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ORGANISATIONAL READINESS FOR IMPLEMENTING INTERNET-BASED COGNITIVE BEHAVIOURAL INTERVENTIONS FOR DEPRESSION ACROSS COMMUNITY MENTAL HEALTH SERVICES IN ALBANIA AND KOSOVO

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Abstract

Background: The use of digital mental health (MH) programs such as internet-based cognitive behavioural therapy (iCBT) hold promise in increasing the quality and access of MH services. However very little research has been conducted in understanding the feasibility of implementing iCBT in Eastern Europe.
Methods: We used qualitative semi-structured focus group discussions (FGDs) that were guided by Bryan Weiner's model of organisational readiness for implementing change. The questions broadly explored shared determination to implement change, (change commitment), and shared belief in their collective capability to do so (change efficacy). Data were collected between November and December 2017. A range of healthcare professionals working in and in association with the CMHCs were recruited from three CMHCs in Albania, and four CMHCs in Kosovo, which are participating in a large multinational trial on the implementation of iCBT across nine countries (Horizon 2020 ImpleMentAll project). Data were analysed using a directed approach to qualitative content analysis, which used a combination of both inductive and deductive approaches.
Results: Six FGDs involving 69 MH care professionals were conducted. Participants from Kosovo (n=36, 52%) and Albania (n=33, 48%) were mostly female (n=48, 69.9%) and nurses (n=26, 37.7%), with an average age of 41.3 years. A qualitative directed content analysis revealed several barriers and facilitators potentially affecting the implementation of digital CBT interventions for depression in community MH settings. While commitment for change was high, change efficacy was limited due to a range of situational factors. Barriers impacting 'change efficacy' included lack of clinical fit for iCBT, high stigma affecting help-seeking behaviours, lack of human resources, poor technological infrastructure, and high caseload. Facilitators included having a high interest and capability in receiving training for iCBT. For 'change commitment', participants largely expressed welcoming innovation and that iCBT could increase access to treatments for geographically isolated people, and reduce the stigma associated with MH care.
Conclusions: In all, participants perceived iCBT positively in relation to promoting innovation in MH care, increasing access to services and reducing stigma. On the other hand, a range of barriers were also highlighted in relation to accessing the target treatment population, a culture of MH stigma, underdeveloped ICT infrastructure and limited appropriately trained healthcare workforce, that reduce organisational readiness for implementing iCBT for depression. Such barriers may be addressed through, (a) a public facing campaign that addresses MH stigma, (b) service-level adjustments that permit staff with the time, resources and clinical supervision to deliver iCBT, and (c) establishment of suitable clinical training curriculum for healthcare professionals.

Keywords: *Digital mental health, internet-based cognitive behavioural therapy, implementation science, MENTUPP, organisational readiness for implementing change.*

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1. Introduction

Albania and Kosovo are middle income countries in the Southeast of Europe, that have populations of 2.9 million and 1.8 million, respectively (1–3). The burden of mental illness in Albania and Kosovo is reportedly high with disproportionately lower human resources available. In Albania there are 1 psychiatrist, 1 psychologist and 7 nurses, per 100,000 population (4). In Kosovo there are 2.6 psychiatrists, 0.49 psychologists, and 14.91 nurses per 100,000 population. Limited human resources are however not the only barrier to accessing mental healthcare. A review of mental healthcare systems in the region for people with severe mental illness found that Central and Eastern Europe experienced higher reports of public stigma associated with mental health, compared to other EU countries (5). Poppleton and Gire (6) proposed that optimisation of mental health care systems, should include the use of innovative digital technologies, which have been lauded to hold significant potential, including: increased access to mental health services, reduced stigma, increased access to evidenced-based interventions, convenient access in relation to location and time, allowing for independent self-directed use, and enabling interventions to be tailored for relevant linguistic and cultural adaptions of interventions (6). However, little to nothing is known about the readiness of mental health services in implementing digital mental health interventions. The aim of this study was to undertake a qualitative assessment of the organisational readiness for implementing internet based cognitive behavioural therapy (iCBT) interventions for people with depression, in seven community mental health centres (CMHCs) across Albania and Kosovo. To our knowledge, this report will be the first to explore organisational readiness for implementing iCBT, and a mental health service in general, in Albania and Kosovo.

2. Methods

Qualitative focus group discussions (FGDs) were conducted with community mental health staff in Albania and Kosovo. Participants were recruited from seven community mental health centre (CMHCs) across Albania (located in Tirana, Shkoder and Korce) and Kosovo (Prizren, Gjilan, Prishtine, and Mitrovice). A purposive sampling method for data collection was used to facilitate access to key informants and maximum variations within an organisation (Elo & Kyngäs, 2008; Green & Thorogood, 2014). Participants were selected in relation to diversity considering factors such as age, gender, job role, the level of experience of working with people with depression (Green & Thorogood, 2014).

