

# Linking Training with Implementation to Improve Mental Health Care



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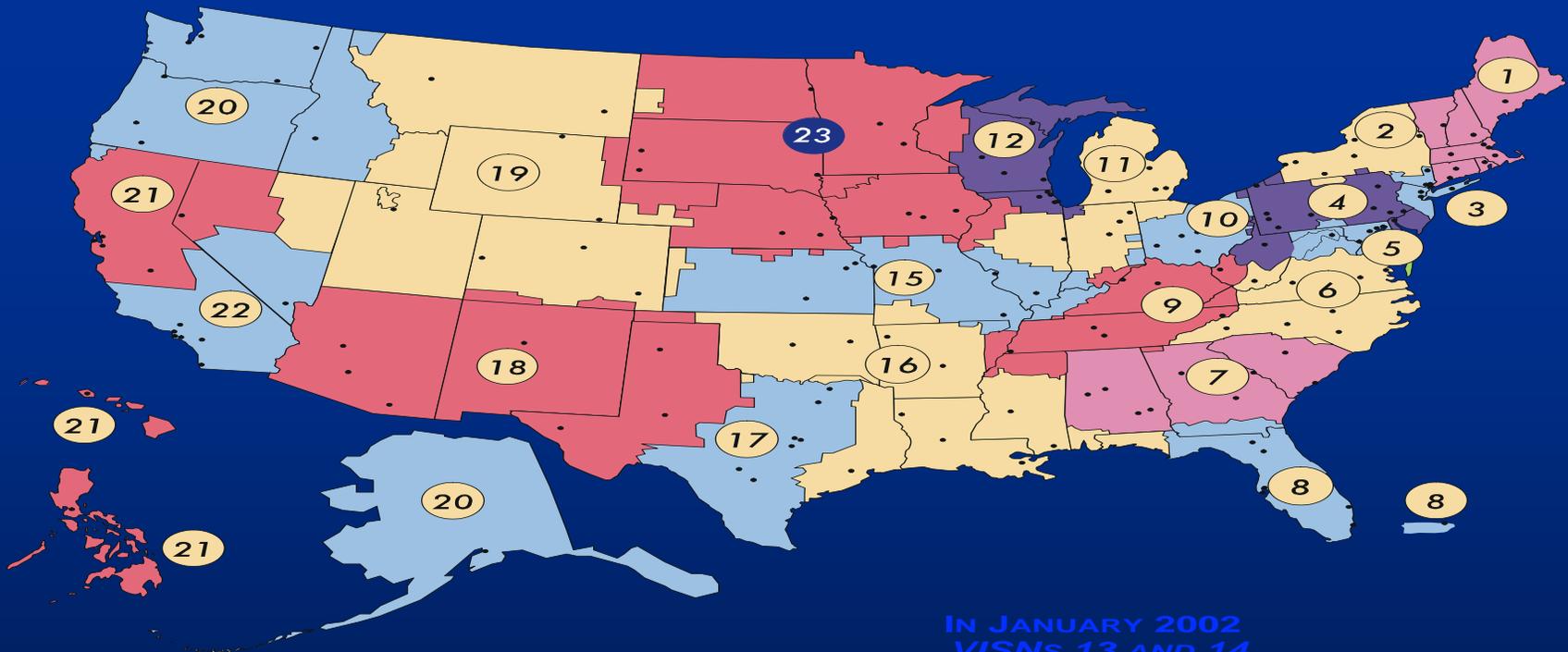
# Outline

- **Present implementation challenge**
- **Describe service system**
- **Present case studies**
- **Outline observations or lessons**
- **Discuss conclusions**

# Mental health providers need more expertise in EBPs.

- Older providers not trained in newer EBPs
- Younger providers' skills may be rusty
- Psychotherapies are especially challenging
  - Labor intensive training
  - Time consuming
  - Practice and supervision required
  - Motivation?

