

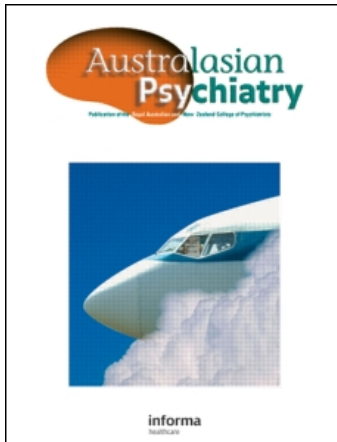
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The promise of online cognitive behavioural therapy training for rural and remote mental health professionals

James Bennett-Levy and Helen Perry

Objective: The aim of this paper is to indicate how online cognitive behavioural therapy (CBT) training for rural and remote health professionals can enhance access to evidence-based treatments in rural communities and address psychotherapy training shortfalls for rural practitioners treating Australians with high prevalence psychological disorders.

Conclusions: Issues of cost, distance and disruption to services have meant that, until now, it has been very difficult to provide really effective training in evidence-based therapies (in the main, CBT) for Australian rural and remote health professionals. The recent development of online CBT training provides new opportunities. Online training, supplemented by regular supervision, can fulfil many of the functions of face-to-face training at significantly reduced cost. While face-to-face residential workshops will still be necessary to embed new skills, we estimate that online training can reduce the face-to-face time required by at least 50%.

Key words: cognitive behavioural therapy training, distance education, online training, rural workforce, therapist skill development.

There is growing recognition in Australia and elsewhere of the human, social and economic cost to the community of high prevalence mental disorders such as depression and anxiety.¹ For instance, the latest Australian National Action Plan on Mental Health has highlighted the importance of increasing access to mental health services and early intervention in order to reduce the prevalence of mental illness.² Mental disorders (including depression, anxiety, alcohol abuse, heroin dependence and personality disorders) are estimated to contribute around 13% of the total disease burden (both fatal and non-fatal) in Australia.³ Depression and anxiety account for about 55% of the mental disorder burden. According to Medicare (2008) data,⁴ in any one year approximately 18% of Australian adults experience a mental disorder, while in any given 6 month period, 14% of children and adolescents experience a mental disorder.

The 2006 government initiative, *Better Access to Mental Health*,² which sought to reduce the extent of mental disorder by enhancing access to psychological services, extended the Medicare subsidy to cover short-term (up to 12 sessions [or 18 in exceptional circumstances] per calendar year) psychological interventions by psychologists, and appropriately qualified social workers and occupational therapists. Recommended treatments are those with a strong evidence base, in particular cognitive-behavioural therapy (CBT). *Better Access to Mental Health* has significantly increased access to psychological therapies.⁵ However, there remain real gaps in services particularly for people living in rural and remote communities and

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disadvantaged metropolitan areas. As predicted,⁶ recent Medicare data has revealed major inequities in delivery of service due to the lack of appropriately qualified health professionals able to deliver evidence-based psychological therapies in these settings.⁵

Various options have been proposed to address the issues of cost, distance and lack of appropriately qualified professionals in rural communities able to offer evidence-based treatments including internet-based treatments⁷ and telephone counselling.² These approaches may well address some of the needs. However, there will be some patients, especially those with more severe depression and anxiety disorders and substance abuse problems, for whom a more intensive one-to-one evidence-based treatment with a local health professional would be indicated, particularly to stem the significantly higher rates of suicide in rural communities.^{3,8} Furthermore, telephone counsellors and internet-based treatments cannot provide the knowledge of local contexts, community contacts and community resources, which a local health professional can provide and which can help patients with depression to get back on their feet. Therefore, where a community lacks access to evidence-based therapies locally, it makes sense to train some local health professionals to provide this option, particularly for patients with more severe mental health problems.

Until recently, the options to train rural and remote health professionals in evidence-based therapies were severely limited by cost, distance, and time away from the workplace. However, the recent development of online CBT training for health professionals offers new possibilities for training the rural and remote workforce. In this article we address the advantages and limitations of online CBT training, drawing on empirical research on therapist training and models of therapist skill development; and we outline the requirements for a successful program focused around online training.

ONLINE CBT TRAINING: WHAT IS AVAILABLE?

Two CBT training online packages have recently been developed in the UK: OCTC ONLINE (www.octc.co.uk) and PRAXIS CBT (www.praxiscbt.com). The Evidence-Based Therapies Training Unit at the Northern Rivers University Department of Rural Health is also starting to develop Australian content.

