecutive tapes rated at 50% or above using the CTS-R (see figure 1)

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FIGURE 1: CBT$_P$ COMPETENCY PROTOCOL

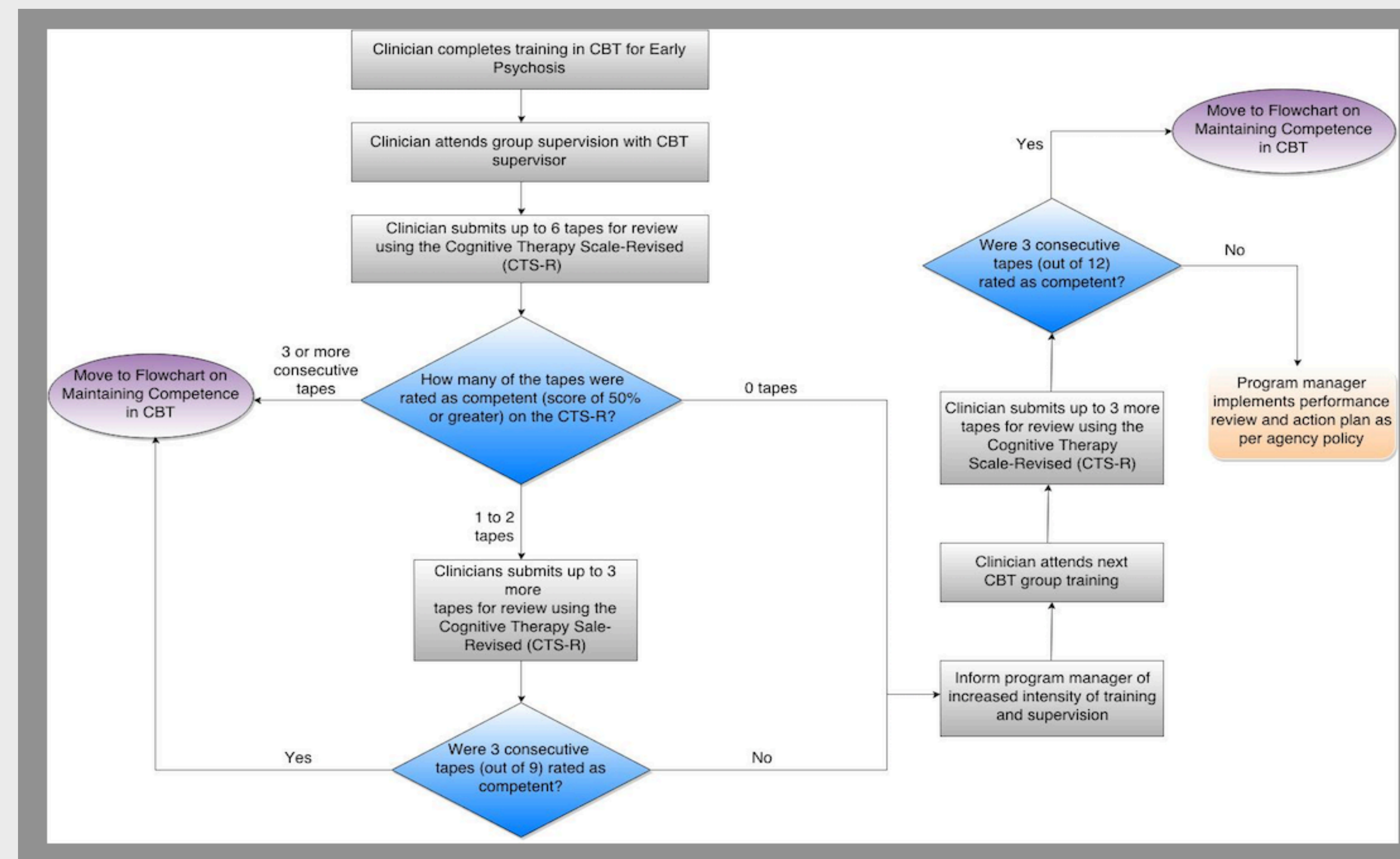
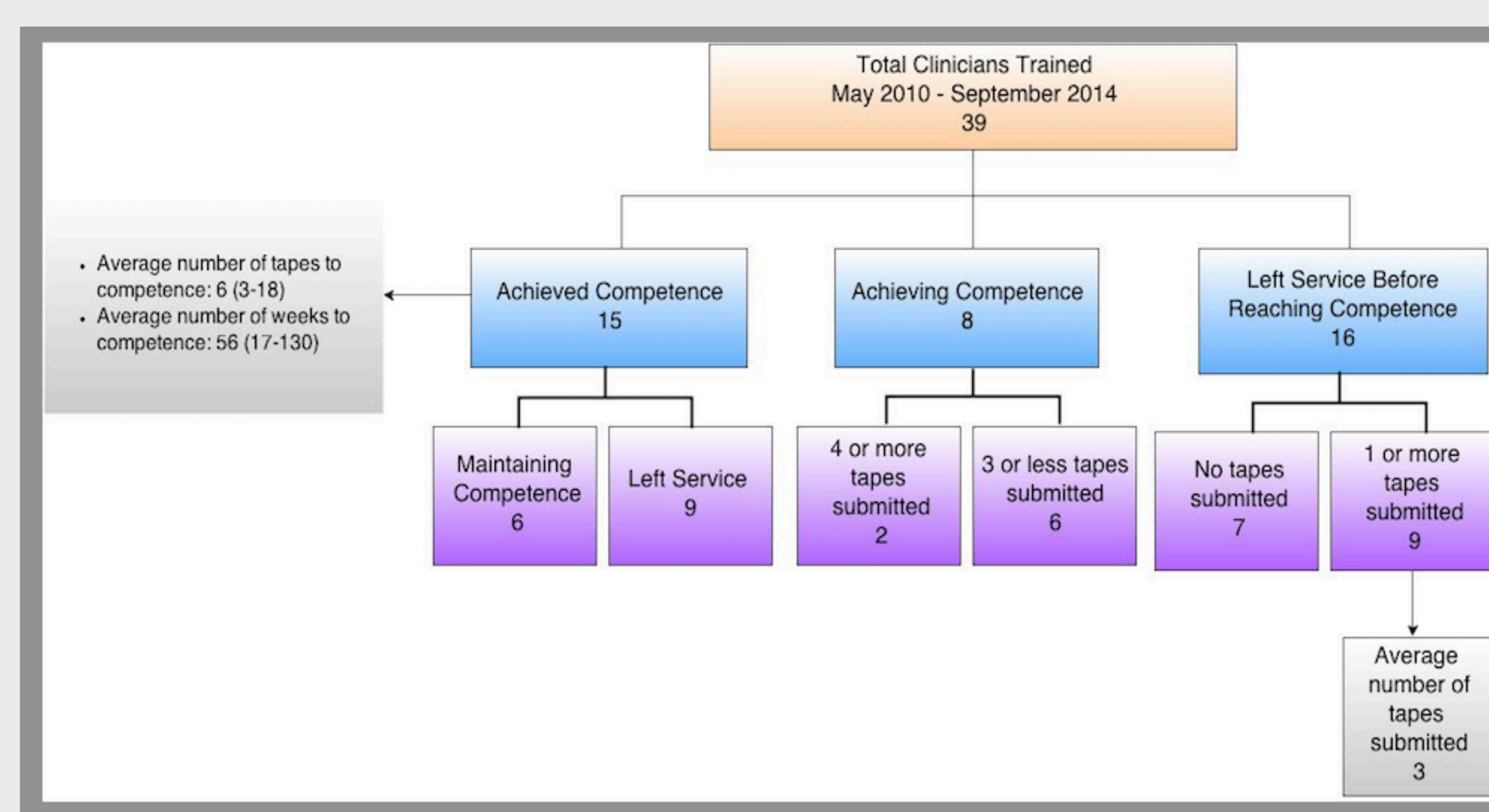