Interviews were guided by Weiner's (7) concept of organizational readiness for implementing change (ORIC), a topic guide with 'directed questions' (8) that related to the categories outlined in Weiner's (7) theory. The interviews were conducted in Albanian by ACP, GQ and AM in Albania and by ACP, NF and SM in Kosovo. In Albania, interviews were audio-recorded with a digital voice recorder. In Kosovo, the participants declined to be recorded, therefore special efforts were made to capture the interviews verbatim, in real-time. After each FGD, the recordings of the interviews were transcribed verbatim in Albanian and subsequently translated into English.

2.1. Analytical framework

Our study employed a qualitative methodology to explore ORIC as theorised by Bryan Weiner (7). ORIC (7,9) is a multi-level and multi-faceted construct that refers to the organizational members' shared determination to implement a change (change commitment) and shared belief in their collective capability to do so (change efficacy). The categories outlined in Weiner's (7) theory were reviewed by the research team to ensure that they align with the pre-implementation context that the FDGs took place in. The team made a decision to exclude all categories under the 'change-related effect', as efforts to initiate change were not experienced at the time in which the FGDs were conducted.

2.2. Data analysis

Data was analysed at two levels, (a) at a manifest content analysis which refers to the use of only transcribed interview text, and (b) latent content analysis which relies on the reflections and interpretations (10). Thomas and Magilvy (11) suggest that using both types of analysis is important for developing a deep understanding of the data. The unit of analysis for assessing ORIC within the qualitative interview was the CMHC (12).

The directed content analysis commenced with immersion in the data by all authors of this paper. In order to enhance reliability, the analysis and coding was carried out independently and simultaneously in Albanian (ACP, GQ, AM, NF, SM) and in English by AD as well as independent researchers CV, JG (13). The involvement of independent researchers attempted to include and integrate a different subjective perspective in the process of data analysis and in its reflection. Transcripts were analysed in the original

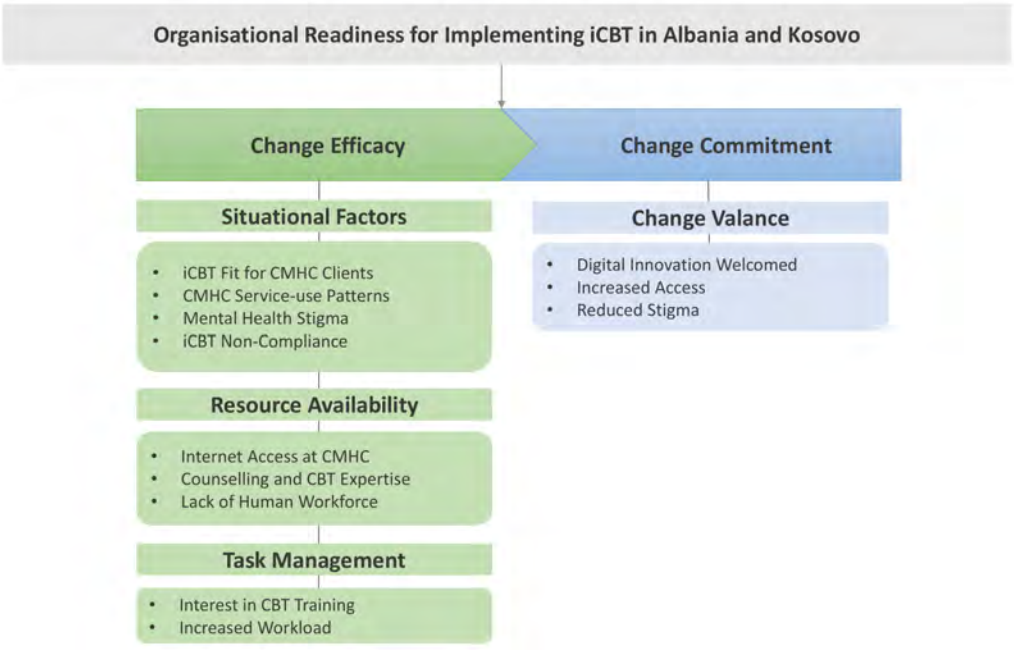
language by Albanian speaking researchers to enable cultural interpretations that may be diluted during translation. Data that could not be coded into an ORIC theory category but was relevant to organisational readiness was re-examined to described different types of organisational readiness. Key emerging themes were mapping into a framework that was reviewed and confirmed by all authors (8,10).

