Children and Youth Services Review 55 (2015) 84–92

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Building an evidence-base for the training of evidence-based treatments in community settings: Use of an expert-informed approach☆

Ashley T. Scudder *, Amy D. Herschell

Department of Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine, 3811 O'Hara Street, Bellefield Towers 506, Pittsburgh, PA 15213, United States

ARTICLE INFO

Article history:
Received 15 December 2014
Received in revised form 1 May 2015
Accepted 2 May 2015
Available online 9 May 2015

Keywords:
Evidence-based treatment
Training practices
Implementation science
Qualitative research methods
Expert opinion

ABSTRACT

In order to make EBTs available to a large number of children and families, developers and expert therapists have used their experience and expertise to train community-based therapists in EBTs. Understanding current training practices of treatment experts may be one method for establishing best practices for training community-based therapists prior to comprehensive empirical examinations of training practices. A qualitative study was conducted using surveys and phone interviews to identify the specific procedures used by treatment experts to train and implement an evidence-based treatment in community settings. Twenty-three doctoral-level, clinical psychologists were identified to participate because of their expertise in conducting and training Parent–Child Interaction Therapy. Semi-structured qualitative interviews were completed by phone, later transcribed verbatim, and analyzed using thematic coding. The de-identified data were coded by two independent qualitative data researchers and then compared for consistency of interpretation. The themes that emerged following the final coding were used to construct a training protocol to be empirically tested. The goal of this paper is not only to understand the current state of training practices for training therapists in a particular EBT, Parent–Child Interaction Therapy, but also to illustrate the use of expert opinion as the best available evidence in preparation for empirical evaluation.

© 2015 Elsevier Ltd. All rights reserved.

1. Introduction

Evidence-based treatments (EBTs) are interventions which have an extensive research base for therapeutic change produced for specific clinical presentations (Kazdin, 2008). Several expert panels have recommended incorporating evidence-based treatments (EBTs) into standard clinical practice, calling it a priority for improving the quality of mental health services (President's New Freedom Commission on Mental Health, 2004). Panel recommendations to incorporate EBTs led to calls for the scaling up of EBTs and a demand for training therapists in community-based settings. However, reports continue to highlight a lack of access to EBTs in community settings (President's New Freedom Commission on Mental Health, 2004; U.S. Public Health Service, U.S. Department of Health & Human Services, & Office of the Surgeon General, 2009). Research continues to indicate that same lack of access and poorer outcomes for community treated children compared to children treated at university clinics (Costello, Jian-ping He, Sampson, Kessler, & Merikangas, 2014; Rones & Hoagwood, 2000) and that "treatment as usual," or usual clinical care, for children in community settings is considerably different from EBTs (Garland et al., 2010).

The lack of both comprehensive guidelines to support the transfer of EBTs to community therapists (McHugh & Barlow, 2010) and empirical information regarding effective knowledge and skill transfer (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Gotham, 2004) creates numerous challenges in the implementation of EBTs in community settings. The differences in the characteristics of community therapists and those involved in controlled research studies examining EBTs leave a particular paucity of data about how to most effectively train those who provide care in community settings (Herschell, Kolko, Baumann, & Davis, 2010). A majority of community-based clinicians are masters-level therapists, with an "eclectic" theoretical orientation, who value the quality of the therapeutic alliance over the use of specific techniques (Garland, Kruse, & Aarons, 2003). To date, the most common way to train community therapists in EBTs has been to ask them to read written materials (e.g., treatment manuals) or attend standalone workshops (i.e., one to two-day workshops without additional training follow-up), but there is little to no evidence that this 'train and hope' approach (Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002), similar to continuing education formats, will result in positive, sustained increases in skill and competence (Beidas & Kendall, 2010; Herschell et al., 2010).

Trainers of EBTs have met the demand for community trained therapists by developing training strategies based on their years of

☆ This research was supported by funding from the National Institute for Mental Health (RO1 MH095750).

* Corresponding author. Tel.: +1 412 578 9485.
E-mail address: scudderab@upmc.edu (A.T. Scudder).

http://dx.doi.org/10.1016/j.childyouth.2015.05.003
0190-7409/© 2015 Elsevier Ltd. All rights reserved.

clinical experience and expertise (e.g., Landes & Linehan, 2012). Training protocols have been developed for several EBTs, which have contributed to their successful implementation (Herschell, McNeil, & McNeil, 2004). Examples include Multisystemic Therapy (MST Services, Inc., 2014), Dialectical Behavior Therapy (Linehan, 1993), and Multidimensional Treatment Foster Care (TFC Consultants, Inc., 2014). Similar to PCIT training, these training processes are often extensive and include multiple training days with time in between for therapists to practice skills with consumers and receive feedback from experts through coaching or consultation (Beidas & Kendall, 2010; Herschell et al., 2010; Sholomskas, Syracuse-Siewert, Rounsaville, Ball, & Nuro, 2005). Several training models are prominently used to implement EBTs to community settings (e.g., cascading model and learning collaborative model). These models vary in how materials are delivered and emphasized across the training process. For example, a cascading model places greatest training emphasis on the role of the trained therapist in delivering the clinical model (e.g., Chamberlain, Price, Reid, & Landsverk, 2008), while a learning collaborative model includes involvement of multiple levels within the organization (e.g., administrator, clinical supervisor, therapist) and specific components which address the organizational context (e.g., culture, climate, resources, leadership engagement) in which the intervention will be implemented (Damschroder et al., 2009).

