Evidence In-Sight:

STAFF TRAINING FOR COGNITIVE-BEHAVIOURAL THERAPY FOR ANXIETY

Date: November, 2010
This report was researched and written to address the following question(s):

1. Are there best-practice approaches to training a large group of staff in CBT, and then a smaller group of staff in a specific anxiety treatment model?
2. If the CBT-based model for anxiety treatment is insufficient for some clients, how should the agency provide supplemental or backup modules?

Within these broad questions, EIS also explored the following:

- How best to disseminate interventions and trainings to all relevant CCTB staff
- Whether the Coping Cat (or other model) has a training and/or accreditation process
- If there are other agencies that are successfully applying Coping Cat (or other model) in Ontario, and can we link them with CCTB for knowledge exchange
- What trainers are available in Ontario for general CBT and for Coping Cat
- Are there communities of practice in Ontario related to anxiety programming for children and youth treatment practitioners

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.
1. **Overview of inquiry**

The requesting contact has already successfully implemented the Triple-P program in their agency and is interested to pursue other evidence-based treatment practices. There is management support to implement EBPs and the organization sees an opportunity for EBPs to treat child and adolescent anxiety. They searched the literature and think that the Coping Cat program is appropriate, as are component models such as those presented by Chorpita.

The agency currently provides a range of services to male and female youth, with treatment teams broken out to those serving ages 0-6 and ages 7-18. Most staff are social workers and, while they might have familiarity with CBT, they have not had formal training in CBT.

The agency request encompasses two broad questions:

3. Are there best-practice approaches to training a large group of staff in CBT, and then a smaller group of staff in a specific anxiety treatment model?

4. If the CBT-based model for anxiety treatment is insufficient for some clients, how should the agency provide supplemental or backup modules?

Within these broad questions EIS also needs to investigate:

- How best to disseminate interventions and trainings to all relevant CCTB staff
- Whether the Coping Cat (or other model) has a training and/or accreditation process
- If there are other agencies that are successfully applying Coping Cat (or other model) in Ontario, and can we link them with CCTB for knowledge exchange
- What trainers are available in Ontario for general CBT and for Coping Cat
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In summary, the agency would like guidance on whether there are existing models for training clinicians in CBT in general and CBT-based anxiety treatments in particular, and which treatments and training approaches are most effective. They want to know if there is a best way to organize training. For instance: should they be training everybody or just a critical mass or those with a particular interest? They would like to know their options of whether to send staff away (train-the-trainer model if so) or to bring experts in. Finally, they wonder about the best way to use training funds.

2. **Summary of findings**

CBT training general conclusions:

- More extensive training leads to increased therapist competence, which is positively related to better patient outcomes
- Workshops and manual provision alone are insufficient in producing significant change in therapist skill or patient outcomes
- As ongoing extensive training is expensive, an option is to use a graded approach to individualize attention by need per therapist
- Initial training can occur through workshops, reading, or web-based instruction, but it must be followed by experiential and interactive training through practice cases, co-therapy, or supervision
• Sustained supervision over time may be necessary to maintain competency gains
• Broader theoretical models of adult learning that include training dosage, spacing, sequence, and scaffolding are pertinent and should be considered in the design of the training program

The key points related to training around and implementation of manualized evidence-informed practices are summarized as:

• Focus training efforts on active learning and behavioral rehearsal, less emphasis on passive didactic sessions.
• Follow the systems-contextual model: multiple variables within the system are inter-related and effect practitioner learning. Organizational support, client factors, and therapist factors play important roles in successfully learning and then applying practices.
• Assessment of implementation fidelity requires going beyond assessments of knowledge and perceived behavior change and actually observing behavior during therapy. Supervision plays a role here.
• The training program should identify core competencies specific to the treatment program. For instance, for CBT for child anxiety, active treatment components such as exposure and cognitive restructuring must be competently practiced.
• Identify barriers to training and adoption early.
• Supervision is crucial for skillful treatment delivery.
• Reassure therapists that their practitioner skills are central to successful implementation and there is latitude for flexibility in applying the program, as long as they achieve the overarching goals of each treatment module via the applied strategies.

It might be worthwhile to apply for an Implementation Support Grant from the Centre once our new program becomes available in 2011. This would provide funding over 2.5 years to research, plan for, implement, and sustain a new treatment program. The Centre of Excellence is just beginning to conduct a full scan of training services in the Province for evidence-informed practices and programs. We should have more information by the end of December and can share all the resources we have identified with CCTB.

3. Findings

A. Cognitive Behavioral Therapy (CBT) training

CBT-based treatments for child and adolescent anxiety have been shown to be effective, and manualized treatment programs are available for adoption by community agencies. However, there is very limited research on models for delivering CBT training to practitioners in community agencies. The existing research suggests that treatments shown to be efficacious in randomized controlled trials might lose effectiveness when transferred to routine clinical practice. Given the lack of direct studies related to the questions posed by Children’s Center Thunder Bay, the Center of Excellence spoke with several experts in the field and reviewed literature pertaining to more general therapist training in evidence-based practice and adult learning.

