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Educational Best Practices

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Abstract

There are few reports from the behavioral health field that focus on educational best practices. This article summarizes a panel presentation from the Annapolis Conference in which four different programs were described. They include a provider educational initiative, a tool-kit project related to evidence-based services, a multidisciplinary faculty training program in addictions, and an AIDS education project. While such innovative educational practices appear to be the exception rather than the norm, they do offer ideas and strategies for challenging and energizing current educational practices in behavioral health.

Introduction

While the health care field is moving toward embracing the notion of clinical best practices, there is considerably less discussion about the structure, process and content of how to best educate health care providers. It would appear, in fact, that educational processes have changed very little over the years, and even emerging advances in technology often have become prisoners of academic norms and traditions. It is ironic that while many educators emphasize to clinicians the need to evaluate and align care-giving processes with the strongest evidence of effectiveness, they often fail to demonstrate or role model a similar belief related to their own educational processes.

There are, however, exceptions to this. Many of the educational best practices that are influencing the field emerge in non-academic settings and in less formal teaching-learning environments. This paper reports on four exciting initiatives that reflect both the diversity and potential of new learning experiences. They derive from different sources – families, professional organizations and research institutions. They also reflect a variety of educational strategies, implementation issues, and targeted outcomes. As such they can assist the field in considering new approaches to the "little red school house."

The NAMI Provider Education Program

In the past, mental health professionals have been led by academic theory and clinical supervision to blame families of individuals with serious mental illness. Best practices now require a professional "Re-Education" perspective to counter this persistent family-culpability bias. The NAMI Provider Education Program seeks to change these

attitudes, and to increase empathy and compassion, through a 10-week course for line staff in Community Mental Health Centers (Burland, 1995). It is taught by a team comprised of two family members, two consumers and a family member or consumer mental health professional, all of whom have taken an intensive three-day training provided by NAMI. The primary knowledge base for this 30-hour training is the lived experience of the team teachers, exposing staff to the subjective, human dimension of coping with the trauma of mental illness. Including this deeply personal perspective creates an appreciable difference in content, adding emotional and practical understanding to the academic/medical information in the course.

The course adopts a holistic bio-psycho-social approach to understanding mental illness, dwelling on the medical, psychological and rehabilitative aspects of rebuilding lives in the wake of schizophrenia, bipolar disorder, major depression, anxiety disorders and obsessive compulsive disorder. Classes are designed to mix didactic presentations with extensive class/team interaction related to the material under discussion. Over the course of these multiple sessions, family members and consumers inform providers about what they need, want and appreciate from the system.

In addition, the course introduces clinical principles and strategies of secondary intervention as a reliable treatment model for developing provider/consumer/family collaboration. This clinical approach is based on knowledge of the family and consumer stages of adaptation to the trauma and life dislocation caused by serious brain disorders. Staff members learn that once they determine where someone is in this adaptation process, they can “provide” pragmatic, concrete, practical remedies to keep things from

going from bad to worse. The course emphasizes strength-based clinical planfulness, and sets the paramount goal of family and consumer empowerment.

In written evaluations of their experience in these classes, staff members from 15 states where the program is now being taught reported that this course was fresh, relevant, helpful, enlightening, and emotionally overwhelming. They state that not only has their approach towards families changed, but that their understanding of the life dilemmas of consumers has expanded as well. Almost every participant described how their own clinical practices had changed in response to what they were learning in class, and how their empathy for the realities of "living with" mental illness had grown as the course progressed.

The Tool-Kit Project: Building the Evidence Base for the Implementation of Evidence-Based Services

The major finding of the Surgeon General's Report on Mental Health is that state-of-the art treatments are not being translated into community settings. As noted through the report, community-based services are of proven value for even the most severe mental illnesses. Yet a gap persists in the availability of these advances in service delivery to local communities and many people with mental illness are being denied the benefits of these advances.

Multiple explanations for this gap exist, including practitioner lack of knowledge, the cost of new innovations and significant differences between academic research settings and actual practice settings. The bottom line that emerges from the literature is

that the willingness, knowledge and skills of the individual clinician or service provider alone will not result in broad-based implementation of evidence-based practices. The literature on the diffusion and implementation of innovations (Zaltman, Duncan and Holbek, 1973; Rogers, 1995; Valente, 1995,1996; Green and Kreuter, 1991) recognizes that the transfer of innovation through training is necessary but not sufficient either for the initial decision to adopt an innovation or for sustained implementation once adopted.

An emergent conceptualization recognizes the systemic nature and underpinnings of broad-based implementation, with facilitators and barriers existing at the level of policy and regulations, the organizational level, the level at which service provision or treatment occurs, and at the levels of the consumer and family member (Corrigan, Steiner, McCracken et al., 2001; Rosenheck, 2001; Goldman, Ganju, Drake et al., 2001; Torrey, Drake, Dixon et al., 2001). This literature recognizes that evidence-based practices have not been widely implemented for several reasons. These include including existing state laws; administrative policies; funding priorities and advocates' concerns; organizational culture and climate, including the lack of leadership and teamwork; clinicians' lack of necessary knowledge and skills; and consumers and family members who may not have been active team members and are therefore not committed to the new regimen.

