

**Core Therapist Competencies for Child Conduct Problems:
Conceptualisation, Case Complexity and Clinical Applications**

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Note: SPSS raw data and output available upon request

Statement of Originality

This is to certify that the content of this thesis is my own work. This thesis has not been submitted for any other degree or purpose.

I certify that the intellectual content of this thesis is the product of my own work, and that all assistance received in preparing this thesis and all sources have been acknowledged.

Jessica M. Barker

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In addition to the authorship attribution statements, permission to include the published material in Chapter 2, for which I am not the corresponding author, has been granted by Prof. David J. Hawes, the corresponding author.

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23.02.2026

As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements above are correct.

David J. Hawes, PhD

23.02.2026

Gen AI Attribution Statement

During the preparation of this thesis, the author used Copilot for the purposes of occasional text enhancement. The use of this generative AI tool was limited to sentence and paragraph restructuring support for clarity improvement. No text was directly copied from Copilot. The author also used Trint for the purposes of transcription of audio from interviews, the method of which is described in Chapter 4. The author confirms that where text was modified based on generative AI suggestions, or where transcripts were generated by AI, the author ensured content remained accurate and free of error or bias. The author takes full responsibility for the submitted thesis, ensures the work is their own, and has used generative AI in accordance with University guidelines and policies.

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Abstract

Effective early intervention for child conduct problems is essential due to negative long term social, academic and mental health ramifications if such problems persist. The gold standard treatments for conduct problems are social learning-based parenting interventions (PIs). These have a strong evidence base, having received substantial research attention, yet many families still do not benefit from intervention. Ongoing improvement of intervention delivery is therefore needed. Therapist training is important to intervention delivery but has received much less research attention than intervention manuals and components. Competency-based training has been effectively used to increase both quality and reach of other psychological interventions and may offer similar benefits for PIs. However, a comprehensive model of core competencies relevant across individual PI programs is lacking, as is a clinical training tool for assessing and developing these competencies. Through four studies, the current research project sought to address these gaps by conceptualising the core competencies for therapists delivering parenting interventions for conduct problems; conceptualising drivers of case complexity and how core competencies can support responses to each driver; and using these conceptualisations to construct and test the utility of a competency-based therapist training tool. The Delphi method was employed with an international panel of expert practitioners, to construct a model of core competencies (Study 1) and a model of drivers of case complexity (Study 2). Co-design focus groups and interviews with an international group of supervisors were then conducted to translate the core competency model into a competency rating tool (Study 3 Part 1). Two alternative tool designs were tested for validity and implementability with 67 PI supervisors and supervisees across 13 countries, to test that the final tool design was fit for clinical practice (Study 3 Part 2). Finally, the effect of competency-based training on trainee therapist reflective practice was examined in an Australian sample in a single case experimental design (SCED) using

multiple baselines (Study 4). Resultingly, this project produced three key outcomes: a consensus-validated model of core therapist competencies for PIs; a consensus-validated model of drivers of case complexity for conduct problems; and a validated 15-item expandable competency rating tool that was shown to improve reflective practice competence for some trainee therapists. Together, the output of this research project advances opportunities for improved scale and quality of delivery of PIs, including by enabling research on distinct competencies and drivers of case complexity.

CHAPTER 1: General Introduction

Addressing child conduct problems is a major priority in mental health care due to high prevalence and negative long-term effects. This research project examines one aspect of interventions for child conduct problems that is often overlooked: the training and competence of therapists who deliver them. The following introduction begins with an overview of child conduct problems, including the importance of addressing them. It then details the psychosocial interventions available, specifically social learning-based parenting interventions (PIs); how case complexity can present in PIs; and current implementation of PIs. Next, competency-based training is introduced as an increasingly promising approach to training which may support increased workforce capacity in PIs. Competence as it relates to therapists is first defined, then developments in competency-based training are explored, followed by important aspects thereof, including reflective practice, self-efficacy and competency rating tools.

After establishing both the context of treatment for child conduct problems and the foundations of competency-based training, the intersection between these two areas is highlighted, as is the rationale for examining competency-based training specifically within parenting interventions for child conduct problems. In closing, the aims of the current research project, and each of the studies designed to address these aims, are presented.

1.1 Conduct Problems and Evidence-Based Treatment

1.1.1 Conduct Problems

Child conduct problems refer to disruptive, externalising behaviours in children, including aggression, vindictiveness and defiance (Leijten et al., 2020; Shelleby & Shaw, 2014). When referred for clinical assessment and treatment, conduct problems often meet diagnostic criteria for oppositional defiant disorder (ODD) or conduct disorder (CD; Fonagy & Luyten, 2018; Frick & Morris, 2004). ODD is defined as a persistent pattern of

anger/irritability, vindictiveness and/or defiance occurring for at least six months in both the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR; American Psychiatric Association, 2022), and the International Classification of Diseases (ICD-11; World Health Organisation, 2022). In the ICD-11, specifiers are used to distinguish between present or absence of chronic irritability-anger, and of limited prosocial emotions. CD, termed conduct-dissocial disorder in the ICD-11, is defined by both diagnostic manuals as a persistent pattern of behaviour over at least 12 months violating the basic rights of others and/or social norms/rules/laws, often including aggression and/or destruction (American Psychiatric Association, 2022; World Health Organisation, 2022). For CD, specifiers for age of onset and limited prosocial emotions are available in both diagnostic manuals. Therefore, whilst ODD centres around conflict with authority figures and others, CD centres around violation of social norms and rights of others.

Extensive research about symptomology, aetiology and prognosis is available on both ODD and CD (Fonagy & Luyten, 2018; Mahendran et al., 2021), as well as recent meta-analyses (Bevilacqua et al., 2018; Chin et al., 2025) and reviews (Fairchild et al., 2019; Hawes et al., 2023) highlighting overlap and distinctions. For instance, ODD often emerges in early to middle childhood, and is understood to arise from genetic and environment risk factor interactions, wherein social relationship patterns contribute to reinforcing problem behaviours (Hawes et al., 2023). CD is also related to both genetic and environmental risk factors, but usually emerges later in childhood or adolescence and is a distinct risk factor for development of antisocial personality disorder in adulthood (Fairchild et al., 2019). Research discussed below highlights how significant child conduct problems are and the consequent importance of addressing them.

Conduct problems are globally prevalent. In a normative sample of 4-year-olds in the USA, 13.4% met criteria for ODD: a higher prevalence than any other mental health or

neurodivergent diagnosis examined (Lavigne et al., 2009). A recent review estimates that globally the prevalence of ODD is approximately 3-5%, but with multiple studies showing substantially higher rates (11-55%) in juvenile justice settings (for a review see Hawes et al., 2023). Regarding CD, a recent review summarises that approximately 3% of school-aged children meet diagnostic criteria (Fairchild et al., 2019). Not only are conduct problems prevalent, they can also have significant and long-term negative consequences.

If left untreated, conduct problems represent a major burden to the individual and family affected, and to society more broadly (Gardner et al., 2019). An extensive global study found that CD is a major mental health burden amongst children aged up to 14 years, being responsible for the greatest number of disability-adjusted life-years and years lived with disability (Ferrari et al., 2022). Meta-analyses of 40 longitudinal studies on CD found that those diagnosed with CD in childhood or adolescence fared significantly worse than those without CD on 13 of 14 long-term academic, mental health and social outcomes investigated (Erskine et al., 2016). For instance, they found that those who had received a CD diagnosis were 2.7 times more likely to fail to complete high school; 2.1 times more likely to have depression or anxiety; 2.3 times more likely to have a substance use disorder, substance dependence or substance abuse; and 3.5 times more likely to have a violence-related arrest or self-report violent behaviour (Erskine et al., 2016). Another 38-year longitudinal birth cohort study, conducted in New Zealand, found that children who displayed life-course persistent conduct problems used significantly more public resources, comprising 53.3% of convictions in the cohort, 15.7% of hospital emergency department encounters, 20.5% of prescription medication fills, 13.1% of injury claims, and 24.7% of months on welfare benefit; all despite only constituting 9.0% of the cohort (Rivenbark et al., 2018). Thus, if left untreated, children with conduct problems have increased rates of criminal offences, decreased financial productivity, and increased rates mental health problems in adulthood (Hawes et al., 2023).

Taking this burden together with high prevalence of conduct problems in early-to-middle childhood, their effective and early treatment is a public health priority.

1.1.2 Treatment of Conduct Problems

Intervention in early-to-middle childhood, approximately 2 to 11 years of age, is recommended for conduct problems (Hawes et al., 2023; Steiner & Remsing, 2007). ODD is most commonly diagnosed by age 8 and many children with ODD later develop CD (Hawes et al., 2023), with estimates being approximately 30% (Steiner & Remsing, 2007). A review has shown ODD is also significantly less expensive to treat than CD (Christenson et al., 2016). Thus, as early intervention can prevent development into harder-to-treat presentations, and has been shown to be effective at reducing child conduct problems (Kaminski et al., 2024), it is preferred to later intervention. Treatment research often investigates early-to-middle childhood (Kaminski et al., 2024; Leijten et al., 2025) separately from older children/adolescents (Boldrini et al., 2023), suggesting a distinct treatment approach is needed. Accordingly, this research project focuses on interventions for conduct problems in early-to-middle childhood given the strong evidence-base and need for intervention in this age period.

The gold standard treatments for conduct problems in early-to-middle childhood are social learning-based parenting interventions (Kaminski et al., 2024), commonly referred to as behavioural parent training or parent management training, and hereby referred to as Parenting Interventions (PIs). Other interventions, such as family problem solving interventions and play therapy, have also shown effectiveness in some studies, although several review studies show the evidence for these is not yet as strong as for PIs (Eyberg et al., 2008; Kaminski et al., 2024; Kaminski & Claussen, 2017). In addition to being clinically effective, PIs have also been shown to be cost-effective long-term: a randomised trial in routine care in Sweden showed their ability to cost efficiently avoid disability-adjusted life-

years (Nystrand et al., 2019). As a cost-effective intervention with the strongest evidence base, PIs are thus the recommended first-line treatment for conduct problems (National Institute for Health and Clinical Excellence, 2013).

PIs are fundamentally based social and operant learning theories (Leijten et al., 2025), and subsequent development of coercive cycles (G. R. Patterson, 1982, 2002). Social learning theory posits that child conduct problems occur in the context of a relationship (Kaehler et al., 2016), with Patterson describing that a child and their caregiver shape the social environment of each other in a dyadic process (G. R. Patterson, 2002). As such, a coercive cycle can develop if a parent responds to an undesired child behaviour in a way that is favourable to the child, and if the child thus repeats that behaviour, with this phenomenon empirically supported (Lunkenheimer et al., 2016; J. D. Smith et al., 2014). For instance, a child may cry or throw a tantrum because in doing so they could avoid completing a task. To stop the child's crying, which a caregiver is socially motivated to do, the caregiver may retract the child's need to complete the task, inadvertently reinforcing the behaviour they seek to avoid. PIs seek to reverse such coercive cycles and support caregivers to set up dyadic processes in which the child is instead motivated to behaviour pro-socially. As such, the foundations of PIs include supporting caregivers to use reinforcement strategies for desired, prosocial behaviours, and to use effective management strategies for disruptive behaviours (Kaminski & Claussen, 2017). The importance of strengthening the caregiver-child relationship to decrease conduct problems is also emphasised in PIs (Kaehler et al., 2016; Reitman & McMahon, 2013), as a positive relationship is needed to socially motivate a change in the child's behaviour.

Several evidence-based PIs are available. Amongst those with the strongest evidence is Parent-Child Interaction Therapy (PCIT), a program initially constructed in the USA and typically of 12 to 16 sessions aimed at 2-7 year olds, involving in-vivo coaching of parents

during play with their children (Eyberg & Calzada, 1998; McNeil et al., 2010). In PCIT, parents are supported to develop mastery in relationship building skills, then mastery of behavioural management techniques in the play setting, with potential for additional modules following this (Kimonis et al., 2019). Another PI program is the Australian Positive Parenting Program (Triple P), which takes a multi-level population approach based on client needs, offering group and individual programs, an online self-directed program, and individual family intervention for families of children with clinical level conduct problems (Sanders & Turner, 2015). Parent Management Training–Oregon Model (PMTO), designed for four to 12 year olds who meet diagnostic criteria for ODD or CD, is based on a similar structure to other PIs and also emphasises the impact of drivers of case complexity, such as economic stress and parental mental health, on child behaviour (Forgatch & Patterson, 2010). Integrated Family Intervention (IFI) is another Australian-made intervention aimed at a broader age range (2-16 years), generally teaching positive reinforcement first, then behavioural management and relationship enhancement (Dadds & Hawes, 2006). IFI was created as a response to branded interventions, aiming to increase accessibility of PI training by not requiring the same certification process as earlier interventions. Multiple other PIs have a similar level of evidence supporting their effectiveness, including Incredible Years (Webster-Stratton & Reid, 2017), Barkley’s Defiant Children (Barkley, 2013), and Helping the Noncompliant Child (Forehand & McMahon, 1981).

Research on the development, effectiveness and mechanisms involved in PIs is extensive, with several randomised controlled trials (e.g., Fleming et al., 2022; O’Connor et al., 2013), and meta-analyses (e.g., Beelmann et al., 2023; Mingeback et al., 2018). Research has also identified core components that drive PI effectiveness across programs, such as increasing positive parent-child interactions, teaching consistency in parenting, and parent practice of skills, amongst others (Kaminski et al., 2008; Leijten, 2021). Specific techniques

with PIs, such as time out (Roach et al., 2022; Woodfield et al., 2022), have also received extensive research attention, and have been shown to be distinctly effective. Furthermore, research has also highlighted that simple interventions may be most beneficial, with decreased effectiveness shown when additional, non-core, components are added (Leijten et al., 2022). At a broader level, research in cultural adaptations of PIs has also burgeoned, exploring how needs of diverse populations can be met (Mejia et al., 2017). However, despite some research on individual components of treatment, treatment manuals and their standardised implementation have most frequently been the level of analysis (Addis, 1997; Chorpita et al., 2005). In response to this, modular intervention models have been proposed (Chorpita & Weisz, 2005; Lucassen et al., 2015), which support clinicians to match intervention modules to client needs, acknowledging that client comorbidities and other needs may not be well addressed by standard manualised interventions.

