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# Adherence and Flexibility: They Can (and Do) Coexist!

Rex Forehand, Department of Psychology, University of Vermont
Shannon Dorsey, Department of Psychiatry and Behavioral Science, University of Washington
Deborah J. Jones, Department of Psychology, University of North Carolina at Chapel Hill
Nicholas Long, Department of Pediatrics, University of Arkansas for Medical Sciences
Robert J. McMahon, Department of Psychology, University of Washington

**Using their experiences disseminating the Triple P parenting program, Mazzucchelli and Sanders (2010) make a strong case for how flexibility enhances provider satisfaction, critical thinking about intervention delivery, and most importantly, adherence and fidelity. Their article makes an outstanding and innovative contribution to the literature on implementation research, advancing the field to a view of flexibility as a feature that may facilitate adherence. In this commentary, we place Mazzucchelli and Sanders's work within the context of ongoing implementation research. We also call for embedding questions about implementation science into effectiveness trials to better inform dissemination efforts aimed at facilitating provider adoption and adherence to empirically supported treatments.**

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In 2007, Kendall and Beidas presented the notion that, when disseminating evidence-based practice with children and adolescents, "we can achieve flexibility within fidelity" (p. 16). Historically, however, there had been a tension between flexibility and fidelity: earlier attempts at disseminating university-developed empirically supported treatments (ESTs), which were found effective in closely monitored efficacy trials, involved dissemination with little room for provider flexibility and decision making in delivery. More recently, Kendall, Chorpita, and others have advanced the idea that distilling key intervention components and allowing for flexibility may be necessary to facilitate successful dissemination of ESTs to community-based settings (Beidas, Benjamin, Puleo, Edmunds, & Kendall, 2010; Beidas & Kendall, 2010; Chorpita & Daleiden, 2009).

Mazzucchelli and Sanders (2010) have advanced the field with their insightful, detailed delineation of strategies they believe promote *both* adherence to and flexibility within the Triple P—Positive Parenting Program. We applaud their efforts in that the strategies they delineate are applicable not just for Triple P but also inform dissemination efforts for a range of interventions. From a conceptual viewpoint, the practical strategies they delineate highlight the necessity of considering adherence and flexibility as two distinct, albeit related, constructs, rather than opposite ends of a single continuum. Utilizing this nuanced framework for thinking about dissemination efforts, increasing flexibility does not necessarily have to mean compromising adherence, and increasing adherence does not necessarily have to mean compromising flexibility.

Triple P is an ideal EST for examining these strategies, given its substantial support as an evidence-based intervention for child disruptive behaviors and the developers' careful and comprehensive attention to training individuals in the broader practice community. As Mazzucchelli and Sanders state, the concept that providers may need to adapt and tailor interventions to meet the diverse needs and presentation of families may not be new; however, to our knowledge, they are among the first to carefully consider how their training, accreditation, and post-training approach may potentially support provider ability to flexibly deliver an EST without moving beyond the evidence base. If this is done and done well, Mazzucchelli and Sanders contend (and we fully agree) that practitioner generalization is much more likely to occur.

In this commentary we highlight how Mazzucchelli and Sanders's (2010) article fits within the dissemination literature, and we call for the inclusion of implementation questions in dissemination and effectiveness trials

Address correspondence to Rex Forehand, Department of Psychology, John Dewey Hall, University of Vermont, Burlington, VT 05405. E-mail: rex.forehand@uvm.edu.

to systematically test strategies such as those put forward by these authors. Identifying ways to increase provider and agency interest in, adoption of, and satisfaction with ESTs (in part, by encouraging flexibility) and ways to simultaneously increase provider fidelity holds great promise for improving mental health services in real-world settings. The comments we offer are based on reviewing the implementation science literature, with particular attention to the Fixsen, Naoom, Blasé, Friedman, and Wallace (2005) monograph *Implementation Research: A Synthesis of the Literature* and our own dissemination experiences with other ESTs (e.g., Helping the Noncompliant Child [HNC], McMahon & Forehand, 2003; Trauma-Focused Cognitive Behavioral Therapy [TF-CBT], Cohen, Deblinger, & Mannarino, 2006). We discuss some of the strategies put forth by Mazzucchelli and Sanders at three distinct phases of implementation: pretraining, in-person training, and post-training support/fidelity monitoring.

#### Pretraining

*Provider Selection.* As Mazzucchelli and Sanders (2010) noted, when possible, allowing therapists and agencies to self-select into the Triple P parenting program is important. In addition, having some choice regarding variations of Triple P to implement increases the chances that therapists will buy into the importance of adherence for better client outcomes. Choices are important! In our experiences disseminating HNC, it is clear that individual practitioner *buy-in* is critical. If therapists do not feel that the program fits with their *therapy worldview*, it can be challenging to engage them and, in turn, it is unlikely that they will successfully engage families in the intervention. Researchers have begun to examine characteristics of providers that are associated with more or less positive attitudes towards ESTs and the factors that may influence these attitudes (e.g., educational attainment and experience; Aarons, 2004). What we have yet to determine is the degree to which attitudes relate to adoption and sustainability of ESTs. In addition, it is currently unclear which of the diverse pretraining, training, and post-training strategies employed are more likely to engage those providers who may not self-select in and who are reluctant to adopt ESTs.

