

FEATURE ARTICLE

Training case managers to deliver focused psychological strategies

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ABSTRACT: Anxiety and mood disorders are prevalent in the Australian community and can be functionally disabling. Access to treatment for these disorders can be difficult, particularly in rural areas where there is limited availability of specialist mental health practitioners such as psychiatrists and clinical psychologists. One way to address this problem is to improve the skills of local mental health practitioners in recognizing and providing treatment for these disorders. This paper describes a program that aimed to enhance access to psychological treatment for depression and anxiety by improving the skills of rural mental health case managers through training and education and support by psychiatrists and clinical psychologists. Thirty-two case managers participated in the program which delivered 10 training modules using a cognitive behavioural therapy framework. Case managers consisted primarily of psychiatric nurses, with others having social work or psychology backgrounds. Participants were assessed pre- and post-training using quantitative and qualitative measures. The effect of the training was noted in several areas including attitudinal changes, improved knowledge of psychological therapies, and changes to stated practice. However, there was concern expressed by participants about their competence and confidence to translate skills learned into practice. While the results of such a program are promising, they highlight some of the complexities of delivering such programs in rural settings.

KEY WORDS: anxiety, depression, mental health, rural, training.

INTRODUCTION

Anxiety and mood disorders are common and disabling. The Australian National Survey of Mental Health and Wellbeing found that anxiety disorders affected just under one in 10 adults (9.7%) and that mood disorders affected 5.8% of adults (Andrews *et al.* 1999). Anxiety

disorders in Australia account for 2.7 million person days out of role per month. The corresponding figure for affective disorders is 2.1 million person days per month (Andrews *et al.* 1999). Both anxiety and mood disorders are also associated with relationship difficulties, alcohol and/or drug abuse, and work-related difficulties.

Effective treatments, both pharmacological and psychological, are available for anxiety and depressive disorders. However, many people do not seek or are unable to access these treatments. This is particularly so for cognitive behavioural therapy (CBT) and interpersonal therapy (IPT), the acknowledged 'first line treatment' for many anxiety and depressive disorders (Nathan & Gorman 2002), which are generally provided by clinical psychologists and, to a lesser extent, psychiatrists. Access to these treatments is especially poor in rural areas where availability of specialist mental health

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practitioners (particularly psychiatrists and clinical psychologists) is limited (Murray *et al.* 2002; Parslow & Jorm 2000).

One way of increasing access to treatment is to enable clinicians who do not have extensive training in CBT or IPT to use focused psychological strategies to target particular problems experienced by clients. This approach has been supported as part of the Australian Federal Government's *Better Outcomes in Mental Health Care* initiative (Commonwealth Department of Health & Aged Care 2001) which includes new Medicare Benefits Schedule (MBS) items to support general practitioners providing longer consultations in which focused psychological strategies are employed.

Focused psychological strategies are circumscribed elements of the broader (CBT, IPT) therapy approaches which can be readily learnt by clinicians and applied within the normal working timeframe of primary care providers. Discrete strategies can be used to assist clients deal with particular symptoms. The strategies taught can be used in the management of clients with anxiety and mood disorders as well as for the treatment of anxiety and mood problems in clients with other presentations. These strategies include breathing retraining, activity scheduling, problem solving, identifying and challenging dysfunctional thoughts, exposure work and psycho-education (Blashki *et al.* 2003; Dattilio 2000).

The current project also aimed to improve access to psychological therapies using this approach. We sought to achieve this by training local mental health case managers (psychiatric nurses, social workers, occupational therapists, psychologists) to develop skills in the provision of focused psychological strategies, and to provide support to these practitioners in the use of these skills.

BACKGROUND AND SETTING

The Loddon Campaspe Southern Mallee (LCSM) Area Mental Health Service (part of Bendigo Health Care Group) provides mental health programs across an area covering 1/6 of Victoria's landmass. This geographical area stretches from Gisborne (51-km northwest of Melbourne) to beyond Swan Hill (on the river Murray). In 1999 there was a collaboration between the Area Mental Health Service and the University of Melbourne's Depression and Anxiety Research and Treatment (DART) Group (Judd *et al.* 2001), to provide a specialist anxiety and depression treatment service to people living in the LCSM area. One of the key areas of activity of the DART program was delivery of a professional development program incorporating training and ongoing support for AMHS clinicians (Hodgins *et al.* in press).