1.1.3 Case Complexity in Conduct Problems

Case complexity has been identified as a potentially impeding factor to delivery of PIs (Kazdin & Whitley, 2006). In both the health literature broadly (Ruscio & Holohan, 2006; Safford et al., 2007; Schaink et al., 2012), and specifically in conduct problems (Kazdin & Whitley, 2006), case complexity has been defined as the presence of factors that complicate the delivery of treatment. As a result of case complexity experienced in routine care, concerns have been raised about the ability of standardised manual-based interventions to meet client needs (Addis et al., 1999; Kazdin & Whitley, 2006), and inadequate guidance available to therapists to implement interventions according to individual client needs (Rodrigo, 2016). In PIs specifically, this has been reiterated in a recent review discussing how intervention outcomes can be limited by complex needs with which clients often present in community settings, such as comorbidity and parent mental health problems (Andrade et al., 2022). Hence, understanding and addressing case complexity through tailoring and intervention

flexibility that is evidence-based is understood to be important to improving effectiveness of PIs in routine clinical settings.

However, whilst case complexity is acknowledged to affect intervention outcomes, it is yet to be adequately conceptualised. Complexity in psychology has been described as a heterogenous concept (Delgado et al., 2017), hindering clarity in its definition. In conduct problems specifically, case complexity has often been used to refer to comorbidity (Dadds et al., 2012). However, research has also recognised that several other factors can also complicate engagement in and delivery of treatment, including parental mental health (Williams et al., 2022), parental attributions (Sawrikar & Dadds, 2018), and other broader ecological factors (Chacko et al., 2016; Williams et al., 2022). Furthermore, literature has called for research to examine various types of complexity present in conduct problems (Fonagy & Luyten, 2018). Consequently, a conceptualisation of case complexity for conduct problems has been described in the literature (Hawes & Dadds, 2021a), yet this conceptualisation has not been validated, nor adopted consistently within the literature.

The lack of consensus in the conceptualisation of case complexity limits effective intervention use. Evidence suggests that PIs often remain effective with complex presentations, including for high severity conduct problems (Leijten et al., 2020; Shelleby & Shaw, 2014), callous-unemotional traits (Hawes et al., 2014; Perlstein et al., 2023), comorbid child psychopathology (Kazdin & Whitley, 2006; Leijten et al., 2020), parental mental health concerns such as maternal depression (Leijten et al., 2020), and socioeconomic disadvantage (Gardner et al., 2019), yet high drop-out and poor attendance can hinder intervention success (Chacko et al., 2016; Piotrowska et al., 2017). To address issues with engagement, therapists frequently adapt PIs in routine care settings when case complexity is present. For instance, one study of state-funded services in Pennsylvania, USA, that included PIs, found that 40% of therapists made intervention adaptations, with 71% of those reporting difficulty retaining

participants as a reason for their adaptations (Moore et al., 2013). Adaptations included changes to procedures, dosage, content, or to tailor to cultural or other specific needs of the target population, with the former three most common and 38% making changes to content (Moore et al., 2013). However, adaptations are often not evidence-based, with 61% of those reported by Moore and colleagues (2013) identified as reactive (i.e., not planned), and 53% identified as inconsistent with the intervention's goals and theory (Moore et al., 2013), and with similar rates in another study on adaptations in a family-based intervention (B. R. Cooper et al., 2016). As such, there is valid concern that adaptations may negate the effectiveness of the original program (H. Hasson et al., 2023; Hawes & Dadds, 2021a; Simons et al., 2013; Wiltsey Stirman et al., 2015). However, there is also strong evidence, including a meta-analysis on tailoring of PIs, showing that adaptations can be effective if formulation-driven (Fleming et al., 2022; Georgiadis et al., 2020; C. Lane et al., 2023). This therefore suggests that adaptations can be helpful in responding to case complexity, but that therapists are currently insufficiently supported to determine appropriate use of adaptations, with training (and research to determine training) on this hindered by the lack of consensus on the conceptualisation of case complexity.

1.1.4 Implementation of Parenting Interventions

An evidence-based intervention can only be effective if used, and therefore the implementation of PIs is an important consideration. To assess implementation, multiple models are available. One of the earliest models of measuring implementation was the RE-AIM model, which identifies five dimensions of public health impact of an intervention: reach, efficacy, adoption, implementation, and maintenance (Glasgow et al., 1999, 2019). RE-AIM is well established, having been used in 450 studies as of 2019 (Glasgow et al., 2019), and cited in 5700 scientific publications as of 2025. Following RE-AIM, another research group proposed a taxonomy of eight implementation outcomes, that is, outcomes of

an intervention that are distinct from its clinical outcomes: acceptability, adoption, appropriateness, cost, feasibility, fidelity, penetration, and sustainability (Proctor et al., 2011). This model was rigorously produced from a literature search of concepts measuring implementation, then narrative review thereof, followed by an iterative discussion process with an expert group. Comparing Proctor's (2011) model to RE-AIM, *adoption* is present in both models; *penetration* is equivalent to *reach* in RE-AIM, encompassing integration of the intervention into the service system; *sustainability* is equivalent to *maintenance* in RE-AIM, describing the ongoing use of the intervention; and all other concepts in Proctor's model are covered by *implementation* in RE-AIM. The most significant difference in scope between the two models is that RE-AIM includes efficacy, whereas Proctor et al., differentiate this from their implementation outcomes, as this is a clinical outcome. In line with this, Proctor et al.'s (2011) model defines acceptability as how agreeable or satisfactory the intervention process itself is, distinct from general client satisfaction with a service, which is also a client-related outcome. The production of both RE-AIM and Proctor et al.'s model of implementation outcomes shows increasing recognition of the importance of accounting for implementation factors in designing health care interventions.

There is increasing recognition in both PIs and other interventions of the importance of addressing implementation outcomes alongside construction of interventions, to ensure intervention effectiveness in routine care settings (Pinto et al., 2024). This can be seen in the increasing number of intervention studies that examine implementation outcomes alongside clinical outcomes (Curran et al., 2022; Landes et al., 2019), which can support refinement of interventions via feedback from user groups (Curran et al., 2022; Shepardson & Polaha, 2023). Without investigating implementation outcomes, the real effect of an intervention at a population level is unknown and may be drastically limited by implementation barriers. As such, a focus on implementation outcomes, alongside clinical outcomes, can help reduce the

research-practice gap, especially as a reported barrier to use of evidence-based interventions is clinician sentiment that they don't fit their practice settings (Shepardson & Polaha, 2023).

Implementation outcome research in PIs specifically is limited, with fidelity and acceptability being the only implementation outcomes tested in more than 20% of PI studies (Pinto et al., 2024). However, the research that has been conducted provides some guidance for future research. Research in PIs has found that implementation conditions, that is, conditions that make the program accessible (e.g., transport, child care, integration into existing resources, fidelity), have been associated with improved client attendance and outcomes, with facilitator skills and training identified as implementation conditions (Rodrigo, 2016). Additionally, difficulty accessing funding and resources, clinician attitudes, and flexibility of evidence-based interventions, have been identified as significant barriers to child and youth mental health care (Peters-Corbett et al., 2024). Furthermore, implementation barriers identified for Triple P (a specific PI), have included lack of therapist self-efficacy; lack of program fit and flexibility to client needs; lack of ongoing professional support; and low perceived program benefit (Shapiro et al., 2012; Turner et al., 2011). Taken together, this research highlights the importance of therapist training for the effective implementation of PIs for child conduct problems, and hence capacity of the workforce to meet demand for PIs.

Currently, the rate of implementation of PIs globally appears inadequate to meet demand. In 2002, a survey of 800 families, conducted through general medical practices in the UK, found a significant portion of families (18%) were currently experiencing child conduct problems, yet only 38.1% of those who had previously experienced conduct problems had participated in a PI (J. Patterson et al., 2002), suggesting that many fewer families are accessing intervention than needed. Additionally, a more recent survey of agencies providing parenting services to parents involved in the criminal justice system in Queensland, Australia found that only a third of agencies offer evidence-based PIs (Prguda et

al., 2020), highlighting gaps in the workforce responding to families with complex needs. This low availability of PIs is unsurprising given limited, or complete lack of, training in PIs during broader training pathways (e.g., psychology, nursing, social work or counselling training), and the expense of PI training external to broad training pathways. Consistent with this, research in mental health interventions broadly, and cognitive behaviour therapy (CBT), shows that therapists in community settings often do not deliver evidence-based interventions and suggests this is due to training deficits (Herschell et al., 2010; Simons et al., 2013). Further literature also discusses other factors that may reduce use of PIs, including lack of policy supporting use of PIs (Doyle et al., 2023); decreased engagement from parents due to implementation of a PI that does not fit the client's cultural perspective and or experiences of being parented; and parent difficulty accessing or engaging in services due to other personal factors, such as, but not limited to, stress, mental illness, finances, housing instability, and child care demands (Weisenmuller & Hilton, 2021). A review found that fewer than half of families identified with child conduct problems engage in treatment, either dropping out or not attending (Chacko et al., 2016), suggesting that poor engagement is a major barrier to implementation. Consequently, poor implementation (both rate and quality, including due to ineffective use of adaptations) precludes many families from benefitting from PIs.

Accordingly, strategies are needed to strengthen the capacity of the workforce to deliver PIs.

1.2 Competency-Based Training

Historically, mental health therapist training has relied on programs combining coursework, other didactic methods, and supervision (Herschell et al., 2010; O'Donovan et al., 2011), and in some cases observing more experienced therapists in practice (Brattland et al., 2022; Feinstein, 2021). This apprenticeship model, which involves learning from explicit modelling of an expert (e.g., supervisor), was first established in medical education, originating with William Osler and Abraham Flexner in the 20th century medical education

reform (Dornan, 2005). Whilst such supervision has been shown to support supervisee wellbeing and training, it has been shown to be inadequate for developing supervisee competence and promoting client outcomes (O'Donovan et al., 2011). As a result, the authors recommended more “databased” feedback on supervisee competence and client outcomes, to reduce bias and more effectively meet supervision needs (O'Donovan et al., 2011).

Furthermore, close supervision typically diminishes following post-graduate mental health training, replaced by less frequent supervision from a supervisor often not directly involved in the supervisee's professional setting (Frank et al., 2020). Mental health therapists generally practice alone, and with growing privatisation of the workforce. These factors together allow for little oversight of intervention outcomes and therapist intervention delivery quality post-training, with potential for many practitioners to be inadequately supported to deliver effective interventions. Consequently, competence of many therapists may be inadequate to effectively deliver evidence-based interventions that they purport to deliver, therefore jeopardising client outcomes and causing a shift away from evidence-based interventions.

In recent years, however, there have been efforts to improve large-scale therapist training. Examples of such efforts include; the UK's National Health Service Improving Access to Psychologist Therapies (IAPT; now Talking Therapies) program (Clark, 2018); reform in German psychotherapist training (Henrich et al., 2023); and initiatives to upskill paraprofessionals in low-resource settings (Kohrt et al., 2024). These approaches include a competency-based approach to ongoing monitoring and supervision, to support therapist competence and improved intervention implementation. Notably, medical education, from which the psychological supervision model originated, is undergoing a similar transition to that for mental health therapist training, with conceptualisation of graduate medical competencies and assessment thereof within training programs in the USA (Lee, 2008).

1.2.1 Competence

Therapist competence should be the central goal and outcome of training to allow for effective delivery of evidence-based interventions and prevention of harm (Fairburn & Cooper, 2011). The definition of *professional competence* described in medical literature applies to therapist competence: “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in the daily practice for the benefit of the individual and community served” and depends on “habits of mind, including attentiveness, critical curiosity, self-awareness, and presence” (Epstein & Hundert, 2002, p. 227). More recently, mental health intervention competence has been specifically defined as “the degree to which a therapist demonstrates the general therapeutic and treatment-specific knowledge and skills required to appropriately deliver [psychological] interventions which reflect the current evidence base for treatment of the patient’s presenting problem” (Muse & McManus, 2013, p. 485). *Therapist competence* is hence defined in this project as encompassing knowledge and skills, both specifically related to the intervention being delivered, and more general knowledge and skills, such as soft skills (e.g., relationship building). In the current research, a *competency* is used to refer to one of those specific skills or areas of knowledge that make up competence and which are “observable, measurable, containable, practical, derived by experts, and flexible” (Kaslow, 2004, p. 775).

Therapist competence is conceptualised as part of intervention fidelity (Simons et al., 2013). Fidelity includes both (a) the use of interventions as intended i.e., adherence, and (b) the quality with which therapists deliver the intervention i.e., competence (Breitenstein et al., 2010; Martin et al., 2023). Adherence has been much more frequently investigated than competence in PIs (Martin et al., 2021). However, a systematic review of 25 parenting programs showed that fidelity was more consistently associated with improved intervention outcomes (parenting behaviours; parent stress; child behaviour, self-esteem and adjustment)

when adherence and competence were both included in measures of fidelity, than when only adherence was included (Basha et al., 2025). Research thus supports that competence is a critically important factor in intervention outcomes alongside adherence.

Research on *therapist effects* further supports the importance of therapist competence. Indeed, therapist competence is central to the definition of a therapist effect, where a therapist effect is the effect of an individual therapist beyond the specific intervention (Wampold, 2015), otherwise stated as the “proportion of the total outcome variance attributable to the variability between therapists,” (Johns et al., 2019, p. 78). In a systematic review of 20 studies, 19 showed therapist effects, contributing to 2.4% to 8.2% of variance in outcomes (Johns et al., 2019), although large heterogeneity across studies and poor design for testing therapist effects was noted. Despite this, therapist effects were upheld in a more recent randomised trial specifically designed to test them, accounting for 3-8% of variance in client outcomes across CBT and psychodynamic therapy (Mehta et al., 2024). Although 8% may not seem significant, this translates to therapy being effective for ten times more clients for most versus least effective therapists (Imel et al., 2015), highlighting the significance of therapist competence to client outcomes. Furthermore, therapist effects have been found to persist in PIs specifically, with a systematic review finding that several parent outcomes were associated with therapeutic alliance, therapist fidelity and other therapist specific actions and variables (Leitão et al., 2021). Thus, the role of the individual therapist is important to evidence-based intervention delivery.