PRAXIS CBT is a coherent modular CBT package. It covers all the basic topics of an introductory CBT course – assessment, formulation, basic CBT skills etc. – through text-based lessons and demonstration by experienced CBT therapists. It provides clear aims and learning outcomes for each section, and various assessment strategies including systematic questions/answers, interactive exercises, and workplace-based tasks to be discussed in supervision. OCTC ONLINE features

11 highly regarded CBT therapists talking in depth about CBT, and demonstrating relevant skills in areas ranging from beginner to advanced. The packages complement each other well. PRAXIS is a well-designed systematic introductory training package; OCTC ONLINE covers relevant areas of clinical practice in greater depth but is not structured as a systematic training program. With both products, the viewer is immediately struck by the value of seeing CBT so richly demonstrated in a clinical context by a wide variety of therapists. For the reasons given below, we believe these demonstrations are a key feature in the potential value of online training.

CBT TRAINING – WHERE DOES ONLINE TRAINING FIT?

The evidence base from training health professionals in CBT in Australia and overseas indicates that:

- (1) Brief courses (e.g. 4–8 days) are largely ineffective in promoting skill utilization and development without additional supervision.^{9–12}
- (2) Concurrent and subsequent supervision by skilled CBT therapists looks to be a prerequisite for adequate skill development in novice trainees.^{11,12} This supervision needs to be regular (once a week, especially during training) and sustained (usually over several years).
- (3) Extended courses (e.g. 1 year diploma CBT courses, around 36 days, 1 day/week) are highly effective.^{13,14}

Therefore, in order to provide effective CBT training for rural and remote health professionals, an extended program and regular supervision is necessary, particularly since it is likely that they would need to focus a significant proportion of their work on patients with more severe, potentially life-threatening depressive disorders. The potential benefit of online CBT training is that it may be able to radically reduce the need for face-to-face time in extended CBT courses, and thus make the training of rural and remote health professionals financially and logistically viable.

A recent study by Bennett-Levy *et al.*¹⁵ is helpful in suggesting the place of online training in therapist skill development. They found that reading and lectures were the most helpful training strategies for the development of declarative knowledge (theory, concepts); modelling provided the essential bridge between declarative knowledge and procedural skills (turning knowledge into practical skills-in-action); and role play was most helpful in embedding procedural skills. Other work by Bennett-Levy and colleagues using self-practice/self-reflection workbooks indicates that self-experience of CBT techniques and reflective practice are particularly useful strategies for deepening understanding and skills in CBT.^{16,17}

The implications of these findings for online training are that:

- (1) Online training can provide the 'lecture format' and reading material necessary for the acquisition of declarative knowledge. Furthermore, content can be watched as many times as required.
- (2) Online training may be particularly useful for modelling CBT skills. There are major advantages here for online training over and above the usual workshop format because trainees can observe a number of different therapist styles; they have the opportunity to watch the clips repeatedly from a variety of perspectives (e.g. watch for the technical content, or watch the interpersonal process), and can observe larger chunks of therapy sessions than would be the case in workshops. In contrast, our observation is that in workshops many trainers are reluctant to do live demonstrations, and the opportunity to observe therapists, if present at all, is usually confined to small video clips watched once.
- (3) Online training can provide useful opportunities for self-experience of CBT strategies and reflective practice via self-practice/self-reflection workbooks. Earlier studies used email as a means for trainees to share reflections.^{16,17} Recently, Farrand has used online 'blogging' to enable trainees to dialogue about their experiences.¹⁸
- (4) Online training provides other good opportunities for reflective practice: to pause a presentation, absorb or make notes on what has just been seen, answer questions, and/or go back and replay it.
- (5) At present, we believe that there is one element of therapist skill development that will still require some face-to-face training at a central location: the need to embed new procedural therapy skills in role plays with other trainees. Feedback from trainers and other trainees appears essential in enabling trainees to learn and refine new skills. While some of this function can be achieved in online supervision, we believe that 'in person workshops' will be necessary, at least until such time as there is a critical mass of trainees remotely who can be guided by local trainers. One further benefit of some face-to-face workshop time is that it may foster a new learning community for the rural health professionals learning these new CBT skills.

Supplemented by online supervision (webcam) or videoconference or phone supervision, our expectation is that the provision of online training can reduce face-to-face training time by at least 50%. Most of the didactic, modelling and self-experiential elements of CBT training can be undertaken remotely, leaving the face-to-face residential training to focus on the experiential practice and role play of new skills.

For such a program to work effectively, there are some necessary requirements. First, trainers cannot guaran-

tee that online material will be watched or attended to. In order for trainees to benefit to the maximum from experiential workshops, all trainees will need to have absorbed the didactic, modelling and self-experiential components of the online materials prior to attendance. Therefore, formative assessments will need to be completed 1–2 weeks before the workshops. Second, online training lacks the interactivity of workshops. Therefore, trainees need to be given the opportunity to contact supervisors or lecturers if they have difficulty understanding some aspect of the material. Third, trainees need access to high speed broadband in order to view the online video content. This is still a problem in certain areas of rural and remote Australia where broadband access remains poor.