FIGURE 2: CLINICIAN ACHIEVEMENT OF COMPETENCE IN CBT$_P$



TRAIN THE TRAINER MODEL

- Community clinicians demonstrating competence in CBTp, and skills in training others, were invited to participate in the 'train the trainer' model to ensure sustainability of the dissemination of CBTp within the service
- Supported by the community partner of the program who offered incentives and stipends for clinicians moving into a trainer position
- Trainers initially co-facilitated CBTp training with the PI receiving feedback on training style, engaging the participants, and communication of CBTp skills and methods
- Trainers were then supported as CBTp consultants for the sites along the following model:
  - Shadowing consultation
  - Co-facilitating consultation
  - Leading consultation
- Trainers were also trained in competence rating using the CTS-R
  - All trainers co-rated initial three training tapes and submitted
  - Compared ratings against consensus ratings and analysed for inter-rater reliability (see table 1)
- All trainers continued to meet weekly with the PI for 'consultation on consultation'

TABLE 1: TRAIN THE TRAINER RESULTS

Trainer	Profession	Date Trained	# tapes to competence	Average score of competent tape	Date started training	Average score of post-competent tapes	ICC
1*	MFTi	June 2009	N/A*	N/A	September 2011	N/A	ICC(2,1) = 0.608
2	ASW	March 2013	7	77	April 2014	80	ICC(2,1) = 0.940
3	PsyD	January 2014	6	60	December 2014	N/A**	ICC(2,1) = 0.921

* Trainer 1 trained before CTS-R implemented as competence scale

** Trainer 3 to submit first post-competent tape November 2014

CHALLENGES/ LIMITATIONS

•High level of staff turnover resulted in over 40% of staff leaving the service before achieving competence and 60% of staff who achieved competence leaving the service

•Trainers/consultants experienced some resistance to implementation of evidence-based practice resulting in delays in submitting tapes and implementation of training

•CBTp consultants not routinely involved in clinician recruitment resulting in clinicians without basic background in CBT (and in some cases resistance to CBT) being hired

•Sites serving monolingual Spanish and Cantonese speakers resulted in difficulties in tape review by English-only speaking consultants

•Development of new sites meant that clinicians received training in CBTp before developing established caseload resulting in delay of implementing skills and submitting tapes for review

CONCLUSIONS

•It is possible to train community clinicians to competence in CBTp

•It is possible to ensure sustainability by supporting key community staff in becoming trainers/ consultants

•Discrepancy between number of tapes to competence submitted monthly (average of 6) and number of weeks since training to competence (average of 56 weeks) suggests training of clinicians should start once a clinician has established caseload to allow for immediate implementation of skills and tape submission

FUTURE DIRECTIONS

•Analysis of further data including

- Clinician competence and clinical outcomes
- Clinician demographics as predictors of achieving competence
- Working alliance data as predictor of clinical outcomes mediated by clinician competence

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