Related research on therapist-related factors also highlights the importance of competence. The therapist and general therapeutic competencies such as alliance, empathy and goal consensus, have been found to account for more variability in therapeutic outcomes than specific components of psychological interventions (for a review, see Laska et al., 2014), with a small effect similarly found in child and adolescent psychological therapy for

therapeutic alliance on treatment outcomes (McLeod, 2011; Shirk & Karver, 2003). Broad research therefore demonstrates that practitioner competence, beyond a specific manualised intervention, is important for effective delivery of psychological interventions, and training should reflect this.

Training plays a key role in developing competence, which therapist training programs increasingly recognise (Asiimwe et al., 2022; Liness et al., 2019b; McCutcheon, 2009; Racz et al., 2025). However, recent data report that there are insufficient competent, trained professionals to meet demand, especially in child and adolescent mental health (Kohrt et al., 2024). The literature points to a lack of effective training, including both limited training and insufficient ongoing support (Frank et al., 2020; Sanders et al., 2009), leading to low therapist competence and/or intervention use. In recognition of this, additional training pathways have been constructed and piloted in Nepal, Jordan, and Palestine in an attempt to increase availability of training in low-resource settings, whilst focusing on competence to ensure safe practice (Kohrt et al., 2024).

1.2.2 The Evolution of Competency-Based Training and Supervision

Competency-based training, including supervision, is becoming increasingly popular as the importance of therapist competence is recognised. Competency-based training is that which identifies the precise competencies, both general and intervention-specific, needed to deliver an intervention, and designs training strategies to meet these competencies (Falender & Shafranske, 2007). It includes assessing competencies and tailoring training based on the competencies needing further support and is hence a move away from input-based training, which focuses on hours of clinical experience and completion of specific clinical activities (Gonsalvez et al., 2021). In this way, competency-based training is also a shift beyond purely manual-based training (Simons et al., 2013). Gaining increasing interest since the 1980s, the competency-based training movement burgeoned in therapist training in the 2000s, especially

following the Competencies Conference in 2004 (DeMers et al., 2008; Kaslow, 2004; Kaslow et al., 2004; Knight, 2011). Now, competencies are increasingly the focus of training program design (L. D. Cooper et al., 2020; Gonsalvez et al., 2013), with a focus on common competencies required across interventions.

Alongside the increasing focus on therapist competencies, common elements across manualised interventions have also been examined in research, particularly for child conduct problems and PIs. A modified Delphi study, which involves expert consensus-building amongst a panel of experts in the field, was conducted to derive common elements of evidence-based interventions for conduct problems, including both therapeutic content and techniques for intervention delivery (Garland et al., 2008). Common elements delivered by therapists included: teaching positive reinforcement principles; teaching effective limit-setting and punishment principles; teaching through didactic instruction; modelling and roleplaying; and identifying shared goals, amongst other elements (Garland et al., 2008). Similarly, a Delphi method has been used to examine common elements in PIs for autism spectrum disorder (ASD; Eskandari et al., 2020), and common PI techniques have also been investigated by meta-analyses (Leijten et al., 2019).

Modular treatment approaches have arisen, derived from knowledge gained from common elements research (Lucassen et al., 2015). The Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) is a modular trans-diagnostic approach that allows for the combination of intervention elements to match a specific child's presentation, including comorbidities (Chorpita et al., 2005; Chorpita & Weisz, 2005). With a randomised trial showing evidence for its effectiveness over standardised treatment protocols (Weisz et al., 2012), there is now further interest in examining the role of discrete intervention elements over full evidence-based protocols (Weisz et al., 2011). This shift towards intervention elements is aligned with competency-

based training, which calls for the teaching of specific skills and techniques, rather than whole treatment manuals.

Competency-based training relies on the formation of core competency models on which the teaching can be based. General competency frameworks have been constructed internationally for this purpose, outlining generic therapeutic competencies relevant across all therapies. Produced in the USA, the Competency Benchmarks Document (Fouad et al., 2009) describes essential foundational and functional competencies needed at each stage of training. Similarly in the UK, competencies that psychologists must obtain through training programs have been identified (The British Psychological Society, 2025). Here in Australia, competencies for psychologists have also been identified and recently updated (Psychology Board of Australia, 2025). Although these competency frameworks provide some guidance, they are limited as they are profession-specific (limited to psychologists), and focus on generic therapeutic competencies only. As such, they provide no guidance on what competencies are needed for specific interventions.

Some intervention-specific core competency models have also been constructed for therapists. A seminal example is the core competency model for CBT for adult anxiety and depression (Roth & Pilling, 2008), which has formed the basis for the NHS Talking Therapies (previously IAPT) program. Following this, other core competencies models in CBT were constructed, including for treating psychosis (Morrison & Barratt, 2010), and child and adolescent anxiety and depression (Sburlati et al., 2011). Furthermore, core competency models have been produced for interpersonal therapy and adolescent depression (Sburlati et al., 2012). Each of these competency models has been constructed through the Delphi method or a modification thereof, where the Delphi method uses iterative consultation with experts in the field to develop consensus, and which is based in the “wisdom of crowds” (Chalmers & Armour, 2019; Jorm, 2015). Whilst these core competency models have been constructed

more vigorously and are more comprehensive than general competency frameworks, no such models exist for PIs for conduct problems.

Additional core competency models have also been proposed by researcher-practitioner groups but not yet validated. For instance, based on Roth & Pilling's (2008) model, further competencies were constructed for the NHS Talking Therapies program, including in systemic therapies (Roth et al., n.d.) and psychodynamic therapy (Lemma et al., 2009). Furthermore, for child and adolescent mental health broadly, a model of competencies has been proposed, with competencies grouped into generic therapeutic competencies, competencies in treatment planning and delivery, and competencies targeting specific ecological domains (Allen et al., 2021). Finally, a model of how professional competencies are developed has been produced for practitioners in family and parenting support programs (Cohen et al., 2020). Cohen et al.'s model does not include specific competencies, instead describing how knowledge, skills, motivation and beliefs shape trust and outcomes. These proposed models hence add valuable insights to therapist competencies, including for PIs, yet they have not been validated by expert consensus nor empirical methods, and still none have been constructed for PIs for conduct problems.

Notably, some competencies have been identified specifically for PI therapists. Firstly, core process competencies have been proposed for assessment and treatment phases of IFI specifically (Hawes & Dadds, 2021a). However, these again have not been validated, and also omit competencies in specific PI skills and techniques. Specific skill and technique competencies for PIs in conduct problems have not been explicitly identified, although a meta-analysis that distilled techniques common across PIs for conduct problems (e.g., praise, natural/logical consequences, parent-child play) provides the basis for such competencies (Leijten et al., 2019). As such, some competencies, or foundations thereof, are available for PIs for conduct problems, but a validated core competency model that includes both generic

and intervention-specific competencies remains lacking. This consequently prohibits broad scale competency-based training across various PI programs.

Competency-based training has been successful in other areas of psychological intervention, such as for the previously mentioned UK Talking Therapies initiative (Clark, 2018). During training in the Talking Therapies program, competencies to acquire are specified and assessed by observation of therapy sessions, written assignments, and case reports, with trainees partaking in reflective clinical supervision throughout. Client outcome data of those receiving treatment from therapists trained in the model is made publicly available, with most recent figures showing 670,419 consumers completed treatment in 12 months to June 2025, and 51% moved to recovery (i.e., were determined as not in the clinical range for their original presenting concern according to questionnaire data; NHS England, 2025), consistent with earlier IAPT data (66%; Clark, 2018). These response rates are comparative to randomised controlled trials for CBT for anxiety and depression (Hofmann et al., 2012; Johnco et al., 2025; Loerinc et al., 2015), which points to the strong effectiveness of the implementation of Talking Therapies. The Talking Therapies program has also included diploma-level training in CBT, with 97.4% of 235 trainees meeting competence criteria following training (McManus et al., 2010), and 84% of a sample of 45 graduates maintaining competence at 12 month follow up (Liness et al., 2019b). Finally, a further study of Talking Therapies CBT trainees from various professional backgrounds showed a similar improvement in competencies (72-77%), with competencies predicting a small variance in depression symptoms outcomes (Liness et al., 2019a). Following its success, the NHS Talking Therapies program has now been expanded to other therapies, and similar programs adopted by other countries (O. R. F. Smith et al., 2025). Cumulatively, these data show strong evidence for the effectiveness of the NHS Talking Therapies competency-based training

approach, and therefore the likelihood for appropriately designed and applied competency-based training to be similarly effective in PIs.

1.2.3 Reflective Practice and Self-Efficacy

Reflective practice competence is understood to be a cornerstone of competency-based training. There are many different definition for reflective practice across the mental health therapy literature (Lilienfeld & Basterfield, 2020). Here, it is defined in line with most prevalent definitions in psychology, as the process of critically reflecting on one's experiences, actions and thoughts in the therapeutic context, with the view to inform future actions (Nguyen et al., 2014; Ooi et al., 2023; Schön, 1992). Reflective practice is regarded internationally as a core foundational competency (Ooi et al., 2023), which is reflected by professional bodies in general competency frameworks (Fouad et al., 2009; Psychology Board of Australia, 2025). Reflective practice informs accurate self-assessment and is therefore crucial for developing other competencies (Loades & Myles, 2016). As such, it must be nurtured in training. Indeed, lack of competence in reflective practice is understood to be a temporary state which can be overcome when adequate supervision is provided, according to medical literature on the effect of training on communication with patients (A. S. Lane & Roberts, 2022).

Whilst reflective practice is understood to be central to competency-based training and practice, there is surprisingly little research on the effect of training on reflective practice. Two studies in nursing and medical practice show that it is teachable: in a sample of 93 nursing students, reflective practice ratings on the Reflective Practice Questionnaire (RPQ; Priddis & Rogers, 2018; Rogers et al., 2024) were significantly higher following a reflective practice training program than prior to training (Khalil & Abou Hashish, 2022); and 81% of 103 medical trainees showed an increase in reflective practice competence after compared to prior to training (Sobral, 2000). However, studies are yet to investigate the effect of training

on reflective practice competence in mental health therapist training specifically. Instead, related concepts have been examined in psychological interventions. Firstly, weekly feedback on client progress to therapists has been shown in a large study ($N < 2800$) to improve mental health outcomes compared to no feedback (Harmon et al., 2007), with this proposed to be due to improvement in therapist reflective practice capacity (Bennett-levy et al., 2001; Simons et al., 2013). Additionally, discrepancy between supervisee and supervisor ratings of supervisee competence has been shown to decrease following competency-based CBT training (through NHS Talking Therapies) compared to the beginning of training (Beale et al., 2020). This increased agreement between supervisors and their supervisees suggests that competency self-assessment accuracy, which relies on reflective practice competence, improves during competency-based training. Nonetheless, none of the above studies directly measure whether competency-based training for therapists improves reflective practice competence.

Alongside competence in reflective practice, therapist self-efficacy is also considered a fundamental goal of clinical supervision (Curtis et al., 2016). Therapist self-efficacy is defined as confidence in one's professional competence (Curtis et al., 2016; Turner et al., 2011) and has been associated with the rate of implementation of evidence-based interventions, including both adoption and sustained use (for a review see Sethi et al., 2014), showing the benefit of high therapist self-efficacy. However, self-efficacy has only been modestly associated with actual competence (D. J. Miller et al., 2015), suggesting that it can exist without high therapist competence, which may lead to dangerous practice outside one's competence. Therefore, it is important that self-efficacy is developed alongside reflective practice and other competencies, such that it is well founded (Lilienfeld & Basterfield, 2020).

1.2.4 Competency Rating Tools

As measurement of competencies is a critical component of competency-based practice, competency ratings tools are essential. Such tools allow one to rate the level of

competence a therapist has in specific skills and knowledge, which is critical to therapist assessment, as well as to guide training needs, including content and delivery of training and supervision (Barrett et al., 2020; Gonsalvez et al., 2021; Weisz et al., 2011). Furthermore, empirical studies on the effectiveness of training for improving therapist competence are limited and logically rely on competency rating tools (Barrett et al., 2020). However, valid and reliable measures of core competencies that include specific practice elements have been repeatedly called for in the literature (Gonsalvez et al., 2021; Rodolfa & Schaffer, 2019; Sburlati et al., 2012; Simons et al., 2013), suggesting that current competency ratings tools are insufficient. Therefore, benefits of competency rating tools have been identified to be multi-fold, yet more such tools are needed to support competency-based practice.

Profession-specific competency rating tools, such as for psychology and nursing, have been produced to support therapists with generic therapeutic competencies. As the profession of psychology has shifted towards competency-based practice (for a review see Rodolfa & Schaffer, 2019), several profession-specific psychologist competency ratings tools have been built. For instance, the Clinical Psychology Practicum Competencies Rating System (C ψ PRS) was designed for *clinical* psychology training assessment purposes (Gonsalvez et al., 2015). From C ψ PRS followed the Competencies of Professional Psychology Rating (COPPR) scales, designed for *professional* psychology training (Rice et al., 2022). The COPPR has both self and observer report, with further research on its psychometric validation showing that it can discriminate between practitioners with different levels of training (Rice et al., 2025).

Both the C ψ PRS and COPPR were constructed in Australia, with similar rating tools also built internationally, such as the Practicum Evaluation Form in the USA (PEF; Price et al., 2017). The PEF was derived from the competency benchmarks (Fouad et al., 2009); has been shown to discriminate between different levels of training (Price et al., 2017); and

scores have been inversely associated with client attrition, accounting for over 10% of the variance in symptom distress change over treatment (Dimmick et al., 2023). Furthermore, competency rating tools have been constructed in other languages, such as the Psychological Assessment Competency Scale (PACS) in Taiwan, built at a similar time to the PEF and also based on the competency benchmarks (Lan & Chang, 2016). Similarly to psychology, mental health nursing has also designed a profession-specific tool, the Clinical Competency of Mental Health Nursing (CCMHN) rating scale (Moskoei et al., 2017), which encompasses emotional/moral competencies and specific care competencies. Thus, several profession-specific generic therapeutic competency rating tools now exist for mental health therapists, with Table 1.1 summarising such measures.

