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EVIDENCE-BASED PSYCHOSOCIAL INTERVENTIONS: NOVEL CHALLENGES FOR TRAINING AND IMPLEMENTATION

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The Institute of Medicine's (IOM) report on psychosocial interventions challenges us to think not only about the way we study and deliver these important treatments, but also the way we teach and implement them. The report's emphasis on protecting consumers by ensuring that effective psychosocial interventions are delivered in forms that closely approximate the ones for which the evidence exists has major implications for recruitment and training of faculty, didactic and supervisory teaching methods, competency standards held by national accreditation organizations, and research training. We briefly outline each of these issues below.

Perhaps, the real game-changing suggestion of the report is that psychosocial interventions be delivered, taught, and researched using an "elements approach." In its most radical form, this model, which is somewhat analogous to dimensional model of psychopathology taken by the NIMH's Research Domain Criteria (RDoC), identifies elements that are both effective and common to multiple types of psychotherapy so that these elements can be studied, taught, and delivered á la carte. This is an exciting and challenging way to conceptualize psychosocial interventions that would require an entirely new approach to training. Curricula would cease to consist of separate courses and supervisors for each type of treatment, instead of employing a single "psychosocial interventions" course that would teach each of the effective elements and how and when to use them. Faculty trained in each of the psychotherapies would have to be retrained in the elements approach, with new or harmonized terminology and an "un-silo-ing" of their approach to assessment, treatment, and formulation. This could be difficult, as loyal practitioners of different psychotherapies often mix as well as oil and water. Even if psychotherapies continued to be delivered and taught in their extant forms, beginning to think about the effective elements of these interventions could prompt new and innovative ways to teach these common elements, much as we teach factors such as therapeutic alliance, empathic listening, and maintaining frame/boundaries as being common to all forms of therapy. The elements approach would also require new directions for psychotherapy research training, with requisite reframing for established psychotherapy research mentors.

Beyond the discussion of the elements approach, the major thrust of the report is the importance of delivering psychosocial interventions that maintain fidelity to the effective

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form for which evidence exists. Sadly, much is often lost in translation, leading to less than ideal health care delivery. Changing this for psychosocial interventions will require increased attention to quality measures, as well as altering training in the following domains.

FACULTY RECRUITMENT AND TRAINING

Training mental health professionals to use forms of psychosocial interventions with fidelity, closely adhering to the practice as tested in the laboratory, would require changes to the way we currently teach psychotherapy. First and foremost, it would require training programs to have adequate faculty to teach and supervise these interventions in their most paradigmatic form. This in itself is a tall order. Adequate faculty means having both sufficient numbers of teachers and supervisors and ensuring that they are properly trained. Quite simply, there is a real shortage of faculty who are qualified to teach and supervise evidence-based psychosocial interventions to mental health trainees.[1] In psychiatry, many residency programs offer their trainees a single psychotherapy supervisor, charged with overseeing all psychotherapy cases regardless of treatment modality. Therapist training for clinical trials suggests that truly learning to conduct evidence-based psychotherapies requires model-specific supervision.[2] Many departments lack faculty who are adequately trained in psychodynamic psychotherapy or cognitive behavioral therapy, let alone interpersonal psychotherapy (IPT) or dialectical behavior therapy (DBT), to be able to supervise trainees.[3] Thus, faculty development efforts designed to “train the trainers” would be essential and would require funding. Rather than calling for faculty to engage in years-long psychotherapy training programs, these pedagogical interventions for faculty must be focused, time limited, and specifically geared to training them to teach these essential treatments to trainees. In psychiatry, national organizations such as the American Psychiatric Association, the American Association of Directors of Psychiatry Residency Training, and the Association of Academic Psychiatry could lead the way with these training programs, offering modules that can be delivered to a wide audience through webinars and other distance learning techniques. Brief teaching manuals would need to be developed to help faculty teach these interventions in a variety of settings, such as inpatient units, emergency rooms, and consultation liaison services, as well as outpatient clinics. Importantly, faculty would have to learn not only how to teach these treatments, but also how to conduct them, as supervisors with deep clinical experience in the method are best able to impart clinical knowledge and assist trainees in developing clinical judgment.