The project consisted of a structured program to upskill case managers (mostly psychiatric nurses) within the AMHS to (i) improve recognition of anxiety and depressive disorders, (ii) identify those individuals who are likely to benefit from focused psychological therapies, and (iii) participate in that treatment under the supervision of experienced therapists, thus providing psychological therapy which would otherwise be unavailable.

The program was undertaken in a series of steps including the initial development of the training modules and written resource materials, pre- and post-project assessment of participating practitioners' knowledge, attitudes, practices and satisfaction (KAPS), and a qualitative evaluation of the training program. The project had four aims: (i) to introduce a service-wide shared language for the treatment of clients with anxiety and mood difficulties, (ii) to develop specific skills in evidence-based psychological treatments, (iii) to generate and maintain a culture of professional development and peer review, and (iv) to enhance professional self-esteem. The current paper describes the quantitative and qualitative evaluation of this program and explores the implications of the results for mental health nurses who work as case managers, particularly in rural areas.

METHOD

Training program

CBT was used as the framework for education and training. The training program was based upon the teaching of a set of cognitive behavioural strategies that were introduced as 10 stand-alone modules directed at the amelioration of anxiety and mood symptoms. The modules taught CBT skills including breathing retraining, isometric relaxation, management of the sleep/wake cycle, identifying and challenging dysfunctional thoughts, exposure work, activity scheduling, structured problem solving, assertion and self-esteem training, and challenging negative automatic thoughts. Each of the 10 modules was presented once to each of the community teams in a single monthly workshop. At each workshop a particular CBT skill was taught and resource materials were given to participants. These materials were both clinician resource material for later reference and a series of 'ready made' handouts designed for the case manager participants to use with clients to do specific tasks and homework activities covered by the module. There was a follow-up session with a facilitator a fortnight later in which participants discussed the ways in which they had applied the skills learned and any difficulties encountered. In addition, face to face and telephone supervision regarding the use of skills taught in the modules was

provided to support case managers using the interventions with identified clients.

Subjects

Case managers ($n = 32$) from four rural teams and the Bendigo-based child and adolescent (CAMHS) team were included in the training program. Most participants were psychiatric nurses (61%); other professional groups included social workers (22%) and psychologists (13%). The mean age was 40.4 years, and the mean duration of practice was 14.4 years.

Procedure

The pre-program assessment consisted of a KAPS measure completed immediately prior to the first education and training session. The postproject assessment took place 2–6 weeks after completion of the training, and consisted of a repeat of the KAPS measure and a qualitative evaluation of the training program. Details of the delivery of the education and training program have been previously described (Hodgins *et al.* in press).

Measures

A KAPS questionnaire was designed for this study (Hodgins *et al.* in press). The questionnaire format was similar to that used to evaluate other training programs (Blashki 2003; Brown *et al.* 1993) with the content designed to address the specific areas covered and issues relevant to the current program. Participant's knowledge of cognitive behavioural interventions was assessed by a set of 15 true/false questions. For example, 'Deep sleep typically occurs soon after going to sleep' (True).

Attitudes to using psychological therapies were measured by rating 10 items on a 4-point scale ranging from 1 (strongly disagree) to 4 (strongly agree). Items included: 'My work would be enhanced by further training about cognitive behavioural therapy'. Participants' own current practice in terms of psychological interventions were measured by rating how often participants used a list of 15 psychological strategies on 4-point scale ranging from 1 (not at all) to 4 (for the majority of clients). Typical items included 'relaxation techniques', and 'structured problem solving'. Job satisfaction was measured by rating five questions on a 5-point scale ranging from 1 (completely dissatisfied) to 5 (completely satisfied). Typical questions included: 'Are you satisfied with your opportunities for supervision?' The post-training KAPS also assessed the usefulness of the 10 training modules. Participants were asked to rate each of the modules on a 4-point scale ranging from 1 (very useful) to 4 (not at all useful).