General competency ratings tools have also been constructed for use across professions, including for upskilling paraprofessionals. One example of such is the Enhancing Assessment of Common Therapeutic factors (ENACT) rating scale, which was designed to upskill service providers in low- and middle-income countries (Kohrt et al., 2015). ENACT includes competencies on verbal communication skills, rapport building and self-disclosure; and role-play is also recommended for its use as an assessment tool. Since its initial formation, the ENACT rating scale has been revised down from 18 to 15 items to ensure its relevance across interventions (Kohrt et al., 2024). Derived from ENACT, the Working with children-Assessment of Competencies Tool (WeACT) is another role-play based rating tool, again for upskilling paraprofessionals in low-resource settings, with its use examined in Gaza, Palestine (Jordans et al., 2021). Finally, a third example of a cross-discipline tool is the Italian QACP (Questionario per l'Autovalutazione delle Competenze dello Psicoterapeuta), which translates to the Questionnaire for the self-assessment of psychotherapist skills, designed for psychotherapist trainees and professionals (Settanni et al., 2022). The QACP has 15 subscales across five domains: assessment and case formulation;

therapeutic relationship; implementation; evaluation and conclusion of therapy; and ethics and cultural sensitivity. ENACT, WeACT and QACP are clear evidence that cross-discipline competency rating tools can be generated, yet each of these is still solely focused on generic therapeutic competencies, without the ability to assess intervention-specific competencies.

Examination of intervention-specific competencies, or technical competencies, has found that these are distinct from generic therapeutic competencies (Cecilione et al., 2021). Therefore, assessment of intervention-specific competencies is important to understand competence comprehensively. Some therapist competency rating scales assess both general and intervention-specific competencies. For example, the Cognitive Therapy Scale Revised (CTS-R; Blackburn et al., 2001), is a comprehensive rating scale for CBT, and is one of the most broadly used therapist competency ratings tools (Kühne et al., 2020). The CTS-R was designed to address deficiencies of the original CTS (Young & Beck, 1980), which did not differentiate well between practitioners at different competency levels, and which had lost favour to a later version by the same authors that was not validated (Blackburn et al., 2001). The CTS-R has now been widely used, including in the competency-based Talking Therapies program (Clark, 2018; Liness et al., 2019b, 2019a). Furthermore, the CTS-R has been adapted (see Table 1.1), including into a child and youth version (Gormez et al., 2022; Stallard et al., 2014), and into a brief version (Alfonsson et al., 2022), highlighting the profession's perceived utility of this competency rating tool.

Despite its widespread use, the CTS-R also has limitations as a competency rating tool. Firstly, it is specific to CBT and hence cannot be directly applied to PIs for conduct problems. Secondly, it is originally derived from the experience of only two practitioners rather than empirical evidence or broader expert consensus methods. Finally, perhaps most importantly, it is reliant on direct observation and expert raters, making it extremely resource-intensive (Muse & McManus, 2013), and consequently irrelevant for addressing the existing

workforce issues as highlighted earlier. Therefore, additional competency ratings tools are needed that include both general therapeutic and intervention-specific competencies, and which can be applied with lower resource demands.

A range of other intervention-specific competency tools, largely in CBT, have been constructed. For instance, the CBT Competence Scale (CCS) is a self-report measure including items on non-behavioural skills, behavioural skills, perceptions and knowledge (Rodriguez-Quintana et al., 2021). Additionally, the Cognitive Therapy Adherence and Competence Scale (CTACS) measures adherence and appropriateness in a range of generic therapeutic and intervention-specific competencies, aiming to more broadly encapsulate competencies than the CTS (Barber et al., 2003). Derived from the CTACS, a similar but shorter scale (the Competence and Adherence Scale for CBT; CAS-CBT) has also been designed specifically for a youth anxiety program (Bjaastad et al., 2016). These measures are listed in Table 1.1 and reviews also list earlier competency rating tools (Barber et al., 2007; Muse & McManus, 2013). Thus, there are several intervention-specific competency rating tools available, largely in CBT given its widespread use.

Currently, there are no comprehensive competency rating tools that are validated for use across PIs for conduct problems. While generic therapeutic competency rating tools are relevant, these do not capture PI-specific competencies, which are also important to competence (Cecilione et al., 2021). The Fidelity of Implementation (FIMP) rating system (Forgatch et al., 2005) is one competency rating tool that has been designed specifically for a PI, although it is specific to PMTO, not designed for use across different PI programs. Other PI rating tools have been used in research, often to measure implementation quality, but 40% of these have not been validated, and many focus more on adherence than competent quality of delivery (Martin et al., 2021). What is therefore missing is a comprehensive competency rating tool for use in upskilling practitioners in PIs for conduct problems (i.e., including both

general and intervention-specific competencies), that is both validated and designed for use across different PI programs for conduct problems.

Table 1.1

Examples of Validated Competency Rating Tools for Mental Health Therapists

Tool	Profession	Specificity	Number of items
CψPRS (Gonsalvez et al., 2013)	Psychology (Clinical)	Generic	69; 10 domains
COPPR (Rice et al., 2022)	Psychology (Professional)	Generic	81; 11 domains
PEF (Price et al., 2017)	Psychology	Generic	52; 9 domains
PACS (Lan & Chang, 2016)	Psychology	Generic	45; 9 domains
CCMHN (Moskoei et al., 2017)	Nursing	Generic	45; 2 domains
ENACT (Kohrt et al., 2015, 2024)	MH Para- professionals	Generic	15
WeACT (Jordans et al., 2021)	MH Para- professionals	Generic	14
QACP (Settanni et al., 2022)	Cross-discipline	Generic	63; 5 domains
CTS-R (Blackburn et al., 2001)	Cross-discipline	Specific – CBT	12
CTS (Young & Beck, 1980)	Cross-discipline	Specific – CBT	11; 2 domains
CBTS-CYP (Stallard et al., 2014)	Cross-discipline	Specific – CBT	14; 2 domains
CTSR-4 (Alfonsson et al., 2022)	Cross-discipline	Specific – CBT	4
CCS (Rodriguez-Quintana et al., 2021)	Cross-discipline	Specific – CBT	33; 4 domains
CTACS (Barber et al., 2003)	Cross-discipline	Specific – CBT	25; 5 domains
CAS-CBT (Bjaastad et al., 2016)	Cross-discipline	Specific – CBT	11

Tool	Profession	Specificity	Number of items
FIMP (Forgatch et al., 2005)	Cross-discipline	Specific – PI: PMTO	5

Note. Competency rating tools are listed in the order discussed in-text. C ψ PRS = Clinical Psychology Practicum Competencies Rating Scale; COPPR = Competencies of Professional Psychology Rating Scales; PEF = Practicum Evaluation Form; PACS = Psychological Assessment Competency Scale; CCMHN = Clinical Competency of Mental Health Nursing; ENACT = Enhancing Assessment of Common Therapeutic factors scale; WeACT = Working with children-Assessment of Competencies Tool; QACP = Questionario per l'Autovalutazione delle Competenze dello Psicoterapeuta; CTS-R = Cognitive Therapy Scale Revised; CTS = Cognitive Therapy Scale; CBTS-CYP = Cognitive Behaviour Therapy Scale for Children and Young People; CTSR-4 = Cognitive Therapy Scale Revised–4-item Version; CCS = CBT Competence Scale; CTACS = Cognitive Therapy Adherence and Competence Scale; CAS-CBT = Competence and Adherence Scale for CBT; FIMP = Fidelity of Implementation rating system.

1.3 Intersection of Research

1.3.1 Therapist Competence is Important to PI Quality and Availability

Currently, parenting interventions (PIs) are not optimally effective. After completing a gold-standard PI, 30-50% of children continue to have conduct problems in the clinical range (Overbeek et al., 2021; Scott et al., 2001). Although this is similar to response rates for CBT, and therefore amongst the most effective psychological interventions available (Johnco et al., 2025; Loerinc et al., 2015), effect sizes for treatments for conduct problems were found to decrease over the 50 years to 2017 (Weisz et al., 2019) and have not since increased (Leijten et al., 2025). This suggests that many more children could benefit from improvement

in conduct problems. Decreased effect sizes for PIs over time could be due to increasing complexity of presentations, and/or due to poorer delivery of PIs, which could result from training not sufficiently developing therapist competence. Previous literature supports this hypothesis that therapist competence does not meet demand for PIs, with literature identifying insufficient therapists or services to meet demand (Doyle et al., 2023; J. Patterson et al., 2002), and issues with implementation and engagement (Prguda et al., 2020; Weisenmuller & Hilton, 2021), both of which hinder PI delivery.

Suboptimal PI clinical outcomes therefore may be related to suboptimal therapist competence. Research suggests that CBT is often less effective in routine care settings than research settings (Stewart & Chambless, 2009). Similar research in PIs is limited, but a community-based study also shows decreased effectiveness compared to research settings, with only 40% of families reporting significant improvement in conduct problems following a PI (Abrahamse et al., 2016). Multiple factors may contribute to decreased effectiveness in routine care settings. Firstly, rigorous therapist training is typical for RCTs (Roth et al., 2010), and this may not be delivered or available in routine care settings, resulting in lower therapist competence. Secondly, community samples often have more complex presentations due to absence of exclusion criteria that are applied in recruitment to RCTs (Andrade et al., 2022; Weisz et al., 2015), and therapist training may be inadequate to respond to these complex needs, as is true for psychological interventions broadly (Herschell et al., 2010). The literature in PIs specifically is consistent with these factors, having identified fidelity, adherence, facilitators' perception of the PI, facilitator skills, and facilitator training, as particularly important implementation conditions that affects program outcomes and client attendance (Rodrigo, 2016). Additionally, research has shown that interventions are frequently adapted in routine care settings (in 40% of studies) in an attempt to respond to case complexity (Pinto et al., 2024), even though adaptations may not be evidence-based (Moore

et al., 2013). As such, PI implementation can be poor due to lack of sufficient therapist competence including with case complexity (Rodrigo, 2016).

1.3.2 Competency-based Training Could Improve PI Implementation

Improved training and assessment thereof, would support and likely improve the capacity of the workforce to deliver PIs effectively if it increased competence in more therapists. Research has shown that therapists who receive low levels of support in the workplace and face logistical barriers in using a PI, are less likely to use the program (Sanders et al., 2009), and post-training support was found to predict ongoing PI use (Shapiro et al., 2012). As discussed earlier, barriers to implementation of PIs include therapist training; self-efficacy; ongoing logistical and clinical support in evidence-based PIs; and attitudes towards evidence-based PIs including lack of perceived fit and intervention flexibility (Peters-Corbett et al., 2024; Rodrigo, 2016; Shapiro et al., 2012). Taken together, this evidence highlights the importance of ongoing therapist training and support for therapists' use of PIs, and therefore intervention availability and quality implementation for consumers. Unfortunately, there is still limited evidence as to the effectiveness of current training methods for improving therapists' competence (Valenstein-mah et al., 2020). Hence, further research is needed to investigate if new training methods can improve therapist competence and therefore PI implementation and workforce capacity to deliver PIs. Recent research suggests that greater emphasis on competency-based training could improve the effects of PIs (Leijten et al., 2025).

The limitations of current training in PIs must be recognised for these to be effectively addressed in competency-based training. Firstly, accessing initial and ongoing specific training in PIs is challenging, with few pre-service training programs offering it (Sanders, 2023), and external trainings having additional, often significant costs. For instance, basic training in Incredible Years costs AU\$1,265 (The Incredible Years, 2026); PCIT costs

AU\$5,880 (Karitane, 2026); some other training programs do not have publicly available training information (Generation PMTO, n.d.); and each of these programs requires a certification pathway following initial training. Secondly, PI therapist training is largely in standardised manual-based programs as these are most prominent in the field, with most of the research having been conducted at the level of the manual (Garland et al., 2008). However, overly rigid adherence to manualised intervention can be detrimental to treatment outcomes (Fonagy & Luyten, 2019; Georgiadis et al., 2020), and low perceived program fit has been identified as a barrier to PI use (Rodrigo, 2016; Shapiro et al., 2012). Indeed, researchers have stated that intervention flexibility, within the bounds of the evidence base, is critical to meet complex and diverse client needs (Anyon et al., 2019; Mazzucchelli & Sanders, 2010). Therefore, confinement of training to manualised PIs may be impeding the effectiveness of therapist training. Both availability and flexibility issues thus limit current training, with subsequent calls in the literature to improve training (Allen et al., 2021; Sburlati et al., 2011).

Competency-based training offers an opportunity to address these gaps. Firstly, with identification of discrete competencies relevant across PI programs, the training could be used for ongoing support following initial manualised intervention training, or indeed used as an alternative training method to the manualised approach. In both cases, training costs would be reduced, therefore increasing accessibility of therapist training and subsequent workforce capacity to deliver PIs. Secondly, a focus on competencies in training, especially those grounded in common elements research, would allow a therapist to move beyond the manual in an evidence-based manner. In this way, training could be more flexible, better supporting therapists to address case complexity, which may ultimately also improve the perceived fit of intervention and enhance intervention use and quality of implementation. With the construction of a core competency model for PIs in conduct problems, further research could

adopt a modular evaluation approach to examine whether (and which) specific competencies are particularly important to different complex presentations. Therefore, through both increased access and flexibility, competency-based training could better meet therapists' needs in routine care settings where PIs are delivered. Furthermore, as reflective practice competence is foundational to competency-based training, focus on this should be central to such training in PIs.

1.3.3 Conditions Needed for Competency-based Training

Competency-based training may be well placed to address current gaps in PI implementation and workforce capacity to deliver PIs but a competency-based training program for use across various PI programs has not yet been created. Research has been conducted on creating competency-based training for specific manualised PI programs (e.g., Sigmarisdóttir & Gumundsdóttir, 2013; Turner et al., 2011), and for specific subsets of competencies across PI programs (Burn et al., 2019). However, no competency-based training program specific to PIs has been created that applies across PI programs.

