Published in final edited form as:

Psychiatr Serv. 2013 August 1; 64(8): . doi:10.1176/appi.ps.003602012.

Mental Health Clinicians' Motivation to Invest in Training: Results from a Practice-Based Research Network Survey

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Abstract

Objectives—Little is known about what motivates and inhibits clinicians from seeking training or about their willingness to invest in training.

Methods—This web-based survey of 318 clinicians participating in a practice-based research network was used to examine motivators, deal-breakers, and clinicians' willingness to invest time and money in training.

Results—Clinicians reported desire for training that teaches advanced as opposed to basic clinical skills, that covers an area they see as central to the needs of their clients, and that provides continuing education credit. Training that required clinical supervision or the use of a manualized intervention were not seen as deal breakers by most clinicians. However, the amount of time and money most clinicians reported being willing to invest in training fell far short of the requirements for learning most evidence-based treatments.

Conclusions—Training strategies that combine high intensity with lower cost may be needed.

Keywords

Evidence-based practice; Training; Dissemination; Implementation; Practice-based Research Networks; Community based practice research

Evidence-based treatments hold promise for meeting the mental health needs of children and youth, but only if clinicians implement them with their clients. A growing body of literature focuses on training professionals to deliver evidence-based treatments (1–3). The most consistent finding is that passive approaches to training, such as one-shot workshops or the distribution of manuals may increase provider knowledge and predispose clinicians towards the uptake of a treatment, but they do not consistently produce provider behavior change (1–5). Effective training approaches seem to involve multi-component training packages including elements such as: a treatment manual, multiple days of intensive workshop

Disclosures of Conflicts of Interest

None for any author.

training, expert consultation, live or taped review of client sessions, supervisor trainings, booster training sessions, and completion of one or more training cases (2). Others assert that training should be dynamic, active, and targeted to meet the needs of individuals with different learning styles (5); utilize behavioral rehearsal (1); and include ongoing supervision, consultation, and feedback (1,2,4).

These multi-component approaches require substantial investments of time and money. While this has been noted as a potential barrier to the receipt of training in previous studies (6), a better understanding of the clinician-level factors that influence the receipt of training is needed (2,3,7). We utilized the Missouri Therapy Network (MTN), a practice-based research network (PBRN) of child-serving mental health clinicians who provide psychological assessment or psychotherapy services reimbursed through Missouri Medicaid to examine what motivates and deters clinicians from participating in training, and how much time and money they are willing to spend to learn new treatments.

Methods

In the fall of 2009, MTN members ($N = 816$) were contacted via email and mail and invited to complete a web-based survey related to clinical training. Of the 816 clinicians that were sent the survey, 364 (45%) responded. For this paper, we use the responses of 318 clinicians (39%) who had also completed an earlier survey detailing their demographics, caseloads, and income.

Due to the paucity of studies on this topic, we developed a novel survey that was informed by emerging models of implementation research (8,9) and reviewed for relevance by clinicians on the MTN's clinician advisory board. The survey consisted of 18 items regarding the factors that motivate them to seek training, 22 items that asked clinicians to endorse potential "deal breakers," and two questions about the amount of time and money that they would be willing to spend learning a new therapy.

The items covering potential motivators (e.g., "I was motivated to attend if I received continuing education credits") were scored on a four-point Likert-style scale (1= "Very unlike me" and 4= "Very much like me"). Deal breakers (e.g., "I would not attend if training was aimed at beginning clinicians") were based upon a dichotomous "yes"/"no" response.

All survey data were downloaded in Excel spreadsheets and converted to SAS 9.2. Demographic data were summarized using frequencies and percentages, and differences between respondents and non-respondents were calculated using chi-square and t-tests. Simple descriptive statistics were used for both motivators and deal breakers. Ordinary least squares regression was used to determine whether any of the demographic variables were predictive of the amount of time or money that clinicians would spend learning a new therapy.

Results

The respondents ($N = 318$) had a mean age of 48.35 ± 11.13 , a mean of 14.14 ± 8.82 years of practice experience, were 75% female, 90% Caucasian, and 8% African American. They were primarily masters (71%) and doctoral-level (25%) clinicians holding licensure in counseling (39%), social work (39%), psychology (21%), and nursing (2%). The clinicians worked primarily in urban areas in agency (38%), private (42%), and both agency and private (19%) settings. Approximately 41% of the clinicians earned over \$50,000/year from their therapy practice, and $52 \pm 33\%$ of their clients were on Medicaid. Respondents were older than non-respondents (48.35 compared to 45.42), $t = -3.50$, $df = 783$, $p < .001$; had

more years of professional experience (14.14 compared to 11.91), $t = -3.49$, $df = 767$, $p < .001$; and practiced in less urban areas (10) (.79 compared to .85), $t = 725$, $df = 725$, $p < .01$. There were no other significant differences between respondents and non-respondents with respect to gender, income, race/ethnicity, discipline, percentage of clients on Medicaid, or type of practice setting.

Descriptive statistics for the motivators and “deal breakers” are available online as a data supplement to this article. Three of the most highly endorsed motivators related to whether clinicians thought the training would be a good fit for the kinds of clients that they see. In addition, the availability of continuing education credit was frequently endorsed as motivating. Participants were not motivated to attend training aimed at beginning clinicians, nor were they motivated by the opportunity to charge more money for their services following training.

