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Flexibility and Structure May Enhance Implementation of Family-Focused Therapy in Community Mental Health Settings

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Abstract

This study elicited provider and administrator preferences in implementing an evidence-based practice (EBP) for bipolar disorder or psychosis, family-focused therapy (FFT). Providers (n=35) and administrators (n= 5) from three community mental health centers took part in FFT training and participated in pre- and post-training focus groups. Transcripts were examined using conventional content analysis. Providers and administrators discussed barriers to implementing EBPs. Successful EBPs were described as incorporating flexibility and close supervision to maximize provider adherence. Providers expressed preferences for structured EBPs like FFT that have both explicit implementation steps and built-in flexibility.

Keywords

Bipolar Disorder; Adolescents; Implementation Science; Evidence-based Practice; Community Mental Health

Introduction

Despite the investment of the National Institutes of Health in science to improve health, few evidence-based practices (EBPs) are used in healthcare (Lobb & Colditz, 2013). Implementation sciences have focused on translating and implementing EBPs developed in academic settings into the community (National Research Council, 2001; McHugh & Barlow, 2010). Little is known about what EBP qualities are important to enhance acceptability and appropriateness to facilitate implementation fidelity, two domains that are central to assessing intervention fit for particular contexts (Proctor et al., 2011).

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This manuscript examines perceptions of and preferences for EBPs among providers and administrators from publicly-funded community mental health clinics (CMHCs) during training in family-focused therapy (FFT; Miklowitz, 2010). FFT is an evidence-based therapy for adolescents and young adults with bipolar disorder (Miklowitz & Scott, 2009) and psychosis (O'Brien, et al., 2014) consisting of three modules: psychoeducation about illness management, communication skills training, and problem-solving skills training. Although FFT has been shown to improve patient outcomes in several university-based studies, little is known about how to disseminate and implement FFT in CMHCs. A qualitative analysis of focus group data provides an exploratory understanding of perceived characteristics important for adoption of EBPs, and specifically, FFT, in community settings.

Methods

Participants

A two-day FFT training was held for providers (n=15) and administrators (n=5) working in three CMHCs in July 2012. An additional one-day FFT training for providers (n=20) from the same three CMHCs was held in July 2013. Participant demographic characteristics were obtained by a written survey administered before the training sessions. Of all survey respondents, 82.5% (n=33/40) completed the survey and 17.5% (n=7/40) started but did not complete the survey.

Procedures

Participants from all three clinics attended 45-min. pre- and post-training focus groups. The focus groups were conducted by Ph.D. qualitative researchers with experience in community mental health research. Pre-training questions addressed challenges working with families and adolescents or young adults with bipolar disorder or psychosis, implementing EBPs, and preferences for training. Post-training focus groups addressed perceived benefits, challenges or limitations and desired modifications with implementing and training in FFT. Administrators (n=5) and providers (n=35) were trained together but interviewed separately. To reserve providers' limited time for the training, all trainees present at the July 2012 training (n=15) participated in a single focus group and all trainees present at the July 2013 training (n=20) formed a single focus group. To help circumvent the possibility that a few participants would dominate the discussion in such a large group, for each question the moderator allowed the first five to seven minutes to be designated for open discussion and then asked each participant to briefly address the question moving clockwise around the table. This approach allowed all participants to contribute and also enabled the moderator to distribute the 45 minutes equally across questions. If time remained after all questions were posed, the moderator re-opened the floor for general discussion by revisiting a topic that had previously generated an engaged discussion (e.g., prior experiences with EBPs).

The UCLA institutional review board approved all study procedures. The study was explained in full before written consent was obtained from all participants.

This article describes participants' perceptions of and preferences for EBPs. Pre-training responses commented on EBPs generally, while post-training focus groups elicited specific perceptions of FFT and its implementation, also revealing general preferences about EBPs. Qualitative analysis of focus group data utilized conventional content analysis using open coding and constant comparison to generate themes and categories (Hsieh & Shannon, 2005). Two reviewers read focus group transcripts independently to create an initial coding scheme. Administrator and trainee focus group data were initially analyzed separately; however, similar themes regarding EBP and FFT emerged from both groups, generating a single codebook. The codebook was developed and applied by two raters with satisfactory agreement (Cohen's kappa κ=.76). Discrepancies were discussed and resolved, resulting in codebook modifications. A second round of coding was completed with high reliability (κ=.84).