Important prerequisites are needed to create a competency-based training program. Firstly, a consistent understanding of what competencies are core to PIs is required. Some core competencies have been proposed, but not validated, and some models of generic therapeutic competencies are available. However, no comprehensive core competency model, including both generic and PI-specific competencies, has been validated. Secondly, one of the aims of competency-based training would be to increase flexibility of PIs to address complex client needs. However, there is no agreed conceptualisation of case complexity (Delgadillo et al., 2017), which precludes understanding into how core competencies may be applied to case complexity. Thirdly, a competency-based training program requires a tool by which to operationalise, assess and measure core therapist competencies in PIs (Pinto et al., 2024). However, no competency rating tool specifically for PIs for conduct problems, and designed

for use across various PI programs, has been validated. The foundational components for competency-based training across PI programs are therefore missing, with both a comprehensive model of core competencies for PI therapists and a related competency rating tool needed.

Research discussed above suggests multiple parameters are needed for a competency rating tool to effectively support competency-based training. Firstly, it should be derived from a comprehensive consensus-validated core competency model to ensure it encapsulates all relevant competencies. Secondly, the tool should be valid and reliable to support its utility in assessing competencies. Thirdly, such a tool should improve the foundational competency of reflective practice to support further competency development. Finally, it should be implementable so that it is disseminated broadly and effectively.

Research discussed above, both in PIs and other interventions, has shown the importance of implementation outcomes for intervention effectiveness. Implementation outcomes should similarly be considered in the creation of competency-based training to optimise its utility. Indeed, implementation outcomes are considered an important aspect of the effectiveness of therapy training (Valenstein-mah et al., 2020). As they have supported appropriate refinement of interventions when investigated alongside clinical outcomes (Curran et al., 2022; Shepardson & Polaha, 2023), implementation outcomes could similarly support refinement of competency-based training. In this research project, implementation outcomes of competency-based training are defined as per the model described by Proctor et al. (2011). This model was chosen because it (1) defined implementation outcomes as distinct from clinical outcomes (which are beyond the scope of this project); (2) is more comprehensive than RE-AIM; and (3) has been previously applied directly to PIs (Pinto et al., 2024). The eight implementation outcomes specified by the model are: acceptability, adoption, appropriateness, cost, feasibility, fidelity, penetration, and sustainability. Each of

these implementation outcomes should be examined during creation of competency-based training in PIs.

To support implementability of competency-based training, methods must include stakeholders in the construction process and allow for implementation outcomes to be measured. Accordingly, co-design with therapists, as the service users of a training intervention, is important for constructing a useful and usable design for training. Co-design has been defined broadly in the literature (Masterson et al., 2022), but here refers to the process of including end-users and other stakeholders in the product or intervention design process (Böhm et al., 2022). Co-design originated in the participatory design movement, which commenced in Scandinavia in the 1970s (Masterson et al., 2022), for designing technology for use in the workplace. Like in other workplaces, therapist voices in design of their training is important as they have a unique insider perspective. An example of this is evident in the co-design of a clinical competency support tool for mental health workers in low-resource settings (Böhm et al., 2022), highlighting the value of co-design in therapist competency-based training. Importantly, concerns have been raised about insufficient guidance and control around co-design (Munce et al., 2023), therefore the quality of the co-design process must be a consideration. Ultimately, co-design should be used in the construction of competency models and this should be of high quality.

The Delphi method can be described as a co-design method if the expert group involved are end-users of the product/intervention, such as therapists in the case of competency-based training. Having initially emerged for military decision making (Chalmers & Armour, 2019), the Delphi method is a process of building consensus amongst an expert panel through iterative survey rounds and group-level feedback on responses from previous survey rounds. It has been used broadly across mental health research to answer questions that cannot feasibly be answered experimentally (Jorm, 2015). As such, it has been used

specifically for producing several therapist competency models (Roth & Pilling, 2008; Sburlati et al., 2011, 2012) and tools (Kohrt et al., 2015; Rice et al., 2022; Settanni et al., 2022). Thus, the Delphi method provides an appropriate, high-quality method of co-design that has shown to be appropriate for developing foundational components of competency-based therapist training.

1.4 Current Thesis

My doctoral research aimed to address the above identified gaps in the literature through the following contributions:

(1) constructing the first comprehensive conceptualisation of the core therapist competencies required for delivery of evidence-based parenting interventions for conduct problems;

(2) generating a conceptualisation of different drivers of case complexity that present in treatment for child conduct problems, and the investigation of practitioner perceptions of core competencies that are particularly important for responding to each driver;

(3) building a rating tool of core competencies for PIs, derived from the core competency model, to support operationalisation and utility of competencies in clinical practice;

(4) examining the validity and implementability of the competency rating tool built in this project; and

(5) examining the effect of the above competency rating tool on reflective practice competence.

To address the above five aims, my doctoral research involved four studies, which are laid out in the following four chapters. Study 1 (Chapter 2) describes the production of a comprehensive, consensus-validated model of core therapist competencies for PIs for conduct problems, including both generic therapeutic competencies and specific competencies

relevant to PIs. The Delphi method, an iterative method of expert consensus building, was employed to gather diverse practitioner perspectives to form a core competency model designed for use across different PI programs.

Study 2 (Chapter 3), describes production of a model of drivers of case complexity in child conduct problems and investigates which core therapist competencies are of particular importance to each from practitioner perspectives. This model was intended to address difficulties articulated by practitioners in responding to case complexity, so that training can better support therapists to meet varied client needs. Using the Delphi method, consensus amongst expert practitioners was established for a model of drivers of case complexity, and consensus amongst practitioners was explored around which competencies they considered particularly important for each driver.

Study 3 (Chapter 4) describes the construction and validation of a competency rating tool for PIs to support practitioner training in two parts. Specifically, Part 1 examined whether the core therapist competency model produced in Study 1 could be translated into a competency rating tool. A co-design approach, including focus groups and individual interviews with clinical supervisors of PI therapists, was used to build a pilot competency rating tool. Part 2 then examined whether the competency rating tool constructed in Part 1 was valid and implementable amongst PI supervisors and supervisees. This was done through an online survey in which face validity and convergent validity were investigated, as well as implementation outcomes.

Finally, Study 4 (Chapter 5) aimed to test whether the competency rating tool outlined in Study 3 could improve the reflective practice competence of provisional psychologists training in PIs, when used as the basis of competency-based training. A single case experimental design with multiple baselines examined the use of the competency rating tool over a 16-week period, including a randomised baseline of four to seven weeks, followed by

fortnightly use of the competency rating tool and review thereof in supervision. This design, with reflective practice measured weekly, allowed the relationship between competency-based training and reflective practice to be directly and causally tested in PI therapist training for the first time.

The thesis is then concluded with a general discussion in Chapter 6. The discussion outlines how each study builds on previous chapters to construct the foundational components for competency-based training in PIs. Study 1 represents the first attempt to establish a consensus-validated model of core competencies that is relevant across a range of PI programs; Study 2 used this model to further understand responses to complex presentations of conduct problems and ensure the model's utility for case complexity; Study 3 Part 1 translated this model into the first consensus-validated PI-specific competency rating tool constructed for use across various PI programs; Study 3 Part 2 tested the validity and implementability of that tool to support its utility in clinical practice, from which the tool design was finalised; and Study 4 then used this competency rating tool to pilot competency-based training in PIs. Thus, the studies outlined in this thesis make an important contribution to PI training as they can support identification and assessment of core competencies for PI therapists; training structure including goal development; and development of evidence-based competency-driven responses to case complexity. The significance and implications of outcomes for both research and clinical practice discussed.

CHAPTER 2: Core Therapist Competencies for Evidence-Based Treatment of Child Conduct Problems

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Superficial modifications have been made to the version below, including to wording and formatting. The published version in journal format is included in Appendix A.

2.1 Introduction

Compared to many other fields of mental health, evidence regarding the treatment of child conduct problems is particularly extensive. The interventions with by far the strongest support are parenting interventions based on social learning theory, delivered in early-to-middle childhood (Kaminski & Claussen, 2017) The packaging of these interventions into highly disseminable evidence-based programs can be considered one of the major achievements of mental health science in the last century. The roll-out and transportation of such programs around the world has supported research into a broad range of questions concerning their effectiveness, mechanisms of change, novel adaptations for specific populations, and innovative modes of delivery to improve engagement and reach (e.g., eHealth; Fairchild et al., 2019).

Important strengths of this field have included an emphasis on treatment fidelity (for a review see Garbacz et al., 2014), and a widespread availability of training resources and support attached to key examples of these programs, such as Parent-Child Interaction Therapy (PCIT; Eyberg & Calzada, 1998), the Positive Parenting Program (Triple P; Sanders et al., 1999) and Incredible Years (Webster-Stratton & Reid, 2017). However, while the effective delivery of these interventions is understood to rely on a range of therapist

competencies, these competencies have rarely been an explicit focus of research. In this practitioner review we examine emerging theory and research into core therapist competencies for clinical practice in mental health, and report on the development of a model of core competencies for the delivery of evidence-based interventions to families of children with conduct problems. Of key interest are competencies common to established programs of this kind, as well as competencies most relevant to clinical practice with complex cases of child conduct problems.

2.1.1 The Competency-Based Movement in Mental Health

Definitions of competencies in the clinical literature encompass “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community served” (Epstein & Hundert, 2002, p. 227). Competency-based practices have had a sweeping impact on training and professional development in diverse fields of health in recent years, reflecting a growing emphasis on the identification, teaching, and assessment of these competencies. This movement has also played a key role in the promotion of evidence-based practice in mental health.

Roth and Pilling’s (2008) seminal model of competencies for delivering cognitive behaviour therapy (CBT) to adults with depression and anxiety disorders, was instrumental to the implementation of the Improving Access to Psychological Therapies (IAPT) initiative in the UK (Clark, 2018), and noteworthy for the intensive methods through which the model was developed. Through multiple rounds of consultation with a reference group of expert practitioners, consensus regarding these competencies was achieved, thereby allowing for the conceptualisation of a core competencies model comprising clusters or domains of (1) generic competencies, used in all psychological therapies; (2) basic CBT competencies, common to both low and high-intensity interventions; (3) specific CBT techniques; (4)

problem-specific competencies; and (5) meta-competencies, used to guide intervention implementation (Roth & Pilling, 2008). Models for other adult-focused interventions, such as CBT for psychosis (Morrison & Barratt, 2010), subsequently emerged through similar methods.

2.1.2 Child and Adolescent Mental Health Competencies

This approach to model building has also been applied to widespread interventions in child and adolescent mental health, although to a lesser extent. As in the adult literature, anxiety and mood disorders have been a predominant focus, while nonetheless reflecting the developmental and ecological considerations that make child mental health unique. For example, Sburlati et al.'s (2011) model of core competencies for CBT with child and adolescent internalising disorders differentiates similar domains, but incorporates additional competencies related to knowledge (e.g., typical developmental processes in these periods; risk processes in family and peer contexts relevant to formulation-driven treatment planning; understanding of the unique legal and ethical requirements relating to the provision of therapy to children and adolescents), as well as process skills for building positive therapeutic relationships with parents; collaboratively involving parents in treatment; implementing child/adolescent CBT-specific techniques (e.g., friendship skills, dealing with bullying skills); and modifying the family environment (e.g., parent contingency management, family communication). Other examples of core competency models for child and adolescent mental health include those regarding interpersonal psychotherapy for adolescent depression (Sburlati et al., 2012), and CBT for ASD in young people (Spain et al., 2023).

In addition to intervention-specific models of this kind, there has been growing interest into competencies spanning broader areas of practice. This reflects growing evidence that a therapist's capacity to flexibly adapt treatment to the client, integrating components of distinct interventions as appropriate, may be associated with superior outcomes (Fonagy &

Luyten, 2019). This adherence flexibility is particularly relevant to complex presentations, such as those with comorbid diagnoses. This is reflected in modular approaches to the management of comorbid psychopathology, such as the MATCH intervention method (Weisz et al., 2012). Rief (Rief, 2021) proposed a global framework for categorising intervention components according to mechanisms and subgoals addressed, whereby competencies map on to these categories. Interventions were organised according to their relative emphasis on (1) skills acquisition; (2) working with relationship patterns and modifying them through the therapeutic relationship; and (3) clarification of goals and motives. Within each of these categories, core competencies may include (1) scientific knowledge about relevant treatment processes and mechanisms; (2) competencies for addressing and modifying mechanisms and processes (e.g., engaging clients in skills training); and (3) personal competencies to become a successful therapist (e.g., the therapist's own skills for communication, empathy, perspective taking and emotion-regulation; Rief, 2021).

Global models have also begun to emerge for child and adolescent mental health specifically, such as the unified model of competencies for family-based intervention for child and adolescent psychopathology, proposed by Allen et al. (2021). The three broad domains specified in this model comprise (1) generic therapeutic competencies for practice across child and family settings; (2) competencies in treatment planning and delivery, including knowledge and abilities to plan and flexibly implement evidence-based treatment components according to the unique considerations and needs of the family and clinical setting; and (3) competencies for targeting specific ecological domains, including the therapist's ability to deliver the content of therapeutic components (e.g., psychoeducation, exposure to reduce anxiety, skills training in parenting strategies) in a specific treatment plan. The conceptualization of this final domain reflects an ecological perspective on the multiple

levels potentially targeted within family-based interventions (e.g., individual child/adolescent, dyadic relationships, family level).

The overarching frameworks provided by these global models are valuable given the breadth of training and professional development typically undertaken by mental health practitioners. However, they rely heavily on the availability of in-depth models of competencies related to specific populations and interventions. Although the family-based model of Allen et al. (2021) was designed to encompass a broad range of disorders and interventions, it is important to note that only a relatively small number of these have been subjected to the consensus-based investigation that has been regarded as best-practice for building in-depth models of therapist competencies (i.e., the Delphi method; e.g., Sburlati et al., 2011). Child conduct problems are among one of the major areas of practice neglected by such research to date. This omission is striking considering that conduct disorder is the leading cause of burden among all mental disorders in children aged 0-14 years (Ferrari et al., 2022), and that most children with conduct problems do not receive evidence-based treatment (Johnson et al., 2018).

2.1.3 A Core-Competency Perspective on Conduct Problems

Considerable theory and evidence is available to inform research into core competencies for the treatment of conduct problems, with two bodies of literature particularly germane. The first is research into the common elements (e.g., content, components, program features) shared by the most effective parenting interventions for conduct problems (social learning theory-based parenting interventions; PIs, hereafter referred to as PIs). This perspective is important, given that there is considerable variation between PIs in terms of content, format, and skills-training practices (e.g., use of video materials; in-vivo coaching with the child; role play), and integration of other theoretical principles (e.g., attachment theory; family systems theory).

