Child Abuse & Neglect 53 (2016) 40–50

Contents lists available at ScienceDirect

Child Abuse & Neglect

Research article

Filling potholes on the implementation highway: Evaluating the implementation of Parent–Child Interaction Therapy in Los Angeles County☆

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ARTICLE INFO

Article history:
Received 25 February 2015
Received in revised form 30 October 2015
Accepted 18 November 2015
Available online 17 December 2015

Keywords:
Evidence-based interventions
Implementation outcomes
Facilitators and barriers to implementation
Parent–Child Interaction Therapy

ABSTRACT

In October 2012, first 5 LA funded a unique collaboration between Los Angeles County Department of Mental Health (DMH) and UC Davis PCIT Training Center (UCD PCIT) to train county-contracted agencies to provide Parent–Child Interaction Therapy (PCIT). This $20 million dollar, 5-year grant represented the largest implementation effort of an empirically based treatment to date. The purpose of this paper was to describe the first 2 years of the implementation process of this project, beginning with project start up and pre-implementation phases, and to present agency training and client performance outcomes from our first year of training. Results presented in this evaluation suggest that it is possible to train LA County providers in PCIT, and that PCIT is an effective intervention for DMH-contracted providers in LA County. This evaluation also discusses challenges to successful implementation. Barriers to progress included unanticipated delays building county infrastructure, trainee attrition, and insufficient client referrals. We discuss the results of the current implementation with respect to theory, research, and others' training models, with the aim of evaluating and prioritizing different implementation drivers, noting the ongoing competition between knowing what to do and the need for action.

Introduction

Implementation science scholars have shown us that the process of making an empirically based mental health treatment (EBT) accessible to people requires much more than simply training therapists to provide the treatment. EBTs need to be "planted" in an organization. To survive, EBTs require a system for connecting appropriate clients to providers, for maintaining providers' fidelity to an EBT model, and for sustaining the practice in a site over time. However, the more complex the organizational context in which the implementation takes place, the more complex the implementation process.

The administrative and operational systems that "drive" an organization's ability to implement an EBT because of their ability to facilitate, challenge, and at times actively compete with implementation efforts, are known as *implementation drivers*. Successful implementation of an EBT in a community mental health agency depends on identifying the

☆ The authors are grateful for the funding and support for this project by First 5 LA, Los Angeles, CA.
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http://dx.doi.org/10.1016/j.chiabu.2015.11.011
0145-2134/

implementation drivers in their administrative and operational systems. Successful implementation of an EBT "to scale" in a county or state requires the additional step of identifying the county legal, administrative, and operational systems and procedures that can influence agencies' ability to create an implementation-friendly environment. For example, agencies have internal billing policies that set productivity expectations for their therapists. These agencies' internal policies are in turn influenced by county's claiming guidelines and reimbursement rates. Both sets of policies could drive implementation through their effects on the amount of "release" time trainees were permitted for training. Both agency and county systems influence implementation and should be considered in a large-scale implementation project.

While we have clear guidelines for implementing EBTs, it is not always clear which factors in organizational systems will "drive" our implementation toward success, even if pre-training organizational assessments are conducted. Some factors are hidden, some are glossed over by the organization, and some are identified and addressed but inadequately resolved. In an effort to identify and label specific factors that affect the implementation of evidence-based mental health treatments, this paper describes our attempt to implement Parent–Child Interaction Therapy (PCIT) in the Los Angeles County Department of Mental Health (LACDMH) system of care. By reflecting upon expected implementation drivers described by Fixsen, Naoom, Blase, Friedman, and Wallace (2005), Fixsen, Blase, Naoom, and Wallace (2009), and our experiences implementing PCIT during the first 2 years of a 5-year training project, we hope to identify the potholes along the path of implementation, so that others may avoid them. We begin by describing the context of the training, project start up and pre-implementation phases, followed by a description of the training process and outcomes of our first year of training.

The context: Los Angeles County

Los Angeles County, with a population of approximately 10 million residents (U.S. Census Bureau, 2014), is more densely populated than most states (U.S. Census Bureau, 2014). Los Angeles County Department of Mental Health (LACDMH) is the largest county public mental health system in the United States, with 80 directly operated programs and contracting with more than 700 non-governmental agencies and individual practitioners to provide mental health services (Los Angeles County Department of Mental Health, n.d.). In 2009, the County implemented a Prevention and Early Intervention plan that created strong financial incentives for their contracted providers to use EBTs, which in turn created strong incentives to have clinical staff trained in those EBTs. Since 2010, LACDMH has facilitated trainings in at least 20 EBTs for their directly operated and contracted providers by providing organization, infrastructure, and additional incentives. As of December 2014, there were 33 interventions on their list of approved EBTs. All this paints a picture of a county with a well-established mental health service bureaucracy familiar with the demands of EBT training and their supporting role.

In October 2012, First 5 LA funded Los Angeles County (DMH) and UC Davis PCIT Training Center (UCD PCIT) to collaborate in training therapists in at least 58 county-contracted agencies to provide PCIT over a 5-year period. First 5 LA, a non-profit child advocacy organization funded by a voter-approved tax on tobacco products, contributed $20 million dollars toward a 5-year effort to implement PCIT in LA County. At that time, PCIT was one of the few EBTs for young children that had not been implemented widely in LA County; and the proposal was strongly supported by the chair of the LA County Board of Supervisors. Funding covered the cost of agencies' capital expenditures to outfit a PCIT treatment room, encrypted video conferencing equipment to support the telehealth training modality, the cost of lost productivity to the agency during training, a 5% match for funding of the cost of client services during training, and associated costs for LACDMH to support and administer the training project. LACDMH was responsible for selecting agencies, coordinating reimbursement for capital expenditures and training time, and supporting training via monthly support groups, consultation, and outreach. UCD PCIT was responsible for the content and coordination of "basic" training (i.e., how to provide PCIT) and for workshops in advanced PCIT topic areas.

Implementation drivers

Fixsen et al. (2009) identified seven core implementation drivers: staff selection, pre-service and in-service training, ongoing coaching and consultation, performance assessment, decision support data systems, facilitative administrative support, and systems interventions. These are basic mechanisms they found to be critical to the success of the implementation effort. They are conceptualized as falling into one of three categories: leadership, organization, and competency drivers. Some of these mechanisms driving the implementation are engaged before the implementation takes place, and some become active during the training process. Good responsive leadership and effective management anticipate the effects of training on an agency's internal systems, on other programs, and agency staff, and the needs of training participants. Qualities of the organization that facilitate successful implementation of EBTs are the ability to acquire good information about training effectiveness, good communication among staff, and the flexibility to change systems to better support the new EBT. The quality and effectiveness of the training itself are competency drivers, including the selection of appropriate trainees, having content necessary and sufficient to teach core skills, and a mode of teaching and coaching that facilitates learning in trainees. We will define and discuss these terms as they relate to our countywide training efforts.