It is worth noting that part of the challenge of dissemination involves *selling* a predominately behaviorally oriented skills training program like Triple P to clinicians who may have trained in an era or at a site when/where behaviorally oriented training programs were the exception rather than the rule. Although there will always be a diversity of orientations represented across training programs in counseling, psychology, social work, and related fields, the increasing emphasis of insurance companies on treatment plans and evidence-based interventions may someday decrease the onus on developers to obtain agency and therapist buy-in. University-based training programs will begin to take over some of this work. Ideally, such programs would teach Triple P, HNC, and other behavioral parent training programs with both adherence and flexibility in mind; budding clinicians then could approach the manuals not only from the perspective of learning the program as it was tested, but also with an eye for how they would flexibly use the manual given their conceptualization of the particular child and family sitting before them (see Castonguary, Boswell, Constantino, Goldfried, & Hill, 2010, for a broader discussion of these issues). Such a training approach has a number of distinct advantages in that it can address the following issues: (a) decrease the common concern among therapists that manuals limit therapist creativity and the ability to meet the individual needs of families; (b) provide opportunities early in training to experiment with flexibly utilizing the manual, while receiving direct supervision and feedback; and (c) allow early opportunities for learning the critical importance of tailoring the parenting program to the needs and presenting issues of the child and family.

In various places across the country, initiatives exist that are aimed at enhancing cross-disciplinary workforce attitudes and knowledge about ESTs. One such initiative, the Washington State–funded Workforce Initiative (involving both Dorsey and McMahon), provides a university course each quarter in one EST (including HNC) aimed at graduate students who likely will be future providers (e.g., clinical social work, educational psychology, clinical psychology, psychiatry, nursing students). The initiative also includes a university-wide lecture series introducing ESTs at a lay level, aimed at future brokers or gateway providers of

services for children and adolescents (e.g., medical students, social work students in child welfare tracks, education students). With initiatives like these, we hopefully are increasing the potential pool of providers who will self-select into EST approaches and/or actively seek out ESTs for youth and families. Until such a shift in training programs occurs, however, the impetus is on program developers to obtain buy-in not only from agencies and clinicians but also from policy makers invested in the mental health and well-being of children and families.

*Organizational Support.* As the authors state, self-selection of providers is not sufficient. Increasingly apparent is the importance of pretraining work with the organization or agency to identify facilitative administrative supports (e.g., Glisson & Hemmelgarn, 1998). As Mazzucchelli and Sanders (2010) mention, promoting organizational support is an important component for ensuring fidelity and adherence. In a recent review of dissemination of seven successful evidence-based treatments, including several for child mental health, McHugh and Barlow (2010) found that a common component of successfully disseminated interventions was that they included a needs and barrier assessment. Some developers, and particularly those of more complex, multiply involved systems interventions (e.g., Multisystemic Therapy, Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009; Multidimensional Treatment Foster Care, Chamberlain & Reid, 1991), have developed readiness measures specific to their intervention to assist organizations with identifying strengths and weaknesses in their organizational culture and climate that may facilitate or impede uptake and adoption. Other more general readiness measures also exist (e.g., Hoagwood, personal communication, 2005). The goal of these measures is not to exclude agencies with weaknesses, but rather to allow them to identify areas that may need attention prior to, or along with, agency investment in an EST. This upfront work with organizations, administrators, and supervisors is a key factor for facilitating adoption, fidelity, and appropriate tailoring of the intervention. The investment, from an agency or system perspective, in deciding to implement an EST goes beyond the cost of the training and loss of productivity for training days. Rather, it extends to some or all of the following, depending on the EST: ongoing supervision from experts, time for peer supervision within agency, and session preparation time. As a consequence, it is crucial that agencies are aware of, and plan for, these costs upfront.

Interestingly, research attending to implementation questions has identified some positive, unexpected outcomes of EST adoption that can be of great interest to agencies, systems, and administrators. For example, EST adoption with necessary supports (e.g., ongoing consultation) has resulted in decreased provider turnover in agencies (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009). In addition, structured supervision, focused on fidelity to maintaining components of a program, has been found to be directly linked to better outcomes for youth (Schoenwald, Sheidow, & Letourneau, 2003). Sharing these findings with organizations during pretraining work may increase their willingness to partner in the intensive in-person training and follow-up required by adopting an EST.

