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Dissemination of an evidence-based parenting program: Clinician perspectives on training and implementation

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ABSTRACT

The present study used a qualitative approach to examine clinicians' experiences as trainees of an evidence-based parenting program, parent–Child interaction therapy (PCIT). In order to explore factors related to successful implementation and maintenance of the PCIT program in a community setting, twenty-nine community clinicians completed phone interviews six months to four years after an initial forty-hour PCIT training workshop. Clinicians reported positive experiences with the training, but also described barriers related to agency, client, program, and training factors. Findings suggest that (1) trainees view the core components of PCIT as acceptable and valuable, (2) training costs and problems with third-party reimbursement can impede implementation, (3) clinicians may benefit from training that includes skills in motivation enhancement, and (4) ongoing consultation is valuable to clinicians, although trainees differ in their preferences regarding the manner of delivery (e.g., tele-conference, live). This study brings clinicians into the conversation regarding barriers to and facilitators of evidence-based training and implementation.

1. Introduction

Each year, large numbers of children and families suffering from psychological difficulties seek services in community mental health (CMH) settings (National Advisory Mental Health Council [NAMHC], 2001; Ringel & Sturm, 2001). Unfortunately, typical care in these settings often does not reflect the advancements made in research (Drake et al., 2001; Shafron et al., 2009; Torrey et al., 2001). Typical services tend to reflect traditional approaches and beliefs rather than evidence-based approaches (Chaffin & Friedrich, 2004), and at least one controlled study has demonstrated that typical CMH services have little, if any, effectiveness (Weiss, Catron, Harris, & Phung, 1999). More effective dissemination of evidence-based treatments (EBTs) is needed to improve outcomes for children and families (American Psychological Association [APA], 2008; Stewart & Chambless, 2007). However, a number of difficulties exist related to transporting interventions from research to community settings (Jensen, Hoagwood, & Trickett, 1999; Shafron et al., 2009). Clinician training proves time-consuming and costly (Sholomskas et al., 2005; Torrey et al., 2001), adoption tends to be low (Jensen-Doss, Cusack, & de Arellano, 2008; Zoellner, Feeny, & Rothbaum, 2006) and clinician turnover among child and adolescent service agencies surpasses 50% each year (Glisson, Dukes, & Green, 2006). These factors increase agency costs and contribute to diminishing transfer of knowledge and skills over time (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009). In order to maximize the benefits and minimize the costs of training, it would be valuable to develop a better understanding of clinicians' perspectives on effective training and the barriers and facilitators of EBT implementation.

In response to calls for more research on efficient methods of disseminating EBTs (Shafron et al., 2009), the present study used a methodologically rigorous qualitative approach to explore clinician experiences regarding training in and implementation of the behavioral family intervention, parent–child interaction therapy (PCIT). PCIT is an evidence-based intervention that was developed for families of children between 2 and 6 years 11 months who are displaying conduct problems (Eyberg & Funderburk, 2011). The empirical support for the intervention is strong and growing (e.g., Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Gallagher, 2003; McNeil, Capage, Bahl, & Blanc, 1999; Nixon, Sweeney, Erickson, & Touyz, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). Current guidelines for training in PCIT require therapists to complete 40 hours of initial didactic training. Subsequent to the initial training, therapists participate in continuation training including therapy session review and feedback at least biweekly until they have successfully completed two PCIT cases and demonstrated core competencies in the protocol (PCIT International, 2013). The training required of therapists to practice PCIT is comparable to the training formats of other evidence-based child and family interventions (e.g., Parent Management Training-Oregon; Implementation Sciences International Incorporated, 2011; Brief Strategic Family Therapy; Brief Strategic Family Therapy Institute, 2009). For instance, the training models require a combination of didactic and experiential formats, require review of therapy sessions, and take place over an extended period of time (more

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than 12 months). Such similarities may make the study of PCIT training a useful exemplar for dissemination efforts beyond the PCIT model.

Quantitative investigation of factors influencing successful training is important; however, traditional quantitative methodology alone can minimize or miss valuable information available through other approaches (Creswell & Plano-Clark, 2011). In addition, the top-down nature of most quantitative dissemination research has historically impeded collaborative relationships between researchers and clinicians (Hatgis et al., 2001; Herschell, McNeil, & McNeil, 2004; King, Hawe, & Wise, 1998; Reback, Cohen, Freese, & Shoptaw, 2002). It is generally argued that a bi-directional, collaborative relationship is necessary for dissemination efforts to be successful (Herschell et al., 2004; Jensen et al., 1999; Kendall, 2002; King et al., 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). However, there is a dearth of published research exploring clinician perspectives regarding training and dissemination of EBTs that could facilitate such collaborations. Few qualitative studies on clinician's perspectives have been published in regards to implementing EBTs in community settings, and they focus on EBTs for substance abuse and family-based treatment for anorexia among adolescents (Amodeo et al., 2011; Bagley, 2011; Couturier et al., 2013; Schonbrun et al., 2012; Wood, Ager, & Wood, 2011). From this literature, four general categories of themes emerge that are likely to have relevance to the implementation of PCIT, including themes regarding barriers to implementation at the client, clinician, agency, and intervention levels. Because of substantial differences in the types of interventions studied, specific themes cannot be generalized from these broad categories. We, we sought to fill this gap in the literature by conducting a qualitative study of clinicians' experiences receiving training in and implementing an evidence-based behavioral parent training program (parent–child interaction therapy). We used a systematic qualitative approach based on the work of Marshall and Rossman (2010) to explore the experiences of community clinicians regarding the PCIT model, training, and implementation.