Although the research base on effective CBT training is thin, studies indicate that workshops alone and/or manual provision by itself is ineffective. In one study of substance abuse professionals, knowledge of CBT and implementation of CBT with clients was significantly higher when practitioners participated in a training seminar plus supervision after training, compared to practitioners who only received a manual. A group that received a manual plus web-based
training scored higher than the manual-only group. Similarly, a study in Ontario found that a workshop followed by a 20-week group supervision component increased practitioner knowledge, confidence, and desire to practice CBT in child mental health treatment. Videoconferencing did not adversely effect training compared to face-to-face training, and peer support groups in agencies facilitated learning. This study suggests that older, more experience therapists with a significant background in other child therapy skills may benefit the most from CBT training. Also, ongoing supervision helps learning and skill application in practice.

A 2010 review by Rakovshik and McManus found that while direct studies of CBT training lack clear definitions and specificity regarding methods, there is considerable data concerning learning and behavioral change methods. Some guidance can also be drawn from existing studies to help inform planning for training practitioners in CBT.

CBT training general conclusions:

1. More extensive training leads to increased therapist competence, which is positively related to better patient outcomes
2. Workshops and manual provision alone are insufficient in producing significant change in therapist skill or patient outcomes
3. As ongoing extensive training is expensive, an option is to use a graded approach to individualize attention by need per therapist
4. Initial training can occur through workshops, reading, or web-based instruction, but it must be followed by experiential and interactive training through practice cases, co-therapy, or supervision
5. Sustained supervision over time may be necessary to maintain competency gains
6. Broader theoretical models of adult learning that include training dosage, spacing, sequence, and scaffolding are pertinent and should be considered in the design of the training program

B. Leading practices for training evidence-informed practice

In contrast to CBT training, models to train therapists to implement manualized treatment programs are relatively standard and follow common theories of adult learning. Therapist training, specifically for clinical efficacy trials, generally consists of three elements: selecting therapists that are experienced in and committed to the type of treatment they will implement in the trial; an intensive didactic seminar to review the treatment manual, including extensive role-playing and practice; and successful completion of at least one closely supervised training case. It should be noted that, while this approach is widely used in clinical efficacy research, it has been adopted mainly on the basis of face validity and may require more rigorous evaluation. Furthermore, there are significant challenges if applying this approach to training community based practitioners instead of highly trained therapists in an academic setting. Clinicians in community based agencies might (a) have minimal training in the theoretical underpinnings of empirically supported treatments, (b) have variable exposure to and acceptance of evidence-based treatments, and (c) rates of turnover are high. Furthermore, this gold standard for training can be expensive and time intensive.

Sanders and Turner showed that active learning is an effective training method for teaching skills that must be employed within a clinical context, such as the Triple P-Positive Parenting Program. Active learning uses action and reflection – modeling, practice opportunities, building self-efficacy, and interaction among learners. This is in place of or in addition to passively delivered didactic lectures.
Therapist attributes might be an aspect of whether training produces differential learning and subsequent behavior change. Therapist variables include attributes such as clinical experience, theoretical orientation, and therapist attitudes toward evidence-informed practices.\textsuperscript{12} No definitive study has shown whether therapist attitudes and/or experience directly determine their uptake of evidence-informed practices, but it may be worthwhile to consider these studies and how individual therapist histories and experience level might effect their interest in and readiness for training in CBT and evidence-informed practices.

Organizational support, including clinical supervision and organizational environment, can also effect training outcomes for therapists. These include a practitioner’s belief that a particular evidence-informed practice can be useful for the particular client population given the severity and risk factors of such clients.\textsuperscript{9} When matching practitioners to training it is important to address concerns that a particular evidence-informed treatment (such as Triple-P or Coping Cat) is viable for their clients and that the treatment actually allows for flexible application.\textsuperscript{11} In terms of thinking about planning for implementing a new practice or program, it is important to clarify key dependant variables that will help evaluate client outcomes following therapist training and program implementation. This is because it is unclear if knowledge gains alone indicate actual proficiency in treatment delivery and by extension beneficial outcomes for clients.

The key points related to training evidence-informed practices are summarized as:\textsuperscript{12}

1. Focus training efforts on active learning and behavioral rehearsal, less emphasis on passive didactic sessions.
2. Follow the systems-contextual model: multiple variables within the system are inter-related and effect practitioner learning. Organizational support, client factors, and therapist factors play important roles in successfully learning and then applying practices.
3. Assessment of implementation fidelity requires going beyond assessments of knowledge and perceived behavior change and actually observing behavior during therapy. Supervision plays a role here.
4. The training program should identify core competencies specific to the treatment program. For instance, for CBT for child anxiety, active treatment components such as exposure and cognitive restructuring must be competently practiced.
5. Identify barriers to training and adoption early.
6. Supervision is crucial for skillful treatment delivery.
7. Reassure therapists that their practitioner skills are central to successful implementation and there is latitude for flexibility in applying the program, as long as they achieve the overarching goals of each treatment module via the applied strategies.