An earlier Delphi study identified 4 categories of common elements among general interventions for conduct problems in children and adolescence, including therapeutic content; treatment technique; aspects of the working alliance; and treatment parameters (Garland et al., 2008). Subsequent meta-analytic work by Leijten et al. (2019) identified 19 parenting skills/techniques commonly targeted across 386 trials of PIs, the most common of which were praise (97% of interventions), time-out (87%), natural or logical consequences (85%), ignoring (77%), and direct and positive commands (77%). Stronger effects, in both prevention and intervention settings, were associated with the inclusion of natural or logical consequences as a nonviolent limit-setting technique, and positive reinforcement for desired behaviours, especially through praise. Additionally, in intervention settings, programs that included time-out were significantly more effective than those that did not (Leijten et al., 2019). Interestingly, such research has shown that the combination of such components does not always enhance benefits. For example, a recent network meta-analysis of the collective effects associated with targeting various types of parenting techniques found that interventions with behavioural management, psychoeducation and relationship enhancement techniques were significantly less effective than interventions with behavioural management alone (Leijten et al., 2022). Earlier meta-analytic research also tested the effects of these components on externalising behaviour outcomes, finding that parent practice of skills with their child, positive parent-child interactions, time-out, and consistent responding, all contributed significantly (Kaminski et al., 2008). Leijten et al. (2022) further found that interventions are likely to be more effective when content is focused and tailored to the needs of the individual family. This points to the potential importance of competencies for formulation-driven practice, including family assessment and collaborative treatment planning.

Second, a growing body of clinical literature has addressed factors that have the potential to complicate the delivery of such intervention to families of children with clinic-referred conduct problems. Hawes and Dadds (2021a) proposed that these factors relate largely to six domains, which were conceptualised as key dimensions of case complexity among such families. These pertain to (1) the severity of the child's conduct problems; (2) developmental and dispositional factors (e.g., language impairments, forms of temperament such as negative reactivity, fearlessness, callous and unemotional traits); (3) co-morbid child psychopathology (e.g., internalising disorders, neurodevelopmental disorders); (4) highly dysfunctional or adverse caregiving (e.g., harsh or inconsistent discipline, skill deficits in age-appropriate caregiving); (5) parent risk factors (e.g., personality and mental health, parental attributions); and (6) family system and social environment risk factors (e.g., interparental conflict, lack of social support, financial disadvantage, differing cultural beliefs). Many of these factors covary with conduct problems (Fairchild et al., 2019; Fonagy & Luyten, 2018), while at the same time increasing risk for poor engagement and resistance to change among parents, and placing additional demands on therapists (G. E. Miller & Prinz, 1990; G. R. Patterson & Chamberlain, 1994; Piotrowska et al., 2017).

Some PIs have been developed specifically for multi-stressed families, wherein related therapist competencies have been proposed and operationalised (e.g., “genuine respect for multi-stressed families living in complex circumstances”; “humility about what intervention can achieve”; “resolute and quiet enthusiasm”; Day et al., 2011). Other recommendations have focused on additional theory-driven competencies to employ in existing programs when change is not occurring (Scott & Dadds, 2009). Competency recommendations have included those specifically for the clinical engagement of multi-stressed parents in these interventions (Piotrowska et al., 2017); the joint engagement of parents whose own relationship is in conflict (Burn et al., 2019); the enhancement of parent

motivation (Pelham et al., 2017); and overcoming resistance to change (Hawes & Dadds, 2021b; Sanders & Burke, 2014). Also of relevance is emerging evidence regarding novel adaptations of PIs for presentations of conduct problems associated with unique risk pathways. For example, existing programs have been modified to include additional emotion-focused components for children with conduct problems and callous-unemotional traits, based on the unique neurodevelopmental characteristics exhibited by such children (e.g., Dadds et al., 2012; Fleming et al., 2022).

2.1.4 A Consensus Model of Core-Competencies for Conduct Problems

As outlined, the common elements of PIs for conduct problems have been characterised and studied extensively using meta-analytic methods, while literature attached to individual programs has often addressed specific therapist competencies for approaching common challenges and complex presentations. There remains, however, the need for a consensus-based perspective on these competencies, such as that which has contributed significantly to practice with internalising disorders of childhood (Sburlati et al., 2011, 2012). Accordingly, we aimed to develop and validate a model of core competencies for the delivery of PIs for conduct problems in early-to-middle childhood, with an international panel of expert practitioners using the Delphi method. A further aim was to examine consensus regarding these competencies as they apply to complex presentations of conduct problems.

2.2 Method

2.2.1 International Expert Practitioner Panel

Practitioners with expertise in PIs for child conduct problems were identified based on their publication of literature in the area. This included the developers of a number of established programs. Individuals were contacted with invitations to participate and also asked to recommend other expert practitioners. Those who met inclusion criteria (currently practicing in PIs; 5 years' minimum experience; a willingness to complete the multiple

rounds of data collection required by the Delphi method), were recruited. A total of 117 practitioners were approached; 60 agreed to participate, 11 later withdrew, and 49 completed the first round of data collection (42% response rate). The final sample was highly comparable to those initially approached, regarding characteristics such as sex, nationality, profession, and research experience. The completion rate was 84%, with 41 participants completing the final round. A range of countries were represented, including the United States of America (51%), Australia (31%), Canada, New Zealand, England, Wales, Germany, Finland, and the Netherlands. Professions were predominantly psychology (73%) and social work (10%), along with nursing, education, and psychiatry. Clinical experience spanned the major PI programs currently found in the field (e.g., PCIT: 45%; Helping the Noncompliant Child: 24%; Triple-P: 24%; Incredible Years: 22%; Parent Management Training-Oregon Model: 22%; Barkley's Defiant Child: 16%; Parent-Child Care: 14%). Mean years of experience was 18 years, and 98% of participants reported working with complex cases in their current and/or previous positions. A range of settings were also represented, including private practice, university/research clinics, and community health. All participants provided informed consent to participate and were given the option to be identified or remain anonymous (see Appendix B).

2.2.2 Model Development

A preliminary model of core competencies for PIs was drafted and presented to participants for feedback. This preliminary model was informed by a review of PI manuals, as well as literature regarding the common elements of these programs (e.g., Leijten et al., 2019), accounts of core competencies in overlapping interventions (e.g., Allen et al., 2021; Sburlati et al., 2011), and literature in which competencies for clinical practice with complex presentations of conduct problems have been operationalised (e.g., Day et al., 2011; Hawes & Dadds, 2021). Following Delphi method guidelines, this model was revised through iterative

survey rounds in which participants provided qualitative responses and quantitative ratings of the model. Participants remained anonymous to each other, while receiving feedback about the responses of the panel in previous rounds, in order to encourage convergence. Participants were given the option to participate via videoconference (Zoom) interviews or online surveys via the Qualtrics platform, with the majority opting for the latter.

Data collection comprised three survey rounds, undertaken in April-May, June-July, and September-October of 2022. Each was approximately 30-50 minutes in duration, and participants were provided with approximately two weeks to respond. Across these rounds, participants were asked to consider the draft model and propose their own revisions, including edits, additions, and omissions. Survey 1 consisted primarily of open-ended questions regarding specific aspects of the model, while Surveys 2 and 3 consisted primarily of Likert scale ratings. For the purpose of addressing competencies for clinical practice specifically with complex presentations of conduct problems, participants were presented with the definition of such complexity proposed by (Hawes & Dadds, 2021a). Participants were asked to identify what competencies they considered most vital with clients high in such complexity, and how those competencies should be applied.

2.2.3 Model Validation

Content analysis of expert responses was conducted manually, allowing for modifications to the clustering of competencies where appropriate. Deidentified data was used to minimise bias. Reliability of analysis was evidenced by author agreement on content themes and wording of final competencies, and validity of analysis was ultimately ensured by acceptability according to participants based on survey data (Chalmers & Armour, 2019). Criteria for consensus required at least 70% of participants to report being satisfied with how the respective competencies were operationalised. The majority of experts (88%) requested

modifications to the preliminary model in the first round, and, following feedback of model revisions, expert consensus was attained on all 15 competency categories.

2.3 Results

The final model produced by the Delphi method is represented in Figure 2.1. The specific competencies identified through this process clustered into 15 categories, across three broad domains. This model spans the major phases of initial engagement, assessment, treatment planning and delivery, with specific and operationalisable competencies for the delivery of PIs by practitioners.

2.3.1 Generic Therapeutic Competencies (Domain 1)

Generic therapeutic competencies are those considered common to many psychological interventions, and here include those for understanding relevant child and family factors, conducting a thorough assessment, practicing professionally, and building a therapeutic relationship. The latter two can be considered important meta-competencies, in that they enable therapists to adapt the implementation of interventions to the needs of a case in a coherent and informed manner (see Table 2.1). Among these, three novel competencies were formulated, pertaining to limits of expertise (category: Practicing professionally); adult psychopathology (category: Understanding relevant child and family factors); and therapist modelling (category: Building a therapeutic relationship).

2.3.2 Parenting Intervention Competencies (Domain 2)

Parenting intervention competencies are those specific to parenting interventions, but common to parenting interventions for a broad range of problems. The three categories in this domain comprise (1) understanding relevant theory and research; (2) family-based formulation and treatment planning; and (3) collaboratively conducting parent-focused sessions. Meta-competencies for formulation-driven practice with parents feature heavily here (see Table 2.2). Novel competencies in this domain were formulated regarding the

integration of evidence-based strategies for adult mental health and behaviour change (e.g., cognitive challenging, motivational interviewing) into parenting interventions for child mental health.

2.3.3 Specific Parenting Skills/Techniques (Domain 3)

This domain comprises eight categories of competencies for delivering program content that is largely specific to PIs for conduct problems, including that related to the specific parenting skills/techniques targeted in these programs (see Table 2.3). Three novel competencies were formulated in this domain: structuring the environment (category: Proactive parenting); self-care skills for parents; and child general learning and life skills (category: Skills parents teach children). A novel category was also formulated (Coordination of Parenting Skills/Techniques), regarding competencies for supporting parents' coordinated and consistent implementation of a range of techniques to optimise child outcomes (e.g., selecting, sequencing and combining techniques, as appropriate to the situation; being able to “recover” after discipline). This reflects the importance of inconsistent parenting to the maintenance of conduct problems (Fairchild et al., 2019), as well as cautions that targeting an excessive number of parenting skills can be counter-therapeutic (Hawes & Dadds, 2021b; Leijten et al., 2022).

2.3.4 Complex Cases of Child Conduct Problems

When asked to consider what competencies are particularly vital to practice with complex cases, two major themes emerged: (1) prioritise building a strong and positive therapeutic relationship with the family, with trust, rapport, empathy, support, and transparency about the intervention, to gain accurate information about the family, engage them in the intervention, support them in trying new behaviours and approaches, and develop a network of resources for them; and (2) conduct a thorough initial and ongoing assessment of child, parents and other family members, into symptoms, interpersonal dynamics, barriers,

strengths, supports, and hopes/goals. Inadequate assessment may result in a failure to identify complex needs (e.g., comorbid neurodevelopmental problems; interparental conflict) that warrant unique treatment plans, and may contribute to blame and stigma by failing to validate parents' concerns. Assessment competencies therefore underlie both formulation-driven treatment planning and clinical engagement in PIs (Piotrowska et al., 2017). This reflects the dual emphasis on engagement and formulation-driven practice in previous recommendations (Hawes & Dadds, 2021a; Scott & Dadds, 2009).

In addition to recommendations regarding competencies that may be particularly vital to complex cases in general, novel recommendations regarding competencies for specific presentations of case complexity were also generated. Preliminary recommendations were first proposed by panel members through open-ended responses in the first round of data collection. A total of 42 such recommendations were proposed, and addressed clinical scenarios related to comorbidity (e.g., developmental delay, ASD), parent factors (e.g., parental depression, interparental conflict) and other factors. These recommendations were subsequently presented back to the panel to determine consensus. Expert consensus was reached for 21 of these recommendations. As shown in Table 2.4, these recommendations relate to the adaptation of competencies across all three of the major domains. Specifically, six relate primarily to generic therapeutic competencies; six relate primarily to parenting intervention competencies; and nine relate to specific parenting skills and techniques.

