A Model to Transform Psychosis Milieu Treatment Using CBT-Informed Interventions

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Although CBT for psychosis (CBTp) has been recommended as a best practice since 2002, CBTp’s availability is quite limited in the U.S. Integration of CBTp-informed interventions into the milieu of the treatment settings in which the majority of the 2.4 million Americans with psychosis receive treatment may greatly improve access to those services. This paper presents an evidence-based model for training line staff in CBTp principles, in order that more staff throughout the U.S. might better support the recovery of people with psychosis in this way. Examples are provided to illustrate effective strategies and approaches.

Rationale

Approximately 2.4 million American adults, or about 1.1% of the population aged 18 and older in a given year, are diagnosed with schizophrenia (Robins & Regier, 1991). Treatment and other economic costs due to schizophrenia are enormous, estimated between $32.5 and $65 billion annually. In 2010, there were approximately 397,200 hospitalizations for schizophrenia nationwide, and about 88,600 (22.3%) were readmitted within 30 days (Elixhauser & Steiner, 2013).

Large numbers of individuals with a psychotic disorder in the U.S. receive psychological treatment solely through milieu-based interventions such as inpatient units, day programs, partial hospital programs, assertive community treatment, and psychosocial club house (Mueser, Deavers, Penn, & Cassisi, 2013). Many of these programs provide only group therapy, typically delivered by paraprofessionals, with few psychologists or Ph.D.-level clinicians, and very rarely are staff trained in evidence-based psychological therapies (Kimhy et al., 2013; Mojtabai, Fochtmann, Chang, Kotow, Craig, & Bromet, 2009). Even when more advanced clinicians are available, the bulk of interactions that patients have are with “direct care” or “line staff,” who have the least amount of training in how to interact with people with psychosis or promote their recovery.

While some evidence suggests that supportive therapy may lead to clinical gains for this population (Penn, Mueser, Tarrier, Gloege, & Serrano, 2004), more rigorous, evidence-based treatments such as CBT for psychosis may be integrated into these milieu settings to improve outcomes for the millions of individuals receiving services (Mueser & Glyn, 2014; Pilling et al., 2002). Directly training direct care or line staff allows the milieu to move from a simple safety-net to a therapeutic context in which all interactions hold the potential for intervention.

Cognitive behavioral therapy (CBT) has been included in good practice guidelines for the treatment of psychosis in both the U.K. and the U.S. (APA, 2004; NICE, 2014) based on the mounting evidence of its efficacy (Gaudiano, 2005; Grant, Huh, Perivoliotis, Stolar & Beck, 2012; Morrison et al., 2014; Pilling et al., 2002). Despite these guidelines, there remains a dearth of appropriately trained mental health professionals to provide this treatment (Mueser & Noordsy, 2005; Rollinon et al., 2007). In light of the scarcity of trained professionals, access to evidence-based practice remains sorely limited (Jones, 2002). Mueser and Noordsy (2005) have presented a “call to action” for clinical psychologists in the U.S. to design training programs in CBT for mental health professionals working with schizophrenia and other severe mental illness, and the response to that has been rapidly growing. Given that these services are more likely to be underresourced and based in community mental health services by milieu line staff (CDC/NCHS, National Health Interview Survey, 2009–2013), feasible strategies to implement a response must reflect the unique strengths and challenges of these settings.

Keywords: psychosis; cognitive behavioral therapy; dissemination; therapeutic milieu; ACCESS model

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Implementation Process Model