2. Method

2.1. Participants

Participants included 29 of 41 clinicians from Midwestern agencies who had voluntarily attended one of six five-day PCIT trainings offered between 2008 and 2011 (70.73%). Therapists who participated in the training typically reported having been aware of the existence of PCIT, but no trainees had previous experience with the program or had received training in PCIT. The majority of participants were Caucasian women (89.66%) with Master's degrees in a mental health field (93.10%; Table 1). Most clinicians (28) worked within community mental health or private, non-profit outpatient mental health agencies that served clients with a range of disorders (96.55%). One clinician worked within a school setting (3.45%). All clinicians received the training and consultation at no cost to them. Most funding came from state grants.

Researchers attempted to reach all 41 clinicians by phone to invite them for study participation. When job changes meant the contact information was no longer valid, researchers attempted to contact clinicians using the phone book, Internet searches, and by requesting contact information from prior agencies. A total of 29 clinicians were reached; all 29 who were contacted agreed to participate in the study.

At the time of the interviews, 13 clinicians (44.83% of the total sample) had successfully completed the entire training process (i.e., initial 5-day workshop and consultation). These clinicians were interviewed one to four years following the initial workshop training. Seven clinicians (24.14%) were receiving ongoing training (i.e., consultation) and were interviewed six months following the initial workshop training. Nine clinicians (31.03%) had failed to complete training at the time of the interviews, which were conducted two to four years following the initial workshop training for this group. Of the nine, two clinicians (6.90%) had moved and were no longer working with young children; one clinician (3.45%) left during the initial workshop, reporting disinterest, and the remaining six clinicians had failed to meet competency requirements (20.69%).

Table 1
Demographics of interview participants and non-participants.

	Participants		Non-Participants		
	n = 29		n = 12		
	% or M	*n or SD*	*% or M*	*n or SD*	*t or* χ^2
Gender					$\chi^2(1) = 1.39$
Female	89.66	26	100.00	12	
Male	10.34	3	0.00	0	
Ethnicity					$\chi^2(1) = 2.08$
Hispanic/Latino	6.90	2	16.67	2	
Non-Hispanic	93.10	27	83.33	10	
Race					$\chi^2(1) = 5.31$
Caucasian	89.65	26	75.00	9	
African-American	3.45	1	0.00	0	
Asian	3.45	1	16.67	2	
Pacific Islander	3.45	1	0.00	0	
Not Reported	0.00	0	8.33	1	
Age: *M (SD)*	39.14	10.86	39.25	9.00	$t(39) = -0.30$
Education					$\chi^2(1) = 1.22$
Master's level	93.10	27	83.33	10	
Doctoral	6.90	2	16.67	2	

2.2. Measures

2.2.1. Interview: Clinician Use of and Satisfaction with PCIT

The Clinician Use of and Satisfaction with PCIT Interview was developed for the current study to elicit clinicians' experiences regarding training and the PCIT program, with emphasis on barriers to using and sustaining the program. The interview includes closed-ended questions regarding clinicians' current employment setting, use of PCIT, and participation in continuing education as well as 20 Likert-scale items regarding satisfaction with PCIT and training. The heart of the interview is composed of 18 open-ended questions regarding therapists' experiences with specific aspects of the PCIT program, training, and the implementation of PCIT. Nine domains are queried, including clinicians' perceptions regarding (1) the co-therapy model of PCIT training, (2) barriers to the implementation of PCIT, (3) the use of assessment, (4) the didactic sessions, (5) coaching, (6) mastery criteria, (7) length of treatment, (8) termination criteria, and (9) supervision. Examples of questions include "How do you feel about the co-therapy model of PCIT?" "How has your experience been with coaching?" "How do you feel about the PCIT mastery criteria?" "How do you feel about the supervision and consultation you received/are receiving?"

After the initial development of the interview protocol, we conducted pilot interviews with clinical psychology doctoral students who were learning PCIT as part of their graduate training. Based on that feedback, we completed minor rewording of questions. The final version of the interview takes approximately 30 minutes to administer.

2.3. Procedure

We conducted interviews of community clinicians who attended a five-day PCIT training workshop in the Midwest between 2008 and 2011. Clinicians were contacted six months to four years following their initial workshop training for phone interviews. A doctoral student in clinical psychology who had not been involved in the training conducted the interviews.

2.3.1. PCIT clinician training

The PCIT training was led by a clinical child psychologist with more than ten years of experience teaching and supervising PCIT. A team of