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Training in and implementation of Acceptance and Commitment Therapy for depression in the Veterans Health Administration: Therapist and patient outcomes

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ABSTRACT

Objective: The U.S. Department of Veterans Affairs has implemented a national dissemination and training initiative to promote the availability of Acceptance and Commitment Therapy for depression (ACT-D). This paper reports on therapist and patient outcomes associated with competency-based training in and implementation of ACT-D.

Method: Therapist and patient outcomes were assessed on eleven cohorts of therapists ($n = 391$) and their patients ($n = 745$).

Results: Three-hundred thirty four therapists successfully completed all requirements of the Training Program. Ninety-six percent of therapists achieved competency by the end of training, compared to 21% at the outset of training. Mixed effects model analysis indicated therapists' overall ACT-D competency scores increased from 76 to 112 (conditional $SD = 6.6$), $p < 0.001$. Moreover, training was associated with significantly increased therapist self-efficacy and positive attitudes toward ACT-D. Therapeutic alliance increased significantly over the course of therapy. Mixed effects model analysis revealed that mean BDI-II scores decreased from 30 at baseline assessment to 19 (conditional $SD = 5.6$) at final assessment, $t(367) = -20.3$, $p < 0.001$. Quality of life scores also increased.

Conclusions: Training in and implementation of ACT-D in the treatment of Veterans is associated with significant increases in therapist competency and robust improvements in patient outcomes.

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Over the past several decades, a number of psychotherapies have been developed and shown to be effective for a variety of mental health conditions. Despite these advances, research has consistently demonstrated that these therapies are delivered very infrequently in real-world clinical settings (Barlow, Levitt, & Bufka, 1999; Crits-Christoph, Wilson, & Hollon, 2005; Young, Connolly, & Lohr, 2008). Accordingly, effective mechanisms for disseminating evidence-based psychotherapies (EBPs) are urgently needed. Among the most significant barriers to the availability of EBPs is lack of competency-based training for mental health professionals (Aarons, Hurlburt & Horwitz, 2011; Herschell, Kolko, Baumann, & Davis, 2010). Research has identified serious gaps in knowledge related to the principle methods needed to train therapists in ongoing use of evidence-based interventions (Herschell et al., 2010; Rakovshik & McManus, 2010).

In an effort to increase the availability of effective psychological treatments for Veterans, the Veterans Health Administration (VHA) – the health care component of the U.S. Department of Veterans Affairs – has implemented several national EBP dissemination and implementation programs throughout the VA health care system. A key component of these initiatives is the development of competency-based EBP training (see Karlin et al., 2010, 2012; Ruzek, Karlin, & Zeiss, 2012).

Several of VA's EBP dissemination initiatives focus on the treatment of depression, as depression is one of the leading mental health problems among Veterans, with about 14% of

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Veterans seeking care in VHA receiving the diagnosis (Karlin & Zeiss, 2010; National Alliance on Mental Illness, 2009). One of these initiatives focuses on Acceptance and Commitment Therapy for depression (ACT-D; Hayes, Strosahl, & Wilson, 2011). Research has increasingly shown ACT to be effective for depression, as well as other mental and behavioral health conditions (see meta-analytic reviews; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Powers, Zum Vorde Sive Vording, & Emmelkamp, 2009; Ruiz, 2010). Research has also shown ACT to increase self and clinician-rated functioning, quality of life, and life satisfaction (Forman, Herbert, Moitra, Yeomans, & Geller, 2007), suggesting it to be a good treatment option for the many struggles often encountered by Veterans with depression.

To date, there have been limited data on effective methods for providing training in complex psychological treatments, especially for newer acceptance-based psychotherapies, such as ACT. Further, less is known about the effectiveness of ACT for the treatment of depression in routine clinical settings. Accordingly, the purpose of the present paper is to present VA's national approach to training mental health clinicians in ACT-D and to examine the impact of the training and implementation of the therapy on therapists and patients, respectively. Specifically, we report the results for VA mental health clinicians who participated in the VA ACT-D Training Program with respect to changes in their ACT-D core competency skill level, self-efficacy to deliver ACT-D, and attitudes toward the therapy. In addition, we report the clinical outcomes of Veteran patients treated by therapists participating in the Training Program, including depression and quality of life outcomes. Finally, we examine the therapeutic alliance scores and effects of patients' reported use of skills related to ACT-D on patients' changes in depression.