#### In-Person Training

Mazzucchelli and Sanders (2010) delineated a number of aspects of their in-person training approach that either enhance fidelity or promote flexibility—potentially both. One of the flexibility-promoting strategies, using a components-based approach, is receiving significant attention in the field and appears to hold promise across interventions for provider satisfaction and acceptable model-adherent flexibility (Chorpita, Becker, & Daleiden, 2007; Chorpita & Daleiden, 2009).

The Triple P developers have a *core parenting intervention* that can be enhanced with other modules depending on family needs (i.e., home visits, coping skills, pathways/reattributional training). Fixsen et al. (2005) state that the guiding question for developers is "What must be maintained to achieve fidelity and effectiveness at the consumer level?" (p. 25). If the critical components are identified (by theory and ultimately by dismantling or other strategies) and providers adhere to the principles underlying these components, then flexibility in form (processes and techniques) is acceptable and does not necessarily result in sacrificing model fidelity or expected outcomes (Conduct Problems Prevention Research Group, 2002).

One strategy used to promote fidelity to Triple P involves providing high-quality training that is not only didactic but also experiential and includes active learning strategies. Triple P trainings involves a variety of active training strategies, including observing and discussing video examples (positive and negative), practicing techniques with other trainees, and receiving feedback from each other and the trainer. The variety of activities is crucial for engaging adult learners (Lawson, 2009).

*The Devil Is in the Details.* Mazzucchelli and Sanders (2010) note that interventions are more likely to be delivered with fidelity when there are good supporting resource materials. We echo this recommendation and stress that *the devil is in the details*. A mental health professional, particularly one in a community agency, has an overloaded and busy schedule. What can disseminators of programs for children's mental health do to ensure that, once evidence-based skills are learned, practitioners can integrate this form of therapy into their daily practice? Our colleague Dr. Sarah Stearns of Dartmouth Medical School astutely attended to details when disseminating HNC throughout the community mental health system in New Hampshire. For example, she ensured that therapists prepared separate packets of materials for each session (e.g., relevant session content from the manual, parent handouts) and had therapists provide families with pocket folders for storing HNC handouts. She also assisted clinicians with maintaining a calendar for each family of attendance and skills mastered. Clinicians could review the calendar at each session so that the family continued forward momentum. The devil is in the details, but the details may well determine whether practitioners can generalize skills to their everyday work with families.

#### Post-Training Supports/Fidelity Monitoring

Interestingly, likely based on their long history of training providers, the Triple P in-person trainings also include attention to post-training strategies, including peer supervision and provider utilization of their self-regulatory framework. One of the ongoing struggles of developers and implementation scientists is how to best translate in-person training into changes in actual practice after the primary training is completed. By planning for post-training work during their in-person training, the Triple P developers are likely taking one of the important steps toward translation.

In efficacy trials, fidelity monitoring and support for intervention providers are critical. These efforts are also time-intensive, with involved costs supported by grant funding. However, when interventions are disseminated, *gold standard* fidelity monitoring strategies (e.g., audiotape or videotape review or coding, intensive supervision, coaching on implementation with actual cases) can be challenging to implement and costly. Although Triple P provides ongoing coaching and consultation to providers on a case-by-case basis, the standard strategy for supporting fidelity (beyond the accreditation process) involves a provider-implemented, self-regulatory framework. This framework, in addition to peer supervision, is taught during the Triple P in-person training. To our knowledge, many other ESTs require or recommend expert consultation for some period of time as part of the post-training process to support fidelity (in TF-CBT, six months of biweekly consultation is often recommended). Unfortunately, expert consultation is both time-consuming and costly, particularly if it involves tape review or coaching, and can prohibit widespread dissemination. On the other hand, expert consultation allows the developers and/or purveyors to monitor program fidelity, to varying degrees, depending on the monitoring intensity. Some programs, such as Multisystemic Therapy (Henggeler et al., 2009) and Functional Family Therapy (Alexander, Pugh, Parsons, & Sexton, 2000), require ongoing work with the developers or purveyors (i.e., training and quality assurance arm), resulting in very closely monitored, but costly, dissemination.

Given difficult decisions and trade-offs (cost versus close monitoring/support), obtaining qualitative and quantitative data on provider utilization of the Triple P self-regulatory framework would make an outstanding contribution to the literature. If the self-regulatory framework supports fidelity similarly to expert consultation, it may be a post-training practice that could be adopted or adapted by other interventions. Also, given that it is provider administered, the self-regulation framework may promote sustainability, compared to expert consultation and monitoring, which ends or

tapers at some point for most ESTs. In our opinion, research questions of interest for Triple P that have widespread applicability to other interventions include the following: Do providers utilize the self-regulatory framework as intended? Are provider characteristics associated with greater utilization of the framework? Is utilization of the self-regulatory framework associated with provider fidelity? Furthermore, in the same way that we think about tailoring ESTs for different types of families and youth, is there a need to tailor post-training fidelity-enhancing strategies, such as the self-regulatory framework, to characteristics of the provider?