All authors certify that they (a) accept responsibility for the conduct of the study, for the analysis and interpretation of the data; (b) they helped write the manuscript and agree with the decisions about it, (c) meet the definition of an author as stated by the International Committee of Medical Journal Editors, and (d) have seen and approved the final manuscript. The authors also certify that neither the article nor any essential part of it will be published or submitted elsewhere before appearing in the Journal. The authors have no known financial conflicts of interest.

Results

Participant Characteristics

Four of the five administrators (80%) completed the survey. The median age of administrators was 60 years (mean=55.3) and all were female. Three administrators reported ethnicity as White and one was Asian American. Administrators had a median of 22.5 years (mean=20 years) of clinical experience. Two had master's degrees, one had a Ph.D., and one had an M.D. All were licensed therapists, psychologists, or physicians.

Of 35 providers, 29 (82.9%) completed the survey; the median age was 33.0 years (mean=35.4); 34.5% (10/29) were male. Almost half of respondents were White (n=16/29, 55.2%), 20.7% (6/29) Latino, 31.0% (9/29) were Asian American, one responded "other", one responded African American, and 10.3% (3/29) did not respond to this question. Over half (n=16/29, 55.1%) had a master's degree and 44.8% (n=13/29) had a medical or doctoral degree. Providers had 4.0 median years of clinical experience (n=29, mean=4.7). Among providers and administrators completing the survey, 75.8% (25/33) had attended one or more prior trainings in evidence-based psychosocial interventions for mental disorders. The EBPs included cognitive-behavioral therapy, dialectical behavior therapy, exposure and response prevention, and other manualized interventions.

Theme 1: Practical Challenges of EBPs

In the focus groups, participants highlighted practical challenges of EBPs that affected the likelihood of adopting these methods in CMHCs. The time and effort required to learn and implement EBPs was often mentioned. One administrator commented that "clinical staff are

overwhelmed by [EBPs]," while another noted that learning EBPs is "an arduous process." Providers questioned the requirements to learn many EBPs (for example, cognitive-behavioral/exposure treatments, mindfulness-based treatments), preventing mastery of any one EBP. Other practical challenges included how to balance EBP fidelity with productivity expectations. Notably, the implementation requirements of certain EBPs can be inconsistent with allowable billable services.

Theme 2: Therapeutic Limitations and Perceived Inflexibility of EBPs

Participants valued the potential of EBPs to improve clinical outcomes and wanted to implement them correctly. However, participants expressed the importance of deviating from EBPs due to the inadequacy of many EBPs in addressing "very realistic things" including patients' noncompliance, symptom instability, and comorbidity. Several commented that the lack of fit of EBP in CMHCs as a consequence of the contrasting needs of clinical and research contexts.

One administrator expressed that "more research-driven people that aren't necessarily as clinical … sometimes don't realize that there's just no way you're going to slap this EBP on a patient and have it work." Participants perceived this challenge to result from EBPs being rigid and inflexible. Participants believed rigidity and inflexibility limited the ability of clinicians to address patients' needs that fell outside of the treatment protocols (e.g., problematic living situations), to incorporate one's clinical experience into treatment planning, or to focus on nonspecific factors (e.g., working alliance) perceived as crucial for enhancing patient outcomes. One participant described protocol deviations as "interventions that experienced clinicians do … but [that are] not built in a structural way to evidence-based treatment." Similarly, providers valued FFT's flexibility and the balance between research and clinical aims. For example, the FFT modules do not need to be implemented in a strict linear order and can be revisited later if needed: "That you could go back – if there's an issue, you could move to problem solving, and if people aren't communicating, you can move to the communication module. Even though there's a track to run on, there's a lot of flexibility to deal with what comes up and there's also the encouragement not to get derailed. … it allows you to respond to the family and what needs are at hand without losing your bearings."

Theme 3: Benefits of EBP Structure

Providers also noted that EBPs should be equally detailed and structured to enhance adoption and implementation. In other words, providers expressed preferences for both flexibility and structure in EBP protocols. Providers commented that structured training and manuals are important for providing clarity about aims and procedures. They expressed feeling more competent about EBPs that offered more than the "bare bones" (i.e., step-by-step protocols and explicit instructions for each treatment module). One provider valued the structure FFT provided because working with bipolar disorder "can be chaotic and derailing, so this helps at least give you a map." Most providers appreciated the FFT training videos showing an expert implementing each EBP stage and the unambiguous modeling of treatment delivery. Detailed EBPs like FFT were also valued because they provided a structure and rationale for treatment decisions not found in unstructured clinical care. So

even when providers deviated from the EBP protocols, the structure of these practices provided the therapists with a framework to make more sound clinical judgments than when providing usual care. As one provider noted, “you have to know [the EBP] well enough to be able to know how to modify it and the only way you can do that is with consistency in the training.”

