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

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CBT FOR PSYCHOSES TRAINING MODEL

1. To develop a CBT training and supervision model that could be implemented within a community-based service
2. To train community-based, predominantly Master’s Level, clinicians in CBT to competence
3. To develop a ‘train the trainer’ model to allow for sustainability in program growth

CBT FOR PSYCHOSES 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

FOR MORE INFORMATION CONTACT

consultants?
monthly tape review?
competence in

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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-ordinated 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

<table>
<thead>
<tr>
<th>Trainer</th>
<th>Profession</th>
<th>Date Trained</th>
<th>Tapes to competence</th>
<th>Average score of tape</th>
<th>Data started training</th>
<th>Average score of post-competent tape</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MTS</td>
<td>June 2009</td>
<td>N/A</td>
<td>N/A</td>
<td>September 2011</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>ASW</td>
<td>March 2013</td>
<td>7</td>
<td>77</td>
<td>April 2014</td>
<td>80</td>
</tr>
<tr>
<td>3</td>
<td>Psy</td>
<td>January 2014</td>
<td>6</td>
<td>60</td>
<td>December 2014</td>
<td>N/A**</td>
</tr>
</tbody>
</table>

* 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

REFERENCES


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