SUMMARY

Online CBT training provides an exciting new opportunity to bring quality evidence-based psychological therapies to rural and remote Australians by being able to train local health professionals at vastly reduced cost and disruption to service. Effective supervision is a pre-requisite when training novice CBT therapists.^{11,13} Therefore, if training a new rural and remote workforce in CBT, it is essential that training is provided in CBT supervision skills for more advanced CBT therapists. Once supervision capacity is built into the system, the opportunity will be there for effective evidence-based practices to be available in the farthest reaches of Australia.

REFERENCES

1. Mathers C, Vos T, Stevenson C. *The Burden of Disease and Injury in Australia*. Canberra: Australian Institute of Health and Welfare, 1999.
2. Council of Australian Governments. *National Action Plan on Mental Health 2006–2011*. Canberra: Council of Australian Governments, 2006.
3. Begg S, Vos T, Baker B, Stevenson C, Stanley L, Lopez A. *Burden of Disease and Injury in Australia 2003*. Australian Institute of Health and Welfare, cat.no. PHE 81. Canberra: Australian Institute of Health and Welfare, 2007.
4. Department of Health and Ageing. Utilisation of mental health Medicare items, April 2008. Available from URL: [http://www.health.gov.au/internet/main/publishing.nsf/Content/92C4BC433ED5C171CA25742C00837BBB/\\$File/utitab.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/92C4BC433ED5C171CA25742C00837BBB/$File/utitab.pdf).
5. Medicare subsidised primary care mental health services fact sheet, April 2008. Available from URL: [http://www.health.gov.au/internet/main/publishing.nsf/Content/F3896D1E02667807CA257474001A1C42/\\$File/utifact.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F3896D1E02667807CA257474001A1C42/$File/utifact.pdf).
6. Dunbar JA, Hickie IB, Wakeman J, Reddy P. New money for mental health: will it make things better for rural and remote Australia? *Medical Journal of Australia* 2007; **186**: 587–589.
7. Proudfoot JG. Computer-based treatment for anxiety and depression: is it effective? *Neuroscience and Biobehavioural Reviews* 2004; **28**: 353–363.
8. Krysinska KE, De Leo D. Telecommunication and suicide prevention: Hopes and challenges for the new century. *Journal of Death and Dying* 2007; **55**: 237–253.
9. Kavanagh D, Clark D, Manicavasagar V *et al*. Application of cognitive-behavioural family intervention for schizophrenia in multidisciplinary teams: What can the matter be? *Australian Psychologist* 1993; **28**: 181–188.
10. King M, Davidson O, Taylor F, Haines A, Sharp D, Turner R. Effectiveness of teaching general practitioners skills in brief cognitive behaviour therapy to treat patients with depression: Randomised controlled trial. *British Medical Journal* 2002; **324**: 947–952.

11. Westbrook D, Sedgwick-Taylor A, Bennett-Levy J, Butler G, McManus F. A pilot evaluation of a brief CBT training course: Impact on trainees' satisfaction, clinical skills and patient outcomes. *Behavioural and Cognitive Psychotherapy* 2008; **36**: 569–579.
12. Mannix KA, Blackburn IM, Garland A *et al*. Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners. *Palliative Medicine* 2006; **20**: 579–584.
13. Bennett-Levy J, Beedie A. The ups and downs of cognitive therapy training: What happens to trainees' perception of their competence during a cognitive therapy training course? *Behavioural and Cognitive Psychotherapy* 2007; **35**: 61–75.
14. Milne DL, Baker C, Blackburn I, James I, Reichelt K. Effectiveness of cognitive therapy training. *Journal of Behavior Therapy and Experimental Psychiatry* 1999; **30**: 81–92.
15. Bennett-Levy J, McManus F, Westling B. Are some therapist training methods better than others? It depends on what you're training. Paper presented at European Association of Behavioural and Cognitive Therapy Conference, Helsinki, September 2008.
16. Bennett-Levy J, Turner F, Beaty T, Smith M, Paterson B, Farmer S. The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy* 2001; **29**: 203–220.
17. Bennett-Levy J, Lee N, Travers K, Pohlman S, Hamernik E. Cognitive therapy from the inside: Enhancing therapist skills through practising what we preach. *Behavioural and Cognitive Psychotherapy* 2003; **31**: 145–163.
18. Farrand P, Perry J, Linsley S. Enhancing self-practice/self-reflection through the use of reflective blogs. Paper presented at British Association of Behavioural and Cognitive Psychotherapy Conference. Edinburgh, July 2008.