Implementation is only beginning to be studied in the context of mental health treatment. The literature on diffusion identifies various factors that affect sustained adoption including attributes of the innovation (e.g. cost, complexity), attributes of the practitioner (e.g. expertise, perceived advantage, perceived support), and attributes of the

consumer/family member (e.g. perceived advantage, commitment/adherence). However these studies do not identify the specific factors most likely to predict adoption and implementation of a particular mental health treatment or service. That is, the evidence-base needed to guide successful large-scale implementation of evidence-based practices has yet to be developed (Torrey, Drake, Dixon et al., 2001; Schoenwald and Hoagwood, 2001).

This systemic approach has profound implications for the development of the workforce. A major thrust of any development effort would be to ensure that the multiple levels which may have an impact on implementation are focused on assuring that the evidence-based practice is implemented in a manner proven to be effective. Fidelity to the model is critical for success. Too often, the problem with achieving expected outcomes is related to a dilution or erosion of such fidelity.

A major initiative by Drake and colleagues (Drake, Goldman, Leff et al., 2001) has developed implementation intervention packages for six different evidence-based services (assertive community treatment, supported employment, integrated services for persons with co-occurring mental health and substance abuse problems, medications, family psychoeducation, and illness self-management). Each of these has components for the state mental health authority, the provider organization, the clinician, the consumer and the family member. These packages are being tested and refined in a multi-state research initiative so they will ultimately include implementation strategies at each of the levels at which barriers must be surmounted to achieve broad-based implementation.

These packages can be the basis for workforce training at the different identified levels: the training of the caregiver, the training of those responsible for the systemic context of treatment and care, and the recipients of services. A key aspect is the mutual understanding of the contributions that each level makes.

Another important issue is the sustainability of implementation. In the context of high turnover rates and an erosion of resources for mental health services, a training and education infrastructure that is an inherent component of the service delivery system, or intimately tied to it, much like the infrastructure for information technology, can provide both expertise and continuity. That is, while the increasing emphasis on evidence-based services will require changes in curricula to address the needs for new knowledge and skills, the structure and delivery of training and education may need revamping as well.

A nascent science is providing building blocks for the implementation of evidence-based practices. The challenge for the field is to implement evidence-based services in the context of the larger mental health system while the science related to implementation is still emerging.

AMERSA: Multidisciplinary Faculty Training in Addictions

The Association for Medical Education and Research in Substance Abuse (AMERSA) is a multidisciplinary organization dedicated to improving education in the care of individuals with substance abuse problems. Physicians from several different specialties, nurses, social workers, psychologists, pharmacologists, dentists and other professionals who hold faculty positions in academic centers around the country

collaborate on substance abuse education projects. The organization has over 300 members, holds annual meetings in November and publishes a peer-reviewed journal, entitled "Substance Abuse." Its web site is: www.amersa.org . In addition, there are four active AMERSA task forces: 1) Faculty Development; 2) Physician Education; 3) Assistance for Healthcare Professionals; and 4) Multicultural Task Force.

One of the most important activities of the organization is Project MAINSTREAM (the Multi-Agency Initiative on Substance abuse TRaining and Education for AMerica), a collaborative training project established by HRSA, AMERSA and SAMHSA/CSAT. The program funds groups of three fellows from different disciplines to work on faculty development and community projects. For the first round of the project, 49 groups (147 potential fellows) applied and five groups were selected. These groups began their work in the summer of 2001.

Several AMERSA members have focused on medical school teaching. Teaching medical students about addictions can be challenging because of the stigma of mental illness in general and the stigma of addiction in particular. Medical students see patients who suffer from such illnesses as trauma, cancer, or diabetes as people "worth fighting for," but they often find addicts to be "lost causes." While overall societal bias may be largely responsible for this misperception, it appears that there are other forces operating as well. When one talks with first year medical students, they are sympathetic to addicted patients and eager to help with their struggles. Is it possible that something toxic happens in their medical education by the time they reach the clinical rotations in the third year? While these dynamics are not well understood, faculty efforts to expose medical students

to the challenges and rewards of addiction medicine have made a remarkable impact at certain medical schools. In New York and other cities, faculty members take students to AA meetings and then hold process groups to discuss the students' impressions and feelings. In Florida, medical students can pass their required course in addiction medicine by teaching high school students about substance abuse. Also, there is a web course on combining spirituality with biomedical approaches in the treatment of addictive disorders, that is pending publication on the Internet.

