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Cover Page Footnote

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An Exploration of Self-Reported Training Needs for Anxiety Interventions among Primary Care Behavioral Health Consultants

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ABSTRACT

Introduction: Despite the need for greater training in evidence-based interventions for the treatment of anxiety in primary care behavioral health (PCBH), there are limited data on which interventions are desired by behavioral healthcare consultants (BHCs). The objective of this study was to identify which interventions BHCs desired more in training in when treating anxiety in PCBH practice, and to examine if this preference was associated with theoretical orientation. **Method:** We conducted an online survey of PCBH providers regarding their training preferences for treatment of anxiety symptoms. The final sample comprised 291 BHCs recruited from e-mail listservs of national professional organizations. Providers reported their primary theoretical orientation as well as the top three interventions they wanted more training in from a list of 17 interventions. **Results:** BHCs most frequently endorsed training needs for Acceptance and Commitment Therapy (ACT; 63%), mindfulness (43%), and exposure (31%) interventions. Results were independent of theoretical orientation. **Discussion:** Clear training needs emerged for ACT, mindfulness, and exposure interventions in PCBH. Based on these results, further training should be given to implement these interventions in real world settings. Novel research strategies should also focus on implementing more complex CBT interventions in real-world PCBH settings. These results suggest implications for clinical training, intervention design, and future implementation efforts.

Keywords: anxiety, integrated primary care, primary care behavioral health, training

INTRODUCTION

In the Primary Care Behavioral Health (PCBH) model, behavioral health consultants (BHCs) embedded in primary care teams provide mental and behavioral health care for the primary care patient population (Reiter et al., 2018). BHCs provide brief, targeted treatment (e.g., 1-6 30-minute sessions; Beehler et al., 2017) for a wide range of concerns with a goal of improving functioning. Providing brief episodes of care ensures BHCs can maintain accessibility and wide reach, which are key benefits of this model (Reiter et al., 2018).

Successful PCBH practice requires a broad range of competencies, yet most BHCs don't receive specialty training prior to entering the primary care setting (see Serrano et al., 2018). One key competency for BHCs is delivering brief, evidence-based interventions (Robinson et al., 2018) for a broad range of presenting concerns in primary care. One mental health concern that has received increased attention is anxiety. Based on recognition of the prevalence and under-treatment of anxiety symptoms in primary care, the United States Preventative Services Task Force (USPSTF) has recently recommended that adults complete screening for anxiety symptoms in primary care (Barry et al., 2023). Increased anxiety screening is likely to lead to increased identification of individuals who would benefit from evidence-based interventions for anxiety symptoms in primary care, thus BHCs must be prepared to meet this increased need.

Recent research has examined interventions delivered to patients with anxiety and found that psychoeducation (e.g., about anxiety, cognitive-behavioral model), relaxation training (e.g., diaphragmatic breathing, progressive muscle relaxation, guided imagery), and supportive therapy (e.g., reflective listening) are most common (Shepardson et al., 2020). Some studies have found higher rates of BHC delivery of more specific cognitive-behavioral therapy (CBT) interventions, such as exposure and cognitive therapy (e.g., Sawchuk et al., 2018), in clinics with robust CBT training and supervision; however, it is unclear if these findings would generalize to less well-resourced clinics. Qualitative research has found that BHCs report challenges in succinctly delivering interventions with more complex concepts (e.g., exposure, cognitive therapy, Acceptance and Commitment Therapy [ACT]; Shepardson et al., 2023).

One potential reason for an implementation gap is lack of training and supervision in evidence-based interventions, which may be less accessible outside of sites offering academic training programs or clinical trials. Lack of training in evidence-based interventions has been identified as a barrier to their utilization among mental health providers broadly (Frank et al., 2020). Among BHCs in PCBH specifically, much previous research assessing training needs has identified broad competencies (e.g., knowledge of medical conditions) and practices (e.g., apprenticeship versus didactic, increased training in graduate-level internships; Glueck, 2015; Waxmonsky & Williams, 2020) to support development of BHC training programs. Additional research assessing training needs with respect to specific mental health symptoms and interventions can further guide curriculum development to support BHCs in providing evidence-based treatment in PCBH.