Figure 2.1

Core Competencies for Delivering Evidence-Based Parenting Interventions for Conduct Problems in Early-to-Middle Childhood

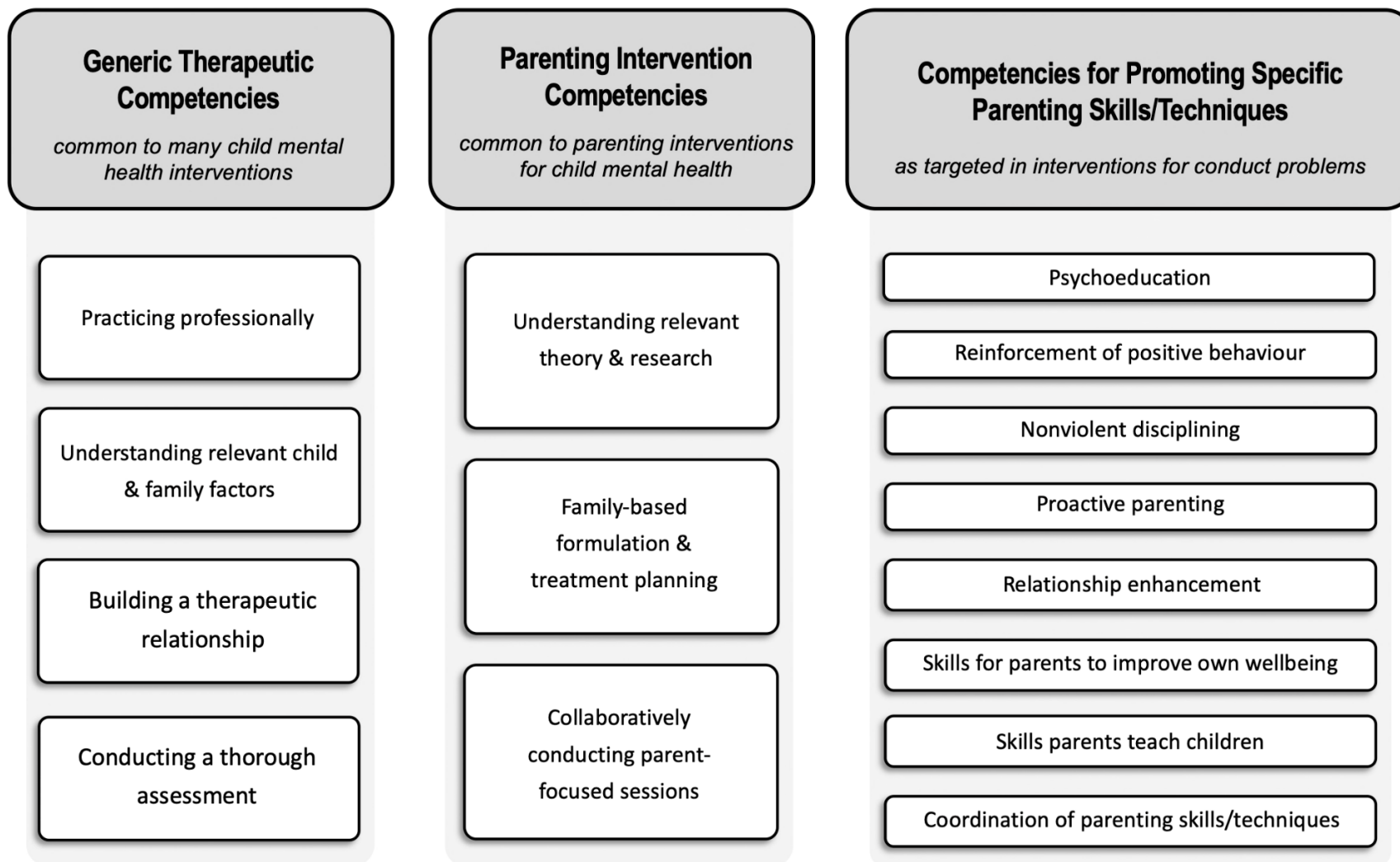


Table 2.1*Descriptions of Generic Therapeutic Competencies*

Competency category	Description
<i>Practicing Professionally</i>	
Codes of conduct	Have knowledge of and ability to work within professional, ethical, legal codes of conduct relevant to children & families;
Supervision & development	Actively participate in supervision or professional development/consultation;
Research evidence	Have knowledge of the research evidence supporting interventions; be able to identify and critically evaluate available evidence of effectiveness, and utilize this evidence to inform practice;
Reflective practice	Engage in reflective practice (e.g., self-assess current competencies, process personal reactions, manage transference/countertransference);
Systems knowledge	Understand the role, purpose & responsibilities of key disciplines & institutional systems involved in the care of children/families, while supporting families to engage with such systems where appropriate;
Limits of expertise	Be aware of the limits of one's own expertise and/or the interventions being provided, and refer on as appropriate for out-of-scope issues.

Understanding Relevant Child & Family Factors

Child development	Have knowledge of child development and developmental stages, including age-appropriate behaviour, physical, cognitive, emotional and social maturation;
Culture & race	Have knowledge and recognition of factors related to culture and race and their significance to therapy;
Family structure, experiences, dynamics	Have knowledge of child and family structure, experiences, and relationship dynamics and how they can affect therapy;
Child psychopathology & individual differences	Have knowledge of risk pathways to conduct problems, child psychopathology, comorbidity and other individual differences, and how these can affect therapy;
Adult psychopathology	Have knowledge of adult psychopathology and substance abuse and how these can affect therapy.

Building a Therapeutic Relationship

Engagement with parents/caregivers	Foster and maintain engagement with parents/caregivers in a collaborative therapeutic alliance (e.g., identifying & inviting in the child's parenting team; managing in-session conflict between parents; managing resistance and ruptures, including parent challenges to the competence of the therapist);
Inclusive practices	Use practices inclusive of all genders, non-traditional family structures, cultural diversity, sexuality and gender identity when engaging parents/caregivers;
Hope and optimism	Instil hope and optimism for change;

Therapeutic alliance with child	Foster & maintain when appropriate;
Age-appropriate engagement	Use age-appropriate methods/pacing when engaging children;
Partnerships with stakeholders	Form partnerships with other family members/stakeholders where appropriate;
Culturally responsive & strengths-based practices	e.g., acknowledge the unique experiences of families, recognise parents as experts on their child;
Therapist modelling	Model appropriate behaviours, reactions and emotion regulation consistently.

Conducting a Thorough Assessment

Assessment method	Use skills for evidence-based multi-method, multi-informant assessment;
Integration of reports	Integrate reports from diverse informants along with clinical observations;
Diagnosis	Determine diagnoses with consideration of differential diagnosis, including physical health problems;
Assessment areas	Assess symptoms, function of behaviour, strengths, history, resilience, stage and intervention suitability;
Assessment of violence & risk	e.g., create a family safety plan;
Parental assessment skills	e.g., supporting parents to discuss personal thoughts/emotions & sensitive issues beyond the child, including family of origin experiences.

Table 2.2*Descriptions of Parenting Intervention Competencies*

Competency category	Description
<i>Understanding Relevant Theory and Research</i>	
Behavioural theories	Have knowledge of the behavioural theories underpinning PIs for conduct problems, particularly operant conditioning, classical conditioning, social learning theory;
Implementation based on theory	Be able to implement PIs in line with theoretical underpinnings and related behaviour modification strategies;
Additional theoretical perspectives	Be able to integrate additional theoretical perspectives while maintaining PI fidelity;
Risk, maintenance and protective factors	Have knowledge of PI research, including evidence of contextual/child/parent/family factors implicated in risk/maintenance and protective processes, and how these differ for specific subgroups;
Adult mental health strategies	Be able to integrate evidence-based strategies for adult mental health and behaviour change while maintaining PI fidelity.
<i>Family-based Formulation & Treatment Planning</i>	
Formulation development	Collaboratively devise & revise case formulations, accounting for the presenting problem, comorbidity, developmental level, individual differences related to subtype of conduct problems, and family/parental/social/contextual factors, including family strengths;

Treatment plan development	Collaboratively devise, implement, flexibly revise PI treatment plans by selecting, sequencing, applying the most appropriate PI techniques, at the appropriate dosage, based on the formulation and the family's values and priorities, while maintaining PI fidelity;
Communication of formulation	Communicate psychoeducation about the nature of the problem nonjudgementally to parents and stakeholders, and support them to reflect on their own parenting where appropriate;
Treatment goals	Collaboratively negotiate concrete and measurable treatment goals with parents & other stakeholders (e.g., teachers) informed by baseline measures;
Roles in treatment	Collaboratively negotiate roles and presence of family members & other stakeholders in treatment;
Engagement of wider network	Engage additional family members & stakeholders as appropriate, including other clinicians where needed;
Progress monitoring	Use measures & self-monitoring to guide therapy & monitor outcomes;
End of treatment planning	Plan for the end of therapy and long-term maintenance of progress;
Limits of treatment	Distinguish between parent/family needs that can be addressed in the current PI versus needing longer term work.

Collaboratively Conducting Parent-Focused Sessions

Session goals	Collaboratively set & adhere to session goals/agenda;
Communication of rationale	Communicate the rationale for therapeutic processes and techniques;
Client feedback	Elicit & respond to feedback from parents & family members;

Flexible technique implementation	Implement specific techniques flexibly for the client's presentation, needs/preferences, cultural background, family relationships & mental health;
Experiential strategies	Utilise experiential strategies to implement and promote specific parenting skills in session;
Technique monitoring & shaping	Monitor & shape implementation of strategies/techniques, sharing feedback on progress with family;
Sensitivity to parent factors	Conduct sessions with sensitivity to parent factors;
In-session family collaboration	Facilitate in session collaboration between members of the parenting team/other family members;
Strategy implementation between sessions	Facilitate parents to implement strategies as a supportive parenting team between sessions;
Between-session activities	Collaboratively set, plan & review personally meaningful between-session activities;
Information sharing	Manage how information is shared across the family system;
Family boundaries & routines	Empower parents to improve boundaries/routines with other caregivers;
Barriers to treatment & resistance to change	Support parents to overcome this by assessing, formulating and managing barriers to engagement, including relational dynamics; and applying motivational interviewing / enhancement strategies.

Note: PI = Parenting intervention.

Table 2.3*Descriptions of Specific Parenting Skills/Techniques*

Competency category	Description
<i>Psychoeducation</i>	
Child development	Explain child development, including information about typical & atypical development, including developmental effects of trauma, correcting misinformation e.g., harmful effects of time-out on development; praise/rewards viewed as coercive control;
Parent-child interactions	Explain parent-child interactions including information about how parents & children shape each other's interactions in daily life, including effects of temperament; family of origin and systemic/contextual/cultural influences on parenting; the importance of self-care to parenting; the functions/ABCs of behaviour from operant and attachment perspectives.
<i>Reinforcement of Positive Behaviour</i>	
Social rewards	e.g., verbal praise, non-verbal cues such as smiles, thumbs up; physical affection; quality time/activities with parents;
Tangible rewards	e.g., tokens, charts, incentive systems.

Nonviolent Disciplining

Time-out	Using time-out for inappropriate behaviours, using least restrictive practice that is appropriate;
Planned ignoring	Using planned ignoring or selective attention for inappropriate behaviours;
Natural/logical consequences	Using natural/logical consequences, including removal of privileges and addition of chores, as age-appropriate.

Proactive Parenting

Effective commands	Using effective commands that are direct, positively stated, specific, age-appropriate;
Rule setting	Setting rules about appropriate & inappropriate behaviour; techniques for managing rules;
Child monitoring & supervision	Knowing what child does & with whom they play when out of view, including media use and supervision observing them in the moment;
Environmental structuring	Pre-emptively structuring environments and routines to avoid problem behaviour;

Relationship Enhancement

Quality parent-child time	Having parent-child quality time and child-directed interaction/play, including spending time focused on child; showing interest/engaging in what they are doing; having daily child-led play with child; involving warmth and mutual enjoyment;
Empathy	Understand what child feels in different situations;
Active listening	Concentrate on what child says, show that they are listened to, reflect back to them what they say, and show them that they are valued in the family.

Skills for Parents to Improve Own Wellbeing

Emotion regulation & stress-management skills	Parents recognising their own emotions and how they affect parenting, validating & regulating;
Problem-solving & conflict management skills	Parents generating & implementing solutions to difficult situations and crises directly and indirectly related to parenting;
Partner/social support	e.g., improving relationship/communication between parents; support from partner/family/friends;
Self-care skills	e.g., parents engaging in personal/pleasant activities and time for self; support parent(s) to access own therapy where appropriate.

Skills Parents Teach Children

Child emotional regulation skills	Giving child words for emotions, validating emotions, modelling how to regulate emotions and control impulses/attention;
Child problem-solving skills	Teaching child how to solve everyday problems;
Child social skills	Social skills including communication and conflict resolution skills; prosocial behaviours such as helping others;
Child general learning and life skills	e.g., teaching colours, promoting independence in child self-care.

Coordination of Parenting Skills/Techniques

Technique coordination & consistent implementation	e.g., selecting, sequencing, and combining techniques, as appropriate to the situation; being able to “recover” after discipline, so as to optimise child outcomes.
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Note. ABC = antecedent, behaviour, consequence

Table 2.4*Adaptations for Specific Complex Presentations of Conduct Problems*

Competency category	Description
<i>Understanding Relevant Child & Family Factors</i>	
Child psychopathology & individual differences	For a child with comorbid developmental delay and/or autism spectrum disorder (ASD), the therapist should have an understanding of theory and research related to developmental delays and/or ASD
<i>Building a Therapeutic Relationship</i>	
Engagement with parents/caregivers	When access-to-care barriers are evident (e.g., financial or transportation difficulties, difficult work hours), particular focus should be given to parent/caregiver engagement
<i>Conducting a Thorough Assessment</i>	
Assessment areas	For comorbid anxiety and/or OCD (obsessive compulsive disorder), particular attention to any parental accommodation to the child's anxiety/OCD-related demands (e.g., parent participating in child's checking rituals) is recommended
Assessment of violence & risk	<p>When a child presents with comorbid ASD, there should be consideration of a safety plan for self-injurious behaviour, including (but not limited to) the context of time-out</p> <p>In the presence of severe interparental conflict, it is recommended to engage in safety planning</p> <p>When physical discipline towards the child occurring, a safety plan should be developed to address this</p>

Understanding Relevant Theory and Research

Additional theoretical perspectives	For comorbid anxiety and/or OCD, the therapist should have knowledge of the importance of exposure
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Family-based Formulation & Treatment Planning

Treatment plan development	In group interventions, individual support should be given to families with high needs
	When a parent presents with significant depression, slow the pacing of material and content

Collaboratively Conducting Parent-Focused Sessions

Experiential strategies	When a parent presents with significant depression, provide more practice via role play / as much as parent allows
Between-session activities	When a parent presents with significant depression, home practice assignments should be made smaller
Barriers to treatment & resistance to change	If a parent is disinhibited or difficult to contain, within-session boundaries should be set up and maintained

Reinforcement of Positive Behaviour

Social rewards	For a child with comorbid anxiety and/or OCD, emphasis is recommended on caregivers praising brave behaviours
Both Social & Tangible rewards	If harsh or inconsistent parenting is occurring, further emphasis on positive parenting skills to enhance the parent-child relationship is advised
	For children with callous-unemotional (CU) traits, therapists should place extra emphasis on positive reinforcement strategies for good behaviour

If the child has a language impairment, rewards for child communication skills are advised (in addition to using general behaviour management techniques e.g., rewards and non-violent discipline)

Nonviolent Disciplining

Natural/logical consequences

In the case of heavy parental reliance on consequences, time-out and/or harsher practices, therapists should emphasise properly dosed, consistent, predictable evidence-based natural and logical consequences

Proactive Parenting

Effective commands

If the child has a language impairment, commands should be simplified

Relationship Enhancement

Quality parent-child time

Empathy

Active listening

In the context of long-term disruption in the caregiver-child attachment, emphasise relationship enhancement

Skills for Parents to Improve Own Wellbeing

Emotion regulation & stress-management

skills

Self-care skills

If the child has a developmental delay, parent self-care and emotion regulation should be emphasised

Skills Parents Teach Children

Child emotional regulation skills

For a child with CU traits, emphasis on promoting the child's emotional skills is advised

2.4 Discussion

Despite the considerable variation among widely disseminated PI programs, in terms of content, format, and skills-training practices, there appears to be considerable consensus among practitioners regarding the core competencies that these interventions necessitate. In addition to highlighting this consensus, the current model also reflects some of the recent shifts in conceptualisations of these interventions in the field at large, which have numerous implications for clinical practice and training. This includes a growing recognition regarding the importance of engaging not only mothers, but also fathers, in such interventions, and that this inclusion should extend to non-traditional caregivers (Burn et al., 2019; Gonzalez et al., 2023). It likewise reflects growing recognition that the successful delivery of parenting interventions often necessitates competencies that extend well beyond those focused on parenting, to encompass those concerned with broader aspects of the family system (e.g., the parents' own relationship and mental health; Piotrowska et al., 2017) and the wider ecology of the child (e.g., parent-teacher communication; cultural/historical context; Dishion & Stormshak, 2007). Similarly, there has been growing interest in the integration of theory beyond social learning theory (e.g., attachment theory; family systems models) into these traditionally behavioural interventions (Cavell & Quetsch, 2023; Dadds & Hawes, 2006; McNeil et al., 2010). This was also reflected in the final model, with an emphasis on ensuring that such integration does not undermine the integrity of the social learning theory foundation that is core to intervention effectiveness (Scott & Dadds, 2009).