These are but some examples of best practice initiatives undertaken by AMERSA. This is truly an exiting time for the teaching of addiction medicine and AMERSA, as a uniquely multidisciplinary organization, is committed to providing cutting-edge models for substance abuse education.

AIDS Education Project

The involvement of psychiatrists in the diagnosis and treatment of HIV/AIDS patients is essential because of the prevalence of HIV-related neuropsychiatric complications, psychiatric comorbidity and psychodynamic aspects of HIV infection and disease. Clinical experience and research provide substantial evidence that HIV directly infects the brain, resulting in central nervous system impairment and neuropsychiatric disorders. Current studies estimate that as many as 75 percent of all AIDS patients present symptomatic central nervous system consequences.

Through funding from the Center for Mental Health Services, (and formerly through the National Institute of Mental Health), the AIDS Education Project (AEP) of

the American Psychiatric Association's (APA) Office of HIV Psychiatry has worked to provide HIV/AIDS-related training, education, and needed resources to the psychiatric community since 1987. Under the leadership of the AIDS Education and Steering Committee and the APA Commission on AIDS, the AEP has trained over 20,000 psychiatrists throughout the United States on the spectrum of clinical, neuropsychiatric and psychosocial aspects of AIDS and HIV infection. Among the program efforts, addressing the special needs of psychiatry residents has been primary.

Since 1996 the AEP has dedicated time and resources to improving AIDS education for residents. Working with the Commission on AIDS and several advisory groups, the AEP developed criteria for training; developed and distributed a comprehensive model curriculum nation-wide; conducted pilot trainings; and proposed HIV training requirements to the Accreditation Council for Graduate Medical Education. While these initiatives have been successful, they have not been problem-free. Over the past several years, surveys have been conducted with residency program directors throughout the U.S. After reviewing the results of these surveys as well as other published findings, and evaluating past training experiences, several barriers to residency training were identified: 1) a discrepancy between the perception of residency training directors and the needs of residents; 2) the absence of a standard HIV curriculum; 3) the lack of experienced HIV faculty; and 4) overwhelming time constraints. AEP realized that effective strategies would need to be developed to eliminate these barriers if any effort was to ultimately be successful.

First, AEP communicated with residency training directors directly. When asked

if there was a need to know the neuropsychiatric aspects of HIV disease, the majority of residency training directors perceived that there was not, while the residents surveyed reported otherwise. AEP thus began working hard to build relationships and correspond with directors. When the information surveyed from residents was shared with training directors, there was a greater openness to consider the possibility of providing training on the neuropsychiatric aspects of HIV disease.

Second, AEP responded to the residency directors' need for a standard training curriculum. Beginning in 1994 the AEP and the APA Commission on AIDS marshaled the knowledge and experience from experts around the country, and set forth to create a model training curriculum that would act as the standard for HIV neuropsychiatric training. Once completed, this curriculum was pilot tested and later distributed to training directors nationwide.

Third, AEP recognized that some programs do not perceive themselves as having the expertise to deliver the training. Consequently, a national network of expert trainers was developed to assist in the training effort. Faculty now consist of psychiatrists whom APA has trained as trainers, as well as local clinicians identified by network trainers or through APA committees and district branches, state and local associations, and/or other AIDS and/or psychiatric organizations. All trainers are required to have significant HIV/AIDS clinical experience; expertise in patient sub-populations significantly affected by the AIDS epidemic, including communities of color, substance abusers and the mentally ill; and/or, training or facilitation experience. APA continues to expand its AIDS training faculty through ongoing identification and recruitment of psychiatrists and

other local mental health care providers involved in the clinical care of HIV/AIDS patients.

And, finally, coordinating training is traditionally the responsibility of the residency training director. Daily duties and tasks, however, may not allow the time necessary to coordinate training logistics including identifying meeting space, developing programs and agendas, or procuring training materials. Therefore, whenever necessary or appropriate, AEP provides support services to residency training directors to relieve them of these responsibilities. In smaller settings, particularly rural areas, this assistance is especially important as resources maybe extremely limited.

As we look toward the future, the AEP would like to further assist training programs and residents by putting mechanisms in place that would make resources available after our training programs have been completed. Efforts include making available AIDS Commission members and other experts who could provide support, clinical consultation and mentorship opportunities; providing continuing education and updated reference and clinical materials that can be easily downloaded from the internet; and providing information updates and newsletters via electronic and traditional mail.

Conclusions

The transfer of information that results in the assimilation of new knowledge and behavior change is a complex phenomenon, whether the intended audience is behavioral health providers or behavioral health consumers. The principles underpinning knowledge translation, dissemination and implementation are the same for both groups.

It is thus difficult to explain the current myopic focus of the field on changing the behavior of consumers and family members to the exclusion of a similar expectation for changes in the ways in which health care providers are educated. Sadly, academic institutions are not often in the forefront of such initiatives. It is clearly time for the field to look in new directions for innovations and leadership to support an evidence-based approach for educational best practices.

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