Methods

Program description

ACT-D Training Program overview

This was a large scale, multi-site, multi-cohort dissemination of ACT for depression within VHA. The Training Program included participation by mental health providers in experientially-based workshop trainings covering the theory and application of ACT-D. These workshops were followed by a 6-month period of weekly case consultation calls lasting 90-min each. Case consultation included verbal discussion of cases, review of taped sessions, and support on the development and implementation of specific ACT-D skills. Each consultation group included approximately 4 consultees. All consultation calls were provided by trained experts in ACT-D who served as training consultants in the program.

Initially, expert consultants were selected based on experience using ACT with clients (minimum of 10 years) and conducting supervision in ACT (minimum 5 years). All of the initial 8 consultants had experience working with Veterans. These consultants attended a two-day workshop for training and program development (also see ACT CCRF). Additional consultants were added from cohorts of clinicians trained in the Training Program. Specifically, a subset of top performing consultees, as demonstrated by competency ratings and other factors, were recommended to apply to serve as training consultants. A structured application process and detailed recommendation form completed by the individual's training consultant were used for evaluating training consultant applicants. There were a total of 19 training consultants in the Training Program during the timeframe covered by the current evaluation. Furthermore, an ACT-D Training Consultant Manual, incorporating logistical and conceptual information and guidelines for providing consultation and running consultation groups was developed and provided to all training consultants.

ACT-D training consultants were responsible for multiple tasks during the 6-month training period, including 1) organizing and conducting weekly consultation of the ACT-D protocol implementation; 2) listening to and providing feedback to each consultee on 10 recorded sessions of the ACT-D protocol conducted with Veterans; 3) providing consultation on at least two cases, one of which had to reach at least 10 sessions; 4) providing an overall core competency rating of each training participant at three time points covering the 6-month consultation period, and 5) participating in telephone meetings with other training consultants and Training Program coordinators for 1 h on a monthly basis to discuss and standardize training issues and problem solve implementation and training barriers.

Training participants were required to meet specified process and performance-based criteria to successfully complete the 6-month Training Program. These criteria included: (1) participation in the 3-day experientially-based training workshop; (2) participation on at least 75% of the consultation calls; (3) implementation of ACT-D per protocol with at least two patients; (4) submission of at least ten audio-taped ACT-D therapy sessions for review and feedback by the training consultant; and (5) receipt of a rating of 90 (range = 30–120) or greater on at least one of three ACT Core Competency Rating Forms (see ACT CCRF description below).

VA mental health clinicians in the professional disciplines of psychology, psychiatry, social work, and mental health nursing were eligible to participate in the Training Program during this evaluation period. Clinicians interested in participating in the Training Program submitted applications through a structured application process coordinated by regional mental health leadership, which has been described in greater detail elsewhere (Karlin et al., 2010, 2012).

There were no limitations on the types of Veteran patients who could receive ACT-D from therapists in training other than they needed to have a diagnosis of depression and not be in acute crisis or impairment that would render them inappropriate for initiation of psychotherapy. Therapists participating in the ACT-D Training Program recruited patients seen in or referred to their current practice setting. Patients were either new to the therapist and entered the clinic through regular means (as determined by the clinic) or were existing patients of the therapists. Patients consented to being audio-taped for the purposes of therapist training and program evaluation. At the first session, patients completed a demographic form that included their age, gender, highest level of education, and ethnicity.

ACT-D implementation and protocol description

The protocol used during the Training Program was based on the structure and format of the 12-session protocol contained in ACT for Depression: A Clinician's Guide to Using Acceptance & Commitment Therapy in Treating Depression (Zettle, 2007). A 12-session manual specific to the delivery of ACT for depression with Veterans (Walser, Sears, Chartier, & Karlin, in press) was developed and provided to training participants to complement the Zettle (2007) manual. Training participants were provided with two clinical texts to support their training and were discussed in consultation: *Learning ACT* (Luoma, Hayes, & Walser, 2007) and *Get Out of Your Mind and Into Your Life* (Hayes & Smith, 2005). Training participants were also provided access to a VA intranet site containing supporting material (e.g., articles, alternative exercises, etc.) and a bulletin board to post questions and discuss implementation issues.

Measures

Workshop evaluation

A workshop evaluation was created specific to this program to gather therapist training participant appraisal of and response to