In addition, a qualitative evaluation of the program was undertaken to enable in depth explorations of the

perceptions of each participant. An experienced researcher who was not involved in the training sessions facilitated focus groups held with each rural team and the Bendigo CAMHS team (five in total). A semi-structured interview schedule using stem questions was used to guide the focus group discussions. Stem questions were related to: usefulness of the sessions, implementation of CBT strategies, barriers to attendance, training quality, and ideas for future training. An average of five people attended each group (range 3–7). Focus group discussions were recorded and subjected to thematic analysis.

RESULTS

Quantitative evaluation

The pre-program KAPS assessment was completed by 32 clinicians. The postprogram questionnaires were completed by 20 of these, representing a return rate of 62.5%. Of the 20 participants who completed the post-training evaluation, three attended all 10 modules and 13 attended more than half. On average, respondents attended six training modules.

Knowledge Pre-training assessment of participants' knowledge of cognitive behavioural interventions uncovered a wide range in terms of per cent correct responses. For example, only 29% knew visual analogue scales are a reliable measure of a client's mood, and only 20% knew that people prone to depression have more unrealistic thoughts about themselves than non-depressed people, but 93% were aware that flooding is not first line treatment for anxiety problems and 100% were aware of the importance of how to use scheduling of pleasurable activities in the treatment of depression. Training led to improvement in the rate of correct responses to the majority of questions relating to psychological strategies.

Attitudes Measures of pre- and post-program attitudes to using psychological therapies are shown in Table 1. Of note, respondents were concerned about time constraints in the use of these therapies, but overall had positive attitudes towards these treatment approaches. Following the program, attitudinal changes were noted. These included a change in the belief that clients would be resistant to psychological therapies, that comorbidity is a barrier to using psychological therapies, and that clients are too ill to engage with psychological treatments.

Practice Assessment of current practice prior to the program showed that supportive counselling and psycho-education were commonly used but, by contrast, one in six respondents reported having never used exposure techniques. The majority of respondents (68.8%)

reported they felt undertrained in psychological therapies. Importantly, following the training, changes were also seen in case managers stated practice (Table 2). There was a clear effect of the training modules on case managers, with an increase in the reported use of strategies which were a particular focus of the education modules such as: breathing retraining, relaxation techniques, structured problem solving, expressing emotions assertively, identifying and working with a client's core schema and management of sleep-wake cycle.

Satisfaction Questions regarding job satisfaction revealed little change between pre- and post-KAPS assessments. Post-training, participants reported a mild increase in satisfaction with respect to the level of professional development in their job and access to consultation opportunities, but a decreased level of satisfaction with respect to opportunities for supervision and the belief

that professional skills were well utilized in their current position.

Qualitative evaluation

Focus group evaluation revealed that although some aspects of the training were perceived as more useful than others, all participants indicated that overall the training had been useful. Most participants were able to describe at least one way in which the training had influenced their practice. Some expressed the view, however, that the clients seen by the teams often had multiple problems and high levels of disability, making it difficult to translate the skills taught into practice. All participants stated that they felt more comfortable with CBT but none felt fully competent to use the skills without ongoing support and supervision. Limited opportunity to practice the skills taught was also highlighted as a problem in developing confidence and competence.

TABLE 1: *Participant's attitudes to using psychological therapies*

	Modal answer	% endorsed answer	
		Pre Training	Post Training
I feel under-trained in psychological therapies	3	46.9	47.4
I believe my clients would be resistant to psychological therapies	2	71.9	55.6
Comorbidity is a barrier to using psychological therapies	2	62.1	44.4
I believe combining medication with psychological therapies is useful	3	53.1	55.6
I believe my time constraints are a barrier to using psychological therapies	3	50.0	33.3
I believe CBT is useful in the management/treatment of my clients	3	53.1	52.6
Psychological therapies cannot be applied to personality disorder problems	2	65.5	66.7
I feel my clients are too acutely ill to engage with psychological treatments	2	71.9	50.0
I believe CBT is one of the most effective psychological therapies for anxiety and depression	3	58.1	76.5
My work would be enhanced by further training about CBT	4	56.3	47.4

Answer codes: strongly disagree, 1; disagree, 2; agree, 3; strongly agree, 4.