1.1. Use of expert-informed strategies

Expert opinion can be systematically organized to provide the best available evidence about a topic which has limited empirical study. In the medical and mental health fields, criterion sampling can be used to select and integrate expertise of individuals with a particular knowledge base. Expert opinion has been used to improve the reporting of clinical trials (e.g., Tetzlaff, Moher, & Chan, 2012b), provision of systematic reviews of controlled trials (e.g., the Cochrane Collaboration), and development of practice guidelines (e.g., August et al., 2008; Frances, Kahn, Carpenter, Frances, & Docherty, 1998; Waltz et al., 2014). These methods embody practice-based evidence through synthesizing existing expertise in order to develop procedures to be empirically tested. Subsequently, these methods provide results that are relevant, readily implementable, and integrate clinical experience with the best available systematic research (e.g., Hanson et al., 2013), which overcome some of the limitations identified with EBT (Minas & Jorm, 2010; Straus & Sackett, 1998; Strauss, 1987). Due to the existing gaps in knowledge related to training methods of EBTs in community settings, qualitative research methods are indicated (Creswell, 2013). The goal of grounded theory study is to generate or discover a "unified theoretical explanation" for a process or action (Corbin & Strauss, 2008, p. 107), which explains practice and provides a framework for further research. A particular EBT, PCIT, was selected to serve as an example for several reasons: 1) children with disruptive behavior difficulties represent the largest source of referrals to mental health agencies, accounting for one third to one half of child outpatient mental health referrals (Kazdin, 1995), 2) a majority of these referrals are received in early childhood (e.g., Garland et al., 2010), 3) PCIT is an early childhood EBT which if effectively provided can change the child's developmental trajectory, and 4) it is an EBT with developed training requirements, a highly structured treatment protocol which eases the development of specific training practices, and has been recommended for wide-scale implementation.

1.2. Examining training practices of one EBT as an example: Parent–Child Interaction Therapy (PCIT)

PCIT is a well-established, evidence-based treatment for young children (aged 2.5–7) who are experiencing externalizing behavior problems such as aggression, noncompliance, and defiance (Eyberg et al., 2001). PCIT was developed from Hanf's two-stage model (Reitman & McMahon, 2013) which includes a relationship focused, behaviorally-oriented play therapy stage (child directed interaction [CDI]) and a behavior management focused stage (parent directed interaction [PDI]). Accordingly, PCIT consists of several core features: (a) the parent and child are actively involved together in treatment sessions, (b) interactions are coded to determine progress and treatment planning, (c) traditional play-therapy skills are taught to enhance the quality of the parent–child relationship, (d) problem-solving and behavior management skills are taught to develop family success in addressing problem behaviors, which include the use of a specialized timeout procedure, (e) parents are coached with the goal of reaching a level of mastery of both play-therapy and behavior management skills, (f) the treatment model is clinically validated, and (g) changes are made based on empirical evidence (Eyberg, 2005). PCIT has also been established as a "Best Practice" for children with histories of child physical abuse (e.g., Kauffman Foundation, 2004). For a more detailed description of PCIT see Scudder, Herschell, and McNeil (2015). Expert groups have recommended the widespread implementation of PCIT (e.g., Substance Abuse Mental Health Administration (SAMHSA), National Child Traumatic Stress Network (NCTSN)), but the best strategy for how to scale-up the treatment for broad public health impact remains in question.

1.2.1. PCIT training history

Since PCIT's development, PCIT training has been primarily provided in training clinics housed in university-based, doctoral-level psychology departments and university-affiliated medical centers. Training in PCIT, like many other EBTs, was historically conducted using an apprenticeship model with intensive supervision of PCIT-related research and clinical skills under the direction of an expert, faculty-level PCIT scientist-practitioner. As the demand for PCIT has increased, it has been implemented more broadly and other modalities of training and supervision have been tried. States such as California, Delaware, Iowa, and Pennsylvania have had large-scale dissemination efforts sponsored by a variety of funding sources (e.g., public and private foundations, SAMHSA, NIMH). PCIT International was developed as a business with the primary mission to ensure high fidelity as well as "foster the growth and expertise of the network of local, regional, national, and international PCIT therapists" (www.pcit.org).

PCIT International has published training guidelines and requirements for certification (P.C.I.T. International, 2009, 2013) that outline requirements of training at all levels (i.e., PCIT therapists, Level I Trainers, Level II Trainers, and Master Trainers). The PCIT International Certified PCIT Therapist Training Requirements (P.C.I.T. International, 2013) specifically outline therapist competencies to be assessed across the training process. At least 40 h of in-person training or 30 h of in-person training supplemented with 10 h of online training is required and should include: (a) an overview of PCIT's theoretical basis, assessment and behavioral coding practice, 2011 PCIT treatment protocol, and session structure, (b) clinical case review of relatively straight-forward to very complex cases, and (c) interactive discussions, modeling, role-plays, and live demonstrations with children and families. These requirements are largely based on clinical experience, but there have also been some empirical investigations examining specific components of PCIT training.

1.3. Empirical examinations of PCIT training components

Training manuals, workshops, and seminars alone have been shown to be insufficient to achieve reliable and competent PCIT skill transfer from training to service provision (Herschell et al., 2009). Studies evaluating the utility of self-directed trainings and workshops have documented that these methods alone do not routinely produce positive outcomes (Beidas & Kendall, 2010; Herschell et al., 2010). The PCIT International Training Guidelines acknowledge that these training methods are insufficient. Instead, they require that following an initial

Download English Version:

https://daneshyari.com/en/article/345963

Download Persian Version:

https://daneshyari.com/article/345963

Daneshyari.com