DIDACTIC AND SUPERVISORY METHODS

In addition to training faculty in these methods, teaching techniques would need to shift to more closely approximate training used for research therapists. Close study of treatment manuals, use of video to closely observe technique, as well as use of adherence measures and objective evaluation of techniques would be central to training mental health professionals to deliver interventions in their most effective forms. Curricula would have to include training in measurement-based care to ensure that trainees are well versed in using objective measures to track outcomes to gauge effectiveness of their interventions.

Ensuring adequate training in psychosocial interventions requires not only technique-specific training, but also clear training in "common factors." These factors such as fostering a therapeutic alliance and empathic listening are used in all psychosocial interventions and have been demonstrated to be essential for good outcome, but are unfortunately often given short shrift in training. Manuals would have to be adapted for use in teaching all psychosocial interventions, and students would have to be specifically trained in how to use manuals. This is essential because students often view manuals as cookbooks or scripts rather than guidebooks, so training in proper use of manuals means more than simply having students read them—it involves role play and use of case-based scenarios designed to teach students to apply the techniques outlined in the manuals to real-life therapy situations. Teaching the use of adherence measures and manuals would have to be done without losing therapist flexibility, which has been shown to be crucial to outcome.[4]

COMPETENCY REQUIREMENTS

Emphasizing evidence-based practices would also likely involve shifts in the competency requirements set by national accrediting organizations. For example, currently, the Accreditation Council for Graduate Medical Education (ACGME) requires that graduating psychiatry residents be competent to "manage and treat patients using brief and long-term supportive, psychodynamic, and cognitive-behavioral therapies."[5] There are no specifications as to whether these are manual-based treatments, and many evidence-based therapies including IPT and DBT are not included. This appears to be true in other mental health fields as well. If the goal becomes training mental health practitioners who can deliver manual-driven, evidence-based psychosocial interventions, these requirements would have to be significantly revised.

PSYCHOTHERAPY RESEARCH TRAINING

Regardless of whether we continue to teach and deliver psychosocial interventions according to the extant model of separate treatments or using the elements approach, the kind of changes the report advocates would require major changes in the way we train psychotherapy researchers. Currently, there are few funding mechanisms to support training in psychotherapy research. Trainees must seek the training in the context of a T32 fellowship or later as junior faculty, as a component of a K-award. Few research mentors exist, who can adequately mentor this work. Research training in this area would also need new models, particularly if we are ultimately studying psychosocial interventions using an elements approach. Development of new treatments might also require research fellowships that focus not only on training in psychotherapy research, but also on linking this work to fields such as cognitive and affective neuroscience in order to use findings in these areas to develop new and effective psychotherapeutic elements.

LEVERAGING IMPLEMENTATION RESEARCH STRATEGIES TO INCREASE DELIVERY OF PSYCHOSOCIAL INTERVENTIONS NOW

The gaps between research and practice result from multiple provider-level and systems-level barriers, including educational issues, provider time constraints, lack of measures and

feedback mechanisms, poorly aligned incentives, and other organizational and cultural factors in institutions where the interventions are to be practiced. However, a key factor is the time-honored view that research should progress in a stepwise fashion through clinical efficacy trials, clinical effectiveness research, and, finally, implementation research. Following this procedure, implementation-related barriers to routine use by providers and sustainability strategies by decision makers are tackled only at the end of the process.[6] Decreasing time to implementation of evidence-based psychosocial interventions will require alternative strategies, such as blending the efficacy and effectiveness stages of intervention development[6,7] and effectiveness and implementation trials.[8] Limited research funding, lack of training in implementation research, and the prevalent traditional views about research methodology are important barriers that require immediate change if we are to decrease the gap from research to practice for these important interventions.

All these changes will only happen if and when mental health providers, departments of psychiatry and psychology, funding agencies, and our national professional organizations recognize, as the authors of the IOM report have, that psychosocial interventions are effective and essential techniques for helping patients with mental and substance abuse disorders. We look forward to the exciting challenges for training in the delivery of the highest quality psychosocial interventions that our patients will require and providers and policy makers will adopt, use, and sustain.

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