Limited previous research has identified BHC training needs with respect to specific mental health symptoms and/or interventions. One investigation identified BHC training needs in evidence-based interventions such as problem solving training and stepped care algorithms (Horevitz & Manoleas, 2013). However, these needs were inferred from BHCs' reported usual practices rather than self-reported by BHCs, were not symptom-specific, and were limited to providers with social work training backgrounds rather than the range of provider disciplines working in PCBH. In one recent qualitative investigation of BHC training needs for treating anxiety specifically, lack of training was identified as a barrier to delivering evidence-based anxiety interventions among BHCs in Veterans Health Administration integrated primary care specifically (Shepardson et al., 2023). Qualitative methods are important in providing depth of information and identifying themes among small groups (Palinkas et al., 2011); an important next step is to extend qualitative findings by evaluating symptom- and intervention-specific training needs among a larger sample of BHCs in a range of integrated primary care settings. Evaluating BHCs' training needs with respect to specific anxiety interventions will aid in designing curriculum to equip BHCs to meet the growing need for anxiety treatment.

This exploratory study utilized a national sample of BHCs from a variety of primary care settings to identify anxiety interventions that BHCs desire further training in. We also tested for differences in training needs based

on providers' theoretical orientation. Due to the lack of previous research on BHCs' training needs, no *a priori* hypotheses were specified.

METHOD

This study is a secondary analysis of a larger online survey assessing BHCs' usual care practices when treating anxiety (Shepardson et al., 2020). For full methodological details, see Shepardson et al., 2020. All study procedures were approved by the Syracuse VA Medical Center Institutional Review Board.

Participants

Participants were BHCs ($n = 291$, 76% female; age $M = 40.2$ [11] years old, range: 26-72) recruited via emails to PCBH special interest group listservs of national organizations (e.g., Collaborative Family Healthcare Association; American Psychological Association Division 38 [Health Psychology]). Recruitment emails provided a brief description of the study's purpose ("We are interested in how behavioral health providers [BHPs] working in primary care settings treat patients with anxiety in real-world clinical practice") and asked BHCs, "Would you be willing to complete a brief online survey about a recent session with a patient you treated for anxiety (e.g., types of interventions you used) in primary care?" Self-reported racial and ethnic identities were 8.9% Hispanic or Latino/a, 1.4% American Indian or Alaska Native, 2.7% Asian, 6.2% Black or African American, 88.0% White, 2.1% other race, and 1.7% prefer not to respond. Inclusion criteria included currently working in PCBH, having worked in PCBH for at least 6 months, and having at least a master's degree in a mental health field. Psychiatric providers were excluded given the focus on behavioral interventions. Provider disciplines were primarily psychology (59%), followed by social work (26%), counseling (11%), nursing (1%), and other (2.4%).

Measures

Demographics including provider age, racial identity, ethnicity, and sex were assessed via self-report.

Training needs were assessed with a single item asking BHCs to select the top 3 interventions they would like additional training in from a list of 17 different interventions (see Figure 1 for list), selected based on prior research, literature, and PCBH experience (Shepardson et al., 2020). The survey provided a brief description and examples of specific techniques within each broader intervention category, such as: relaxation training (e.g., diaphragmatic breathing, progressive

muscle relaxation, guided imagery); exposure (e.g., encouraging decreased avoidance, developing anxiety hierarchy, planning gradual exposure); supportive therapy (e.g., reflective listening, letting patient "vent"); behavioral activation (e.g., activity log, scheduling pleasurable / meaningful activities); psycho-education about anxiety (e.g., common symptoms, how anxiety develops); CBT education (e.g., relationship between thoughts, feelings, and behavior).

Theoretical orientation was assessed with a single item asking BHCs to select their primary theoretical orientation from a list: cognitive-behavioral, behavioral, insight-oriented, interpersonal, eclectic/integrative, family systems, psychodynamic/psychoanalytic, humanistic/existential, ACT, or other. Participants who selected "other" were asked to describe their theoretical orientation.

Procedure

Upon accessing the survey online, BHCs first provided informed consent; written informed consent was not required due to the anonymous nature of data collection. Participants then completed demographics and were asked to identify their theoretical orientation. Brief descriptions of each intervention were presented. Participants were then asked which 3 interventions they would like more training to use in treating (non-trauma) anxiety.