C. Coping Cat: manualized treatment and flexibility within fidelity

The Coping Cat program is a manual-based CBT for children ages 7-13, and the C.A.T. program is an adaptation for adolescents to age 17. It is intended to treat generalized anxiety disorder, separation anxiety disorder, and/or social phobia.\textsuperscript{13} Treatment is divided into two segments, each of approximately eight 1-hour sessions. The first segment focuses on skills training and the second segment focuses on exposure tasks that place the child in and expose them to anxiety provoking situations. The CBT basis of Coping Cat emphasizes the relations between thoughts, feelings, and behavior, and it uses cognitive restructuring, problem-solving strategies, relaxation exercises, and graduated exposure tasks to help the child master and manage distressing anxiety.
As a manualized treatment, Coping Cat explains a treatment framework based on treatment and session goals, it explains therapeutic activities and strategies to meet those goals, and it provides guidelines to manage treatment challenges. Therapist concern about manualization treatment mainly rests on the impression that manuals are designed to implement specific procedures in a rigid and routine manner. However, Coping Cat is intended to allow creativity and clinical skill to play a major role in the proper implementation, and flexibility within fidelity is encouraged. The manual is a guide for goals and strategies, but the therapist needs to proactively address client needs and address therapeutic alliance issues as they arrive. Flexibility only becomes non-adherence if the therapist actually fails to address one or more of the anxiety management strategies that are the overall goal of each session. Also, the practice is non-adherent if the therapist does not frame treatment within a cognitive-behavioral perspective. The key point is that therapists do not need to read session content word for word from – rather they need to achieve the treatment goals by flexibly and creatively applying the guiding strategies, with fidelity to the underlying content but while engaging the individual child’s needs within their context. When applying evidence-informed anxiety treatment manuals, extra rapport-building sessions might be necessary with highly anxious, withdrawn, or unmotivated children before introducing the manual content. The therapeutic alliance is key to working collaboratively with children and families, so empathy and the unique talents of therapists form the foundation of treatment while the treatment manual provides a framework to work through.

Coping Cat has a strong base of research demonstrating effectiveness compared to wait-list control groups, but it is not effective in all cases and as with other treatments may not maintain treatment effects with long-term follow-up. It also may be less effective if there are co-morbid diagnoses. It is well beyond the scope of this paper to discuss the literature on modifying treatment to accommodate other disorders, but children with autism-spectrum disorder are an example of how adaptations are possible.

Key points:
1. Research manuals are not written to be followed word for word – flexibility within fidelity is essential.
2. Fidelity means achieving the core skills and concepts, i.e. applying the correct strategies to work toward and achieve the session goals.
3. Each activity pertaining to strategies should be tailored to the client to make the “story” individual, real, and timely – and to facilitate establishing rapport and engaging with the child.
4. Practitioners need to have a thorough understanding of underlying intervention principles in order to know the difference between an appropriate modification and one that eliminates or contradicts key elements of the treatment manual.

The California Evidence-Based Clearinghouse for Child Welfare rates Coping Cat as “Well-Supported by Research Evidence.” There are no pre-implementation assessments that organizations need to take before adopting the program. Implementation tools include the therapist manuals and student manuals. Training is not formalized, but there are several training DVDs for Coping Cat, including a computer-based training program (CBT4CBT). The original program developer can be approached for training, but we were unable to find a specific training source for Coping Cat here in Ontario.
Staff training for CBT

Rigorous assessment of agency delivery of the program would require taping all of the treatment sessions and having a treatment expert listen and rate the tapes. A less demanding but acceptable approach would be to have a treatment expert rate a randomly selected sample (20%) of the total. Having a treatment expert compare the session goals with what was actually delivered could also assess fidelity. Any of these fidelity assessment processes needs to be conducted either by the developer of the Coping Cat program, or by a designated treatment expert who has been trained by the developer.\textsuperscript{xvii}

More research in Ontario by the Centre of Excellence needs to be conducted to identify leading-practice agencies that can share their experiences with Coping Cat. That work is now being conducted and will hopefully be available by the end of December.

Next steps and other resources

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit:

http://www.excellenceforchildandyouth.ca/what-we-do or check out the Centre’s resource hub at http://www.excellenceforchildandyouth.ca/resource-hub.

For general mental health information, including links to resources for families:

http://www.ementalhealth.ca.

\begin{itemize}
  \item Rakovshik and McManus, 2010.
  \item ibid
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Rakovshik and McManus, 2010.