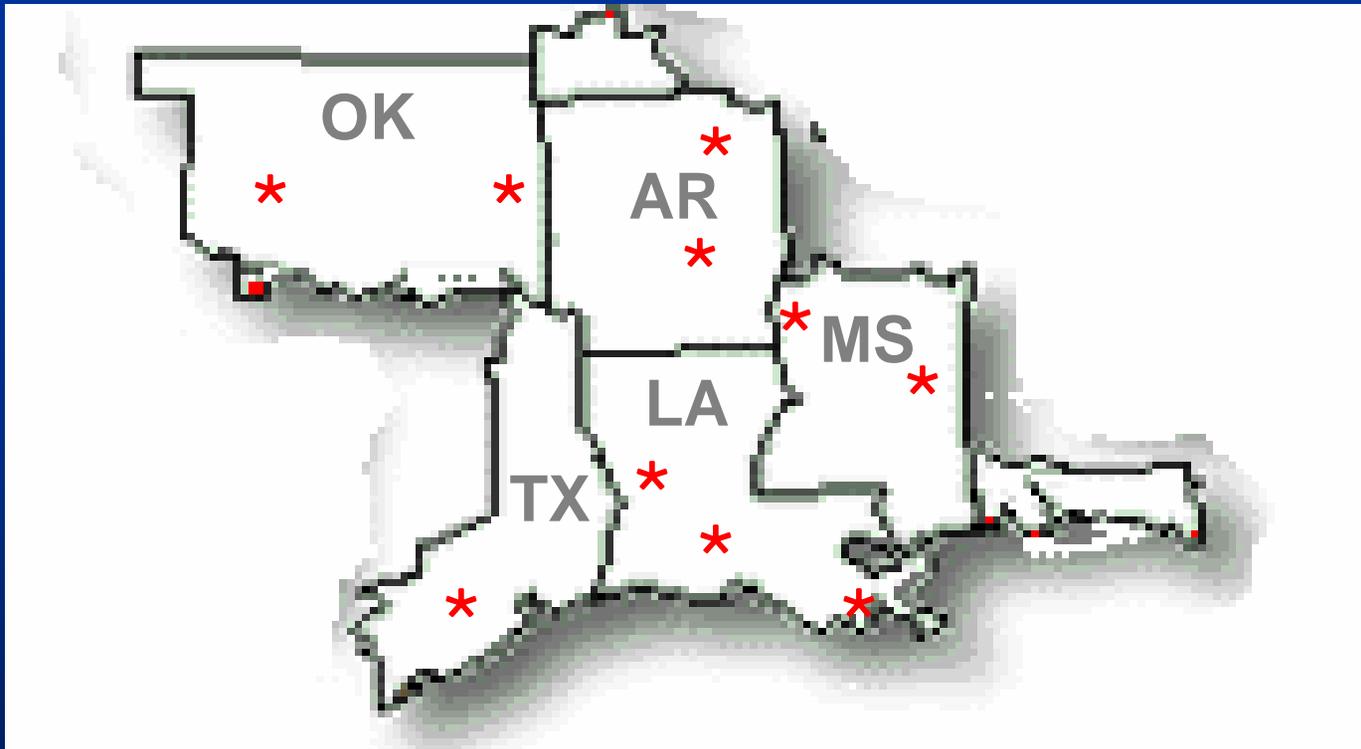
# The VA is divided into 21 networks called Veterans Integrated Service Networks (VISNs).



IN JANUARY 2002  
VISNS 13 AND 14  
WERE INTEGRATED AND  
RENAMED VISN 23

## South Central Network (VISN 16)

# The South Central Network is one of the largest in terms of geography and population.



- 2 million veterans
- 10 medical centers
- 39 Community Based Clinics (CBOCs)
- 1200 + providers of mental health care
- Mental Health Product Line Advisory Council (PLAC)

# **The South Central Mental Illness Research Education and Clinical Center (SC MIRECC) serves the entire VISN.**

- Promote research in mental health
- Provide education for mental health providers, veterans, and their families
- Test novel approaches to delivery of clinical care
- Work in concert with the Mental Health Clinical Leadership (PLAC)

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# In 2001 the SC MIRECC sponsored training in group therapy techniques.