This model contributes to growing literature on the implementation science of PIs, which has often focused on the related construct of therapist fidelity. Fidelity has been found to predict not only improvement in conduct problem outcomes across PIs, but improved parental engagement, parenting practices, and parental psychopathology (Hukkelberg & Ogden, 2013; J. D. Smith et al., 2013; Thijssen et al., 2017). This work has been supported by

progress in the conceptualisation and measurement of fidelity, and the findings of the current study have the potential to inform similar work on the measurement of core competencies.

Likewise, research is now needed to develop measures and related tools for supervision and reflective practice based on the current model. The literature has further emphasised the importance of ongoing supervision and feedback to the maintenance of therapist fidelity and skills, while highlighting the need for further research into the implications of distinct supervision and training methodologies for this purpose (Garbacz et al., 2014).

2.4.1 Implications for Training and Practice

The current model points to a range of core competencies that are often neglected in manualised protocols for PIs, and that are therefore important for practitioners to pursue through ongoing training, supervision, and reflective practice. Competencies pertaining to culture, diversity, and trauma, were prominent among expert recommendations, beginning with the first domain of Generic Therapeutic Competencies. For example, competencies for building a therapeutic relationship encompass inclusive practices for engaging diverse parents/caregivers (e.g., inclusive of women & men; non-traditional family structures; cultural diversity; sexuality and gender identity); and culturally responsive and strength-based practices (e.g., acknowledging the unique experiences of families; recognising parents as experts on their own child). This focus is consistent with evidence that culturally-bound adversities can serve as barriers to parenting interventions, and recent calls for models of service delivery to address these barriers (Weisenmuller & Hilton, 2021).

The second domain, Parenting Intervention Competencies, emphasises the importance of incorporating a family's own values and priorities into treatment planning, while at the same time maintaining program fidelity; the importance of non-judgemental communication of psychoeducation about parenting and child mental health; and the importance of parent-

focused strategies to overcome barriers to treatment and manage resistance to change (Hawes & Dadds, 2021b).

The final domain, Specific Parenting Skills/Techniques, included the competencies with the highest level of consensus among any competency category: parent-child relationship enhancement skills. This is interesting given that these skills are based less explicitly on social learning theory than other positive parenting skills such as reinforcement. It is also noteworthy that, while there was consensus support for the nonviolent discipline skills listed, time-out was the focus of considerable feedback. In particular, experts emphasised the need to be informed by theory and evidence regarding topics such as attachment and trauma when supporting parents to implement time-out, consistent with the growing focus on these topics in the literature (Dadds & Tully, 2019; Morawska & Sanders, 2011).

Expert recommendations regarding complex cases appear to diverge considerably, which may reflect the limited availability of evidence regarding interventions with complex presentations. It is only recently, for example, that the implications of adverse childhood experiences for PIs has been explicitly tested (e.g., Roach et al., 2022). Likewise, emerging evidence regarding interventions for children with callous-unemotional traits was reflected in recommendations to focus on positive reinforcement and the promotion of children's emotion-processing skills in such cases (Dadds et al., 2012; Fleming et al., 2022). Comorbid psychopathology featured prominently among recommendations reaching consensus, which included integrating non-avoidant ("brave") behaviours among targets of positive reinforcement for children with comorbid anxiety. These recommendations further indicated a need to go beyond operant strategies, as seen in the emphasis on competencies for parent-child relationship enhancement in cases involving chronic parent-child attachment problems. Rather than suggesting that these relationship enhancement competencies are not sufficiently

covered in existing manualised resources, our data highlight the role of assessment and case formulation in guiding how these competencies are applied. That is, practitioners should be competent at identifying attachment problems early in assessment and making predictions regarding the optimal approach to relationship enhancement based on the unique needs and strengths of the family. An additional emphasis is placed on competencies for supporting parents facing access-to-care barriers, such as socioeconomic adversity and logistical obstacles, in order to optimise engagement.

2.4.2 Limitations and Conclusions

The findings of this study should be considered in light of some limitations, including those that are inherent to the Delphi method. As a consensus-based method, Delphi does not involve experimental tests, and has the potential to restate received wisdom that may or may not be supported by other empirical data. Moreover, the strength of the evidence produced through this method is highly dependent on the sources of expertise that are available. As noted by Jorm (2015), however, research on the ‘wisdom of crowds’ supports the validity of group consensus judgements when certain conditions are met, and the Delphi method provides a systematic approach to ensure that these conditions are met. Notwithstanding its limitations, the Delphi method has a strong track record in mental research and allows researchers to answer questions in situations where experimental or meta-analytic tests are not directly applicable to a problem, or where existing data are extensive but complex for the purpose of drawing conclusions (Jorm, 2015). Given that Delphi research with practitioners focuses on the views of key end-users of interventions, findings are well suited to informing and promoting implementation of evidence-based practice in real world settings.

The focus here on PIs is based on extensive support for these interventions as the treatment of choice for conduct problems in early-to-middle childhood. The current model therefore reflects consensus regarding core competencies for the evidence-based treatment of

conduct problems for this age group. Distinct models of intervention supported for conduct problems in older children and adolescents, such as multisystemic therapy (van der Stouwe et al., 2014), may necessitate competencies that are somewhat distinct, and future research into those competencies is needed to build on the work presented here.

Although the scope of the current model is consistent with that of models for evidence-based interventions in other child and adult populations (e.g., Roth & Pilling, 2008; Sburlati et al., 2011), this broad scope limits the attention that can be given to each of these competencies individually. Research is especially needed to understand how to effectively support therapists in developing a number of these competencies, such as knowledge and recognition of factors related to culture and race and their significance to therapy. It should also be noted that the findings reported here do not address the relative or unique contributions of the respective competencies to change processes or child outcomes. Furthermore, while participants came from a range of countries, these were largely anglophone, and the southern hemisphere was poorly represented, with the exception of Australia and New Zealand. This reflects the countries in which research on these interventions has most often been conducted, yet limits the generalisability of our findings.

The testing of these competencies as active elements represents a key direction for future research, and could inform the further development and revision of core competency models. There is a particular need to build on the current study through process research based on the coding of therapist behaviour during sessions. This was previously undertaken to investigate the role of therapist behaviours in engagement and resistance to change among parents of children with conduct problems (e.g., Patterson & Chamberlain, 1994), yet has remained limited since. Programmatic research of this kind is needed to test our model in clinical settings and has much potential to support translation into training and practice.

It is important to recognise that the competent delivery of PIs is not always successful, and that clinically significant levels of conduct problems persist for as many as 50% of children in receipt of such treatment (Overbeek et al., 2021). Research with these non-responders remains limited, while recent advances in the development of novel interventions for high-risk subgroups, such as children with conduct problems and callous-unemotional traits (e.g., Fleming et al., 2022), have highlighted the need to regularly update competency-based models, especially those intended to inform practice with complex cases. Additionally, many children fail to benefit from these interventions because their parents decline to participate or face access barriers. In the Connect-Attend-Participate-Enact model (CAPE; Piotrowska et al., 2017), this initial recruitment into PIs is conceptualised as the first stage of clinical engagement (Connect), and the model argued that therapist competencies, as well as service-level practices, in part determine the success or failure of such connection with individual families. This may include the use of effective processes for inviting partners who disagree with the need for intervention, and flexible formats of delivery (e.g., eHealth) to overcome barriers to service access (Weisenmuller & Hilton, 2021).

It is noteworthy that some of the major themes emphasised by the expert panel here concerned topics that programmatic research has only recently begun to investigate, such as the transportation of PIs across cultures (e.g., Mejia et al., 2017), and the implications of child and parent trauma for specific PI components such as time-out (e.g., Roach et al., 2022). Ongoing research on these topics is therefore needed. In addition to informing clinical practice and training specific to child conduct problems, the current model has the potential to inform consensus-based research into core competency models for other disorders that are commonly a focus of parenting interventions, such as ADHD (Coates et al., 2015), and ASD (Green et al., 2017).

CHAPTER 3: Case Complexity in Child Conduct Problems and Core Therapist Competencies

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Superficial modifications have been made to the version below, including to wording and formatting. The published version in journal format is included in Appendix C.

3.1 Introduction

Evidence-based interventions for child conduct problems (e.g., oppositional and aggressive behaviour) are widely available, yet many factors may complicate the delivery of these interventions, and treatment for complex presentations of conduct problems remains poorly understood (Andrade et al., 2022; Fonagy & Luyten, 2018). At the same time, approaches to classifying such presentations as complex have often been inconsistent, thereby hampering progress. In the broader biomedical literature, *case complexity* has generally been defined as the presence of factors that make the delivery of treatment difficult (e.g., Kazdin & Whitley, 2006; Ruscio & Holohan, 2006; Safford et al., 2007; Schaink et al., 2012). It has been theorised that this complexity arises from a cumulative interplay between factors across multiple domains, spanning not only diagnostic features, but also environmental, socioeconomic, and cultural factors (Delgadillo et al., 2017; Shippee et al., 2012). Such a conceptualisation suggests that although the factors that drive case complexity may increase risk for poor treatment outcomes, nonresponse is not inevitable when case complexity is present. Importantly, optimal outcomes may depend in part on practitioner adaptations based on such factors (Georgiadis et al., 2020).

Multiple approaches to characterising presentations of conduct problems can be found in the literature. Diagnostic models of oppositional defiant disorder (ODD) and conduct

disorder (CD) have evolved in recent years to account for this heterogeneity and emphasise multiple factors associated with increased risk. This includes the introduction of specifiers (e.g., irritability-anger in ICD-11), subtypes (e.g., early-onset CD in DSM-5-TR), and severity classifications (e.g., for ODD based on number of problem contexts in DSM-5-TR). These models assume that clinical needs of children vary depending on such distinct presentations, based in part on evidence of treatment outcomes associated with risk pathways (Fairchild et al., 2019; Hawes et al., 2023). For example, the conduct problems of children with limited prosocial emotions are particularly severe and likely to persist following intervention, and novel treatment components for this group have therefore been subject to growing research (Perlstein et al., 2023).

Clinical presentations of conduct problems have also been described as complex due to factors beyond those specified within diagnostic models of ODD and CD. Most frequently, case complexity often refers to comorbid psychopathology (e.g., Dadds et al., 2012; Leijten et al., 2020; Weisz et al., 2012). Beyond comorbidity, clinical needs of children with conduct problems may also be complicated by contextual factors, which may impact adversely on treatment implementation and engagement, placing additional demands on practitioners. This includes caregiver-related factors, such as quality of parenting, parental psychopathology, and factors in the broader ecology of the child, such as cultural fit of the program, socioeconomic disadvantage, and other environmental stressors (Andrade et al., 2022; Chacko et al., 2016; Piotrowska et al., 2017).

Despite the broad range of factors implicated in complex needs of families presenting with child conduct problems, research has often operationalised such complexity on the basis of a single factor alone and has typically focused on individual factors in relative isolation. Based on treatment outcome research and clinical experience, Hawes and Dadds (2021) argued that the needs of children with complex presentations of conduct problems are best

represented across multiple domains. They proposed that the factors that contribute to case complexity among children with conduct problems relate largely to six dimensions. These dimensions reflect complexity arising from (1) the topography of the child's conduct problems (e.g., range and severity; settings occurring), (2) developmental and dispositional factors (e.g., language impairments; temperamental factors including callous and unemotional traits), (3) co-morbid child psychopathology (e.g., internalizing disorders; neurodevelopmental disorders), (4) quality of parenting (e.g., harsh or inconsistent discipline; parenting skill deficits), (5) parental characteristics (e.g., personality; mental health; parental attributions) and (6) the family system and social environment (e.g., interparental conflict; lack of social support; financial disadvantage). However, this model is yet to be tested empirically, and research continues to operationalise complex needs heterogeneously.

Variable definitions of *case complexity* in the literature hamper understanding of it and concerns have arisen amongst practitioners that complex client needs are not met by existing evidence-based parenting interventions for child conduct problems. A major criticism of treatment outcome research in child and adolescent mental health is that it has often been conducted under controlled conditions that may not reflect real-world clinical populations and settings, and this has resulted in a gap between research and practice related to factors of this kind (Ruscio & Holohan, 2006; Weisz et al., 2015). Indeed, lack of program fit with client and service needs and practitioner beliefs has been found to be a core barrier to use of evidence-based parenting interventions (Turner et al., 2011). Many therapists consider that overly rigid adherence to a manualised intervention detracts from therapeutic alliance or ability to respond to complexity arising during session (Addis & Krasnow, 2000; Chorpita et al., 2014). Literature has discussed that practitioners subsequently often perceive that evidence-based interventions would not benefit their clients with complex needs, and that they may be more likely to rely on clinical judgement to determine how to meet these needs,

which may be detrimental to clients (Ruscio & Holohan, 2006). Adaptation to client needs is recognised as necessary and common