Training and supervision provided solely over the Internet were cited as deal breakers by approximately 25% of respondents. Potential impingements upon clinicians’ autonomy, such as having to follow a session by session treatment manual, and incongruities between their theoretical orientation and the intervention covered by the training were noted as deal breakers by 20–23% of clinicians.

Clinicians were willing to invest a wide range of time to be trained (from 0 to 6400 hours; median = 24). The mean (58.69 ± 369.08 hours) was highly influenced by three outliers. Recoding the three highest values (720, 1440, and 6400) to the next highest value (320 hours) reduced the mean to 34.79 ± 45.20 . We ran the OLS regression (see Table 1) with these values transformed. Controlling for other variables, nonwhite clinicians were willing to spend 17.74 more hours than white clinicians. Further, clinicians working in *both* agency and private practice settings were willing to spend 16.24 hours less than clinicians working only in private practice.

The mean amount of money clinicians would spend for training ($\$386.17 \pm 503.53$) was highly influenced by a small number of outliers. Recoding the four highest spenders to the next highest spender (\$1500, which four clinicians would pay) reduced the mean to $\$359.44 \pm 343.76$. The OLS model in Table 1 used the four transformed values. Every 1% increase in the percentage of clinicians’ caseloads that were Medicaid recipients translated in a \$1.86 reduction in the amount of money that they would pay for training. Conversely, moving from an annual salary of less than \$50,000 to greater than \$50,000 was associated with a willingness to pay \$117.11 more for training. Finally, clinicians who worked in agency and private practice were willing to spend \$117.35 less on training compared to clinicians who worked in private practice exclusively.

Discussion

Clinicians were willing to participate in training with only a few caveats, namely that it be relevant to their clients, offer continuing education credits, and not be aimed at beginning clinicians. The latter finding is consistent with research showing that psychologists were not interested in “basic” trainings (6), and is also not surprising given the age and experience of our respondents. Manualized treatments and required supervision were deal breakers to only a small number of clinicians.

The clinicians, however, were not willing to invest the time and money that many evidence-based treatments require. This was particularly true for clinicians who served a higher percentage of Medicaid recipients, had lower incomes, and/or who worked in *both* agency and private settings, perhaps due to financial necessity. Our results highlight the need for

more thought about how the costs of training will be covered. It may be unrealistic for clinicians to bear the full cost of training; it may need to be paid for by employers or subsidized by governments and private foundations.

Our results also suggest a need to develop less expensive training initiatives that sacrifice little in terms of intensity. One option is to deliver trainings over the Internet (4,6). Didactic approaches could be supplemented with expert supervision and consultation, perhaps using a group format to enhance cost-effectiveness and efficiency. Our findings are consistent with other studies that suggest web-based trainings are acceptable to the majority of clinicians (2).

Several limitations should be considered. We obtained a modest response rate, and it is possible that response was related to the variables of interest. For instance, respondents may have been the most motivated to invest in training, making the identified barriers to training all the more salient. The survey was conducted in a Midwestern state with no policy mandate or support for evidence-based treatments, and may not be generalizable to other states with different policies. We were also unable to rely upon an established measurement protocol. It is possible that specifying a specific treatment and/or diagnosis would have influenced clinicians' willingness to invest in training. Finally, there are limits associated with self-report, as the extent to which attitudes predict practice behavior is not well established, and self-report has been shown to be discordant with observer ratings (11).

Conclusions

Further research should examine the amount of time and money that clinicians actually spend on training, and qualitatively examine factors that enhance clinicians' motivation to attend training. Ultimately, the successful implementation of evidence-based treatments will necessitate innovative approaches to financing and providing intensive training.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

This work was supported in part by a Doris Duke Foundation Fellowship for the Promotion of Child Well-Being, a Clinical and Translational Science Award from the National Center for Research Resources at the National Institutes of Health (UL1 RR024992; TL1 RR024995), and by the National Institute of Mental Health (P30 MH068579; T32 MH019960; F31 MH098478).

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Table 1

OLS regression models of clinicians' willingness to spend time and money on training

Variables	Model 1 (Time)			Model 2 (Money)		
	<i>b</i>	SE(<i>b</i>)	β	<i>b</i>	SE(<i>b</i>)	β
Age	-.41	.29	-.10	-1.79	2.15	-.06
Years of experience	-.06	.37	-.01	2.51	2.76	.06
% clients on Medicaid	-.15	.08	.11	-1.86	0.59	-.18**
Proportion urban	6.73	9.16	.04	-101.45	68.55	-.08
Gender	-1.59	6.27	-.02	-1.97	46.91	.00
Income over 50K	3.58	5.93	.04	117.11	44.41	.17**
Nonwhite	17.74	8.36	.12*	-17.37	62.52	-.02
Psychologist	-5.08	7.43	-.05	18.02	55.63	.02
Counselor	9.96	5.95	.11	37.58	44.51	.05
Nurse	-6.65	17.60	-.02	-61.28	131.70	-.03
Agency Only	-7.15	5.73	-.08	-47.98	42.86	-.07
Agency and Private	-16.24	6.95	-.14*	-117.35	51.98	-.13*

Model 1: $N = 318$; $p < .05$; $R^2 = .07$; adjusted $R^2 = .04$ Model 2: $N = 318$; $p < .05$; $p < .01$ **; $R^2 = .10$; adjusted $R^2 = .07$