- Design
  - 5 “matched” pairs of clinics
  - 1 of each pair received intensive training
  - 9 month outcomes = change in amount of group therapy in administrative records
- Training
  - 3 hour video conference with expert trainers for all 10 medical centers (n=136)
  - 2 ½ day face-to-face training + 8 supervision sessions (n=41)
  - All trainees selected by mental health leadership at sites
  - Cost: \$65,000 (includes trainee travel)

**There was no appreciable difference  
in the amount of group therapy  
delivered to patients.**



# Trainees identified specific problems with group therapy training.

- Training not optimal
  - supervision not structured
  - trainers not very familiar with the VA
- Trainees “forced” to participate
- No extra time allowed for planning
- Space limitation
- No co-therapists available
- Patients’ reluctance

# In 2003 the SC MIRECC sponsored training in psychosocial rehabilitation techniques.

- **Design** - pre-post design, nine sites, site-specific goals
- **Training**
  - Contracted with trainers familiar with VA
  - Condensed training to 5 days with 2 booster sessions
  - Certified trainees in 12 core competencies
- **SC MIRECC facilitated training**
  - Selected trainees from applicants (16 of 22)
  - Facilitated 4 months pre-training preparation
  - Identified effective clinical champion
- **SC MIRECC facilitated implementation**
  - Concrete site-specific goals
  - Required sites to contribute resources
  - Facilitate monthly “problem solving” calls x 12 months
  - Reminded clinical leadership monthly

# **At 12 months eight of nine sites not only met but exceeded site-specific goals.**

- Two-thirds of trainees revised goals
- 300 additional clinicians were trained (80 projected)
- More than 1,200 patients received services
- Trainees continued monthly meetings for 18 months, forming a learning collaborative
- Trainees requested advanced training
- VA adopted a “recovery” model shortly after training completed
- Some trainees became national VA “experts”
- VISN obtained fellowship in psychosocial rehabilitation

## **Implementation component was added in the second training.**

- Group therapy training = training only
- PSR training
  - Training linked to implementation
  - Goal setting in advance
  - Goals tailored to site
  - Buy-in of leadership
  - Internal facilitation (champions)
  - External facilitation

# There were other key differences in the two case studies.

- Differences in the interventions
  - Group therapy = modification in current practice
  - PSR = adding new services
- Differences in context (national VA policy)
- Differences in receptivity of patients
- Differences in trainees (advocacy)

# Could external facilitation be key to implementation success?

- Third study = training in cognitive behavioral therapy (CBT)
- 5 pairs of matched clinics, one of each pair receives external facilitation
- Matching criteria more sophisticated = readiness
- Individual site goals
- Capture CBT sessions in administrative data

Debate

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## Translating clinical training into practice in complex mental health systems: Toward opening the 'Black Box' of implementation

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# Recommendations: Facilitating training

## Lessons Learned and Applied

### Participant Selection

- Selection of trainees should be based on motivation and interest
- Where possible, trainees should have similar levels of baseline knowledge
- Trainees should commit to some performance standards, as well as set individual goals

### Training Content & Process

- Trainers should be familiar with trainees' work environment
- Certification or a marketable skill should be offered to motivate trainees

### Consultation & Coaching

- Individual goals should guide post-training activities
- Post-training consultation should be targeted to concerns expressed by trainees
- Regular coaching should emphasize initial goals and performance standards
- Goals should be modified if necessary as the process unfolds

# Recommendations: Facilitating implementation

## Lessons Learned and Applied

### Evaluation Approach

- Utilize objective assessment of skills acquisition
- Concrete site-specific outcomes should be assessed
- Multiple follow up goal assessments allow for real time feedback to the extent possible

### Administrative Support

- Collaboration between administrators and clinicians should ensure mutually-identified goals
- Administrators should agree to commit the resources necessary to accomplish goals
- Each stakeholder should receive recognition for efforts from administrators

### Systems Intervention

- All stakeholders should be engaged in implementation and monitoring
- Training should support the organizational strategic plan

## **If the goal is to get EBPs to patients, training is not enough.**

- Training alone is unlikely to be cost-effective
- Training should be linked to implementation
- A distinction should be made between training (skills transfer) and implementation (getting EBP into everyday care)
- Both training and implementation may need facilitation
- Fixsen's model "fits" this 2-step process