Data Analytic Strategy

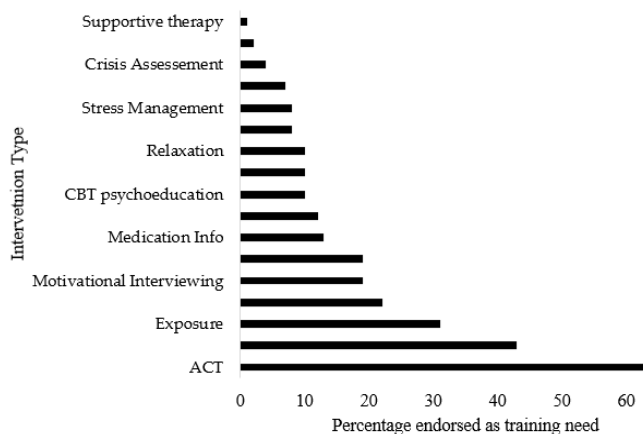
For Aim 1, frequencies were calculated to identify the most commonly reported training needs. For Aim 2 ($n = 243$), Chi-square tests of independence were used to examine whether training needs differed based on BHP theoretical orientation. For Aim 2 analyses, theoretical orientations were collapsed into four broad groups to ease interpretation: cognitive behavioral (58.8%), eclectic/integrative (20.6%), ACT (8.9%), and an "other" category (11.7%) for "insight-oriented," "interpersonal," "psychodynamic/psychoanalytic," "family systems," and "humanistic/existential." As the "other" category was infrequently endorsed, participants who selected "other" for their theoretical orientation were assigned to groups based on their qualitative description of their theoretical orientation. Author RS initially categorized "other" orientation descriptions and consulted with author KB; authors were in agreement on categorization of all "other" orientation descriptions discussed.

RESULTS

For Aim 1, Figure 1 shows the frequency of each

intervention being identified as one of the top three training needs. BHPs most frequently endorsed training needs for ACT (63%), mindfulness (43%) and exposure (31%) interventions.

Figure 1: Percentage of behavioral health providers who endorsed each intervention as a training need



Results from Aim 2 analyses showed no significant differences in endorsed training need based on theoretical orientation. BHPs from CBT, ACT, integrated/eclectic, and other theoretical orientations all desired training in ACT, mindfulness, and exposure techniques at equivalent proportions (Table 1).

Table 1: Tests for differences in 3 most frequently cited training needs by theoretical orientation (N = 243)

Intervention	Orientation	Training need endorsed vs (expected N)	Training need not endorsed vs (expected N)	χ^2 (df =3)	p
ACT	CBT	92 (88)	47 (51)	1.85	.60
	Eclectic	34 (34)	20 (20)		
	ACT	11 (13)	10 (8)		
	Other	17 (18)	12 (11)		
Mindfulness	CBT	68 (60)	71 (79)	6.56	.09
	Eclectic	21 (23)	33 (31)		
	ACT	9 (9)	12 (12)		
	Other	7 (13)	22 (17)		
Exposure	CBT	40 (43)	99 (96)	0.99	.81
	Eclectic	17 (17)	37 (37)		
	ACT	8 (7)	13 (14)		
	Other	10 (9)	19 (20)		

DISCUSSION

In a national BHC sample, the most commonly reported training needs for treating anxiety were ACT, mindfulness, and exposure interventions. BHCs less frequently endorsed training needs in psychoeducation and supportive therapy compared to ACT, mindfulness, and exposure, which may reflect a perceived competency as psychoeducation and supportive therapy interventions are commonly used in PCBH (Shepardson et al., 2020). BHCs also less frequently endorsed training needs in some forms of non-psychoeducational CBT interventions (i.e. self-monitoring, behavioral activation, cognitive therapy). These results appear to be consistent regardless of BHC theoretical orientation.

BHCs' reported training needs in ACT, mindfulness, and exposure interventions may have numerous origins. One explanation is that these interventions are underrepresented in PCBH training, possibly due to their perceived complexity, in favor of more straightforward interventions that are easily adapted to PCBH (e.g., relaxation training). Additionally, ACT and mindfulness-based approaches are relatively more recent advances (Vøllestad, Nielsen, & Nielsen, 2012) compared to traditional CBT interventions such as exposure. Accordingly, while the former are increasingly being incorporated into clinician training programs (e.g., Gockel & Deng, 2016; Impala et al., 2023), they may not yet have achieved the extensive reach of traditional CBT approaches, which was found to be required in 80-99% of programs as early as two decades ago (Weissman et al., 2006). We were unable to collect data on providers' years of training, which may shed light on the extent to which training programs are evolving to include newer ACT and mindfulness interventions in PCBH and should be investigated in future research. However, considerable research attention has been directed toward ACT, mindfulness, and exposure interventions in PCBH, which has demonstrated their effectiveness when adapted for primary care (Glover et al., 2016; Possemato et al., 2022; Cigrang et al., 2017). This evidence may also factor into our findings; BHCs may be aware of the efficacy of ACT, mindfulness, and exposure interventions despite not having received specific training in their delivery in PCBH.