TABLE 2: *Views on participants' own current skills and practice*

	Modal answer	% endorsed answer	
		Pre Training	Post Training
Supportive counselling	4	51.6	55.0
Psychoeducation	3	48.4	52.6
Breathing retraining	2	40.6	52.6
Relaxation techniques	3	56.3	66.7
Management of sleep-wake cycle	2	53.1	57.9
Structured problem solving	3	46.9	88.9
Prescribing exercise and diet modification	2	53.1	47.4
Activity scheduling	3	48.4	52.6
Exposure techniques	2	68.8	68.4
Expressing emotions assertively	3	56.3	66.7
Managing self-esteem	3	62.5	52.6
Challenge negative automatic thoughts	3	62.5	57.9
Identifying and working with a client's core schemas	3	35.5	47.4
Family therapy	2	46.9	42.1
Psychodynamic approaches	2	37.9	52.6

Answer codes: not at all, 1; rarely, 2; often, 3; for the majority of clients, 4.

Participants cited workload and the need to respond to crises as the major barriers to attendance at the training session. Some expressed the view that management did not understand the pressures of this workload. Leave and staff turnover also made attendance difficult. In addition, some participants did not feel any recognition from management for their attendance at the sessions.

Comments on training delivery were positive. Of note was the importance placed on the perceived expertise of trainers and also the informal relationships formed with facilitators. The latter was seen as a particular benefit of a regular trainer travelling to the rural site to deliver the training and then being available at other times for discussion and follow up. This provided the opportunity for secondary consultation, both formal and informal. All participants expressed interest in future training. A number expressed an interest in broadening the theoretical framework to include other therapies.

DISCUSSION

The program aimed to provide upskilling for AMHS clinicians in the delivery of focused psychological strategies. The intent of the program was to teach circumscribed elements of the CBT approach, thus increasing access to treatments otherwise unavailable to clients living in rural Victoria. Our evaluation suggests that the program led to changes in clinician's knowledge about, and attitudes towards, the use of psychological therapies. Clinicians also reported using a number of the strategies taught in the program. However, some of the data collected in the qualitative evaluation raised questions about the translation of theory into practice and thus the extent to which the aim of increasing access to treatment was or could be met. Two important concerns were noted: limited opportunity to practice the skills taught and so limited development of competence and confidence to use the new skills; and difficulty translating skills learned into practice as many of the clients seen in the AMHS had multiple and complex problems.

The first of these highlights the need for an ongoing program in which clinicians can be encouraged to use, and be given supervision to use, new skills. While focused psychological strategies are more readily taught and require less time to develop than do the more in depth skills of CBT or IPT, nevertheless there is a need to practice skills learned with suitable clients and to receive ongoing supervision and support. This suggests that, to be successful, a program such as this needs to be sustained over a period of time to enable competence and confidence to develop. The feedback about satisfaction with supervision suggests clinicians would be willing to

participate in ongoing supervision and skills development if this were available.

The second issue, relating to the complexity of client presentations, is fundamental. In undertaking this program, we taught CBT strategies to target problems, not just defined disorders for which CBT has been proven to be highly effective. This was for two reasons. First, short courses such as this are not a substitute for the training undertaken by clinical psychologists and psychiatrists and the skills developed cannot be equivalent. Second, most clients seen by AMHS clinicians have psychosis, personality difficulties and anxiety or mood disorders with significant comorbidity. We sought to develop expertise in focused psychological strategies. However, in providing the training, the approach used was modified from that used in teaching clinicians to treat clients with anxiety and depression. The feedback provided here suggests these approaches may not be readily translated to teaching clinicians who work with this more complex client group. Perhaps a staged process will be required – first learning the skills and applying them to clients with non-comorbid anxiety and/or depressive disorders. Then, once the skills are mastered, adapting them to deal with clients with more complex and/or comorbid presentations.

A further question is whether, or to what extent, these focused psychological strategies, rather than formal CBT and IPT, are effective. This question applies both to clients with anxiety and depression as well as to those with complex and comorbid conditions. An assumption has been made, extrapolating from effectiveness studies of CBT and IPT, that this approach is valid. However, both efficacy and effectiveness studies are required to demonstrate that this is the case.

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