Effectiveness trials that embed implementation questions offer an opportunity to answer these types of questions. From the area of child maltreatment, we will delineate a few examples of these hybrid approaches to evaluating both EST outcomes *and* aspects of dissemination. In a randomized trial comparing SafeCare (Edwards & Lutzker, 2008) to usual care for preventing the recurrence of neglect, Aarons et al. (2009) also examined the relationship of monitoring and supervision to outcomes for both the EST and usual practice. Hanson (2008) designed a sophisticated effectiveness trial to examine TF-CBT while also systematically varying and examining training and consultation strategies. In examining Alternatives for Families-CBT (Kolko & Swenson, 2002), Herschell, Kolko, Baumann, and Davis (2010) also examined various training strategies, including how to incorporate provider feedback into model adaptations, to promote adoption of ESTs. Finally, it should be noted that funders are increasingly interested not only in model-specific effectiveness trials but also proposals that include questions that inform aspects of implementation for a range of interventions (Sherrill, 2006).

### Ongoing Challenges for the Field

*Is a Little Bit Better Than Nothing?* Mazzucchelli and Sanders (2010) lay out an impressive program of training and accreditation. An issue that we have faced in HNC dissemination efforts is that mental health agencies have very few days per year to devote to in-service training, in part because of lost revenue during these days. Furthermore, resources to expend for follow-up contact between the therapists and trainers can be limited for some agencies. Congruent with Kazak and colleagues' (2010) experience, and that of others, we have found that the financial resources necessary to build evidence-based practice skills in child mental health is lacking. As noted by Kazak et al., ''current national and state policies and practices are not aligned with EBP (evidence-based practices) delivery'' (p. 94). As the field continues to identify effective dissemination strategies, we need to identify individuals at the state and national level who can partner with intervention developers and purveyors to promote policy change that supports and encourages ESTs. The Washington State Institute for Public Policy (WSIPP; www.wsipp.wa.gov) is one such partner, in that it focuses on identifying the cost and cost savings of ESTs. For policy makers, cost savings are persuasive and, in a time of budget deficits, provide an excellent rationale for changing policies to better support ESTs.

Until resources are widely available, developers of programs may be faced with the following question: Is it better to not disseminate or to disseminate under less than ideal conditions? In the latter scenario, program developers may be unable to provide what they believe to be all of the necessary pretraining, training, and post-training supports to achieve adherence and within-model flexibility. Until policy change occurs (hopefully), perhaps there is a middle ground. For example, for four years, the Washington State Department of Social and Health Services has partnered with the University of Washington and Harborview Medical Center to disseminate TF-CBT. Using many of the strategies described by Mazzucchelli and Sanders (2010) and others (e.g., build local agency champions who partner with TF-CBT experts to support flexibility and fidelity), one of the authors (Dorsey) has been involved with a statewide dissemination of TF-CBT with a relatively modest investment from the state and the university.

*Can We Sustain Dissemination Effects?* Mazzucchelli and Sanders (2010) and others (for a review, see Fixsen et al., 2005) advocate for post-training support. In our work disseminating HNC and TF-CBT, we have tried out various post-training support strategies. In one statewide HNC dissemination effort, weekly conference calls were held between mental health workers in 12 state agencies and one of three *expert HNC*

*supervisors*. The *HNC experts* then had regular phone calls with two of the program developers. In addition, one therapist from each of the 12 agencies, who was particularly enthusiastic about and proficient in HNC, was designated as *the keeper of the model*. This individual's role was to be a local leader, a cheerleader, a problem solver, and an advocate for the program. In many statewide and NCTSN-supported TF-CBT dissemination projects, similar expert consultation approaches have been used. In addition, many of the TF-CBT dissemination projects have brought individuals in similar roles together (e.g., supervisors, administrators) across agencies to plan for and problem-solve adoption, adherence, and sustainability questions. These strategies appear to increase adoption and adherence, but it is unclear if they sustain dissemination effects. More longitudinal implementation studies are needed to identify whether pretraining, training, and post-training efforts result in sustainability and which components of training in each of these three phases are important.

## SUMMARY

Mazzucchelli and Sanders (2010) have advanced the field by identifying multiple ways to promote both adherence and flexibility. Their efforts inspire critical thinking about how to improve pretraining, training, and post-training approaches to increase successful dissemination efforts across interventions. We hope our comments have added a thoughtful discussion by placing their efforts in the larger context of dissemination research. Their work points to the importance of continuing to increase the knowledge base on critical elements for dissemination and the importance of continuing to work toward policy change around how ESTs for children's mental health can best be supported.

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