3. Findings

Six FGDs were conducted between November and December 2017: 3 in Albania and 3 in Kosovo. Focus groups included between 9 to 12 participants, with a total of 69 professionals taking part. Participants represented the whole spectrum of health professionals working at and in association with CMHCs with the largest group being nurses (n=25, 37.7%), followed by social workers (n=13, 18.8%), psychiatrists (n=13, 18.8%), psychologists (n=11, 15.9%), general practitioners (n=4, 5.8%), occupational therapist (n=1, 1.5%) and speech and language therapist (n=1, 1.5%). In order to explore referral routes to CMHCs, general practitioners, who are external to CMHCs were also invited to take part. Across all sites, 48 (69.6%) of participants were female. The average age of participants was 41.3 years of age (ranging between 25 – 64 years of age). Managerial positions were held by around 20% of participants (n=14). On average years of work experience in mental health was 8 years in Albania, and above 15 years in Kosovo (see Table 1, for participant characteristics). On average each FGD took 60 minutes in Albania and 80 minutes in Kosovo. Ahead of the FGDs, participants were asked to rate the following question on a scale of 1-10, "Do you feel the iCBT service delivery will become a normal part of your work?", (a single question that was integrated into their sociodemographic form). On average both the Albanian and Kosovan sites rated the implementation of iCBT highly, with average scores of 8.42 and 7.48, respectively[1].

3.1. Qualitative framework

Figure 1. Conceptual framework of factors that influence organisational readiness for implementing iCBT in community mental health teams across Albania and Kosovo.



A directed content analysis based on six focus group discussions (FGDs) revealed a multifaceted and multilevel conceptual framework of organisational readiness for implementing iCBT across seven CMHCs in Albania and Kosovo. Figure 1 outlines a description of the key themes that impact change efficacy (the belief in the services' collective/individual capabilities to implement iCBT based on existing 'situational factors', 'resource management', and 'task management' of services), and change commitment (individual and shared resolve to implement iCBT based on the perceived value to the service) of implementing iCBT in Albania and Kosovo.

[1]All participants responded to this question with the exception of four participants from Prishtine-Mitrovice (*n*=1) and Gjilan (*n*=3) FDGs.

4. Discussion

We conducted a qualitative examination of organisational readiness for implementing an iCBT intervention for people with mild to moderate depression, with healthcare professionals from seven CMHCs across Albania and Kosovo. Our qualitative directed content analysis revealed two overarching themes of organisational readiness for implementing iCBT that aligned with Weiner's (7) ORIC model, that we used to interpret the data heuristically. The first was 'change efficacy', referring to the perception of how possible it would be to implement iCBT, in relation to three themes, 'situational factors', 'resource availability' and 'task management' which were largely perceived as barriers. The second theme was 'change commitment' which included one sub-theme, 'change valance' in which participants largely expressed that iCBT could result in benefits to their organisation and the communities they serve.

4.1. Limitations and strengths

Our study had several limitations. While Albania and Kosovo are in the same region with the same language, cultures and values, they are two distinct countries with different health care systems, that are presented with different challenges and demands. However, data for both settings were merged because there was not enough data to conduct a separate analysis for each country. As a result, contextual or nuanced interpretation of the data could not always be generated. We attempted to address this limitation by indicating which sites endorsed different themes. Moreover, the qualitative data analysis did not reveal any conspicuous differences between the sites. However, many commonalities were discovered, allowing for greater generalisability to be made about our findings. The CMHCs that implemented iCBT mainly provided mental health services for people with severe mental illness because there are little-to-no publicly available psychological services. The mismatch between people who access CMHC services and the target population for iCBT may have negatively impacted perceptions around the feasibility of implementation of iCBT, even though participants reported that they would value the use of digital innovations in their service. Nonetheless, implementing iCBT within CMHCs was the most feasible option, in settings that have limited mental health resources.

The study also had several strengths. Our study is the first to examine organisational readiness for implementing digital mental health intervention in both Albania and Kosovo. A wide range of professionals were involved in the qualitative interviews, representing all professions working at and in association with a CMHC. There was also a good geographical representation of services, across both Albania and Kosovo. The findings of our study provide a unique contribution to the literature in relation to the barriers and facilitators for implementing iCBT in these regions, and which can be used to develop context-specific solutions for implementing iCBT (14).

5. Conclusion

In all, participants perceived iCBT positively in relation to promoting innovation in mental health care, increasing access to services, reducing stigma and high perceived availability of expertise within the team to deliver the intervention. On the other hand, a range of barriers were also highlighted in relation to accessing the target treatment population, a culture of mental health stigma, underdeveloped ICT infrastructure and a limited healthcare workforce. We propose that such barriers can be addressed through, (a) a public facing campaign that addresses mental health stigma, (b) service-level adjustments that permit staff with the time, resources and clinical supervision to deliver iCBT, in order to increase organisational readiness, and facilitate the effective implementation of iCBT in Albania and Kosovo, and (c) establishment of suitable clinical training curriculum for healthcare professionals to enable them to provide evidence based treatments for mental health conditions.

Three directions for future research are proposed. Studies should aim to corroborate findings from our study in relation to stigma and perceived patient barriers to accessing the service, with clients using iCBT. Second, a larger sample size should be employed across different regions of Eastern Europe to enable both in-country, and cross-country analyses to be conducted. Third, in-depth face-to-face qualitative interviews could also be used to develop a more detailed account of organisational readiness at an individual level (15).

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