One evidence-based process model for the implementation of EBPs in community mental health has been developed with the flexibility to train line staff to deliver EBP-informed care within the scope of their job roles, as well as training of more traditional clinicians (Creed, Stirman, Evans, & Beck, 2014; Riggs, Stirman & Beck, 2012). The ACCESS model was originally developed to support the implementation of an EBP with therapists in community mental health (Stirman et al., 2010) and has been expanded into a 6-step process that can be flexibly followed with therapists (the Intensive Model) or line staff (the Milieu Model) to be applied independently or concurrently based on needs of an organization (Creed et al., 2014). The two models share the first, fifth, and final stages of the implementation process, but diverge on the other three steps to allow for flexible adaptation to a given setting. The first step, Assess and adapt, focuses on joining with stakeholders to determine the specific needs of the setting, as well as facilitators and barriers to the implementation process. A core training plan is then adapted to fit the characteristics of the setting. The second step, Convey the basics, relies on the use of experiential workshop to build the necessary foundational knowledge for participants. In the Intensive Model, therapists learn about the cognitive model, case conceptualization, engaging individuals in the development of authentic and personalized goals, and the use of intervention to help individuals move toward those goals. In the Milieu Model, experiential workshops focus on the basics of the cognitive model and basic case conceptualization to create a shared language and understanding among staff, and the development of individuals’ personalized goals. These two models differ in that the Intensive Model prepares therapists with the knowledge needed to plan and deliver cognitive therapy, whereas the Milieu Model prepares line staff to use the cognitive model to inform their day-to-day interactions with individuals treated in the milieu. During the third step, Consult, weekly consultations are held with expert instructors. Therapists in the Intensive Model focus on applying their new knowledge to individuals in recovery, helping these individuals move toward their goals through the use of intervention planning, case conceptualization, and review of work samples. Instructors in the Milieu Model use scaffolding techniques and feedback to help line staff build their basic CT-informed skills. Completion of training and developed skills are assessed in the fourth step, Evaluate work samples. In the Intensive Model, competency is assessed based on work sample review, and observational evaluation is emphasized in the Milieu Model. During the fifth step of the process, Sustain, ongoing practice is supported primarily through the uptake of the EBP by the agency, although the implementation team provides additional supports as needed through web-based training, recertification booster training, and other support as needed. The final step, Study outcomes, emphasized the evaluation of the implementation outcomes, including assessment of the number of behavioral health professionals trained, retention in training, achieved competency, rates of recertification, and differential outcomes in web-based and live training.

The ACCESS model has been used to train staff in more than 40 community mental health programs in cognitive therapy, ranging from traditional outpatient settings to nontraditional settings for cognitive therapy such as acute inpatient care, residential treatment, school-based services, outreach teams, and safe havens for individuals experiencing chronic homelessness (Creed et al., 2013; Creed et al., 2014; Pontoski et al., 2016). Approximately 400 clinicians and 350 line staff have been trained using this model to date (Creed et al., under review). High rates of retention have been demonstrated, with fewer than 8% of clinicians withdrawing or moving to noneligible agency roles. Participants in the training model have reported high acceptability of the training process and model, and, most notably, most clinicians (79.6%) demonstrated a high standard of competency, commensurate with those demonstrated in clinical trials of CT (Shaw et al., 1999).

Overview of the Treatment Model

CBTp is based on the “basic” cognitive model, which states that our perceptions of our experience shape our feelings and resulting behavior (J. Beck, 2011). Additional techniques for engagement and forming a therapeutic alliance are used, which include making modifications to “traditional” session structure and settings, talking about delusional beliefs empathically and without colluding, normalizing the symptoms of psychosis, and understanding psychotic symptoms as part of a spectrum exacerbated by stress, rather than as normal versus abnormal (Sivec & Montesano, 2012). In addition, CBTp aims to instill hope, reduce distress caused by psychotic experiences, and improve quality of life. It uses the ABC model (activating event–belief–consequence) to assess beliefs about psychotic experiences, and uses formulation, Socratic questioning and guided discovery, cognitive behavioral change strategies, and homework to bring about change (Morrison & Barratt, 2010). CBTp skills and strategies have been successfully delivered in group settings (Granholm, McQuaid & Holden, 2015; Hill, Clarke, & Wilson, 2009; Landa et al., 2006; Romme & Escher, 1989; Wright et al., 2014), which suggests that transportability to a group therapy–oriented milieu may be appropriate.

Accordingly, there is evidence that brief CBTp interventions delivered by nontherapists can lead to desirable client outcomes. Community psychiatric nurses working...
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