Theme 4: Desired Features for EBP Training

Providers emphasized the importance of peer provider support when learning a new EBP. Live training in a group setting helped generate ideas, maintain consistency, and receive personalized peer feedback; however, they preferred that supervision be conducted on an individual basis, with close monitoring and detailed corrections by supervisors. One administrator suggested using a webcam so that supervisors could observe in real time and “provide instantaneous feedback to the clinician.” Providers indicated that the most useful supervisory comments were those that specified the “script” that providers should follow. One provider remarked, “tell me exactly the way I should’ve said it. Instead of saying ‘well maybe you want to explore’ … it’s like ‘no, tell me how to explore it. Like give me a sentence or something’.”

Discussion

This study provides exploratory qualitative data to understand what characteristics are perceived to be important for adoption of EBPs, and specifically FFT, by providers and administrators in community mental health clinics. Most of the participants had received specialized training in one or more EBPs. Overall, our study participants were enthusiastic about the potential of EBPs to provide them with effective clinical practices. However, consistent with prior studies finding organizational features and provider skepticism to be EBP implementation barriers (Rapp et al. 2010; Forsner, Hansson, Brommels, Wistedt, & Forsell, 2010; Aarons, Wells, Zagursky, Fettes, & Palinkas. 2009; Torrey et al. 2001), participants in this study noted that EBPs developed in university-based settings may not address the “real world” organizational, economic, and client population features of community mental health settings. For example, focus group participants highlighted the concern that organizational features of community clinics (e.g. time constraints, billing) might be incompatible with the EBP protocols and limit feasibility of implementation. In addition, they perceived EBPs as not always addressing the mood instability or comorbidities of patients in community clinics that fall outside EBP protocols.

We found that a key characteristic perceived by providers to enhance the feasibility and acceptability of EBPs was flexibility; many EBPs were perceived to be rigid and to follow a “cookbook” approach (Proctor et al. 2011; Howard, Himle, Jenson, & Vaughn, 2009). Our participants felt that protocol deviations were often necessary to address complex client needs. As argued elsewhere, site or patient-specific adaptations of EBPs may improve acceptability and adoption (Rogers, 2003). In contrast, providers believed that precise, step-by-step guidelines and supervisory feedback were essential training elements to implement EBPs well, a preference not commonly addressed in the literature. Participants reflected on the seemingly incompatible desire to implement EBPs with fidelity by following step-by-

step instructions, while at the same time deviating from EBPs when the complexities of client care (e.g., treating substance abuse) required such deviations.

Although preferences for flexibility and structure may appear to be incompatible, one approach is to build implementation flexibility into EBPs through clear protocols with modular designs that offer alternative protocols to address the diversity of clinical needs (Rapp et al. 2010; Rogers 2003; Weisz et al. 2012). For example, participants expressed appreciation for the nonlinearity and flexibility of FFT. FFT consists of three modules (psychoeducation, communication enhancement training, problem-solving skills training) that are each important for clinical outcomes, but the clinicians' manual allows providers to use their judgment to determine when it is most suitable to implement each one. Understanding the opposing – but not necessarily incompatible - preferences for flexibility and structure may help improve acceptability, feasibility, and adoption of EBPs in CMHCs.

This study had several limitations. Because of our small sample size, we were not able to able to estimate thematic differences by sub-group characteristics such as years of experience and provider discipline. More than 80% of providers in our sample had less than 6 years of clinical experience and worked during a period when EBP training was commonplace and part of the clinical culture. Thus, the providers may have been predisposed to have positive expectations about EBPs even though none had prior FFT training. Additionally, the post-training focus groups elicited perceptions of FFT before the providers began implementing the treatment with clients. Therefore, we cannot be certain that these attitudes would have remained stable over time or would generalize to other EBPs. Finally, providers did not emphasize organizational features of community clinics as implementation barriers, perhaps because the providers did not have enough experience to make comparisons across clinics.

Our exploratory, qualitative findings indicated that both flexibility and operational detail are key EBP features perceived by providers and administrators to enhance adoption and implementation in CMHCs. Organizational features of community clinics were not emphasized as key implementation barriers, which may reflect providers' levels of experience and inability to make comparisons across clinics. Future work is needed to clarify how perceived acceptability and feasibility of EBPs such as FFT - as well as the context in which these EBPs are administered - affect adoption, treatment fidelity and ultimately patient outcomes (Proctor et al. 2011).

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