Our findings also revealed that certain interventions were not identified as top training needs (i.e., self-monitoring, cognitive therapy), yet previous research

suggests that providers are also not using these interventions very frequently in PCBH anxiety practice (Bridges et al., 2015). This interesting combination of findings may indicate that BHCs had sufficient training in these interventions to feel competent in delivering them, but choose not to utilize these interventions for another reason (e.g., patient preference, low perceived efficacy by the provider, not indicated for presenting concern). Future research should seek to further investigate providers' reasons for using or not using particular interventions in treating anxiety in PCBH, possibly through qualitative inquiry. Although many questions remain regarding BHCs' training in anxiety treatment in PCBH, our findings suggest that training programs may benefit from including training on ACT, mindfulness, and exposure interventions. Brief ACT, mindfulness, and exposure-based protocols have been adapted and evaluated in PCBH (Glover et al., 2016; Possemato et al., 2022; Cigrang et al., 2017) and our results suggest BHCs are likely to engage in trainings on these interventions.

Training programs have many avenues to consider when designing content and selecting a structure/format to provide education on delivering interventions. In particular, comprehensive training that involves multiple components such as self-study and ongoing consultation have been associated with increased provider skill development (Herschell et al., 2010) and satisfaction compared to less comprehensive training (e.g., self-study only; Valenstein-Mah et al., 2020). Comprehensive training methods have been successfully modified to increase provider access to in lower-resourced settings (e.g., rural areas) by adapting training to an online modality (Jackson et al., 2018). Previous dissemination and implementation research can be leveraged to design training on ACT, mindfulness, and exposure interventions in PCBH, and future research should be dedicated to systematically evaluating training programs to ensure that PCBH programs are adequately preparing BHCs to provide evidence-based treatment for a potentially growing population of individuals seeking anxiety treatment in primary care.

Methodological Limitations and Strengths

Limitations include not asking about all possible interventions, not collecting data on BHCs' years of training experience, and self-report data being subject to recall or social desirability bias. Data on years of training experience and objective data on providers' utilization

of a range of interventions (i.e., via independent observer fidelity assessment) could further inform future training efforts. We focused on anxiety interventions, but BHC training needs for a variety of presenting concerns should be explored in future research to inform implementation work. Theoretical orientations were not described in the survey, therefore there may have been inconsistent interpretation of these terms. Key strengths included the national sample of BHCs from varying training backgrounds and settings, the wide range of interventions assessed that may be of interest to BHCs in PCBH practice, and our focus on the high-priority area of anxiety treatment given recent USPSTF recommendations for universal anxiety screening for adults in primary care.

It is important to acknowledge that data were collected prior to the COVID-19 pandemic. Since the start of the pandemic, there have been various restrictions that affected the way providers deliver interventions (i.e., a shift to telehealth), thus providers' training needs may have changed. Future research should investigate whether providers have different perceived training needs following the onset of the COVID-19 pandemic. Results from this study serve as a foundation for future inquiry into current training needs by identifying key variables and how to best assess them (e.g., describing theoretical orientation, obtaining objective data, collecting data on years of training as suggested above) and aiding in hypothesis generation for future studies to assess BHC training needs and inform current approaches to BCH training.

CONCLUSION

This study provides preliminary data on BHCs' training needs to inform future research on PCBH intervention development and implementation. The combination of previous research showing the effectiveness of brief ACT, mindfulness, and exposure interventions in PCBH with this study's findings that BHCs want training in these interventions suggests that PCBH training programs may benefit from adapting training materials to include these interventions. Dissemination and implementation research findings should guide development of these trainings, and future research should evaluate training programs to ensure effective and efficient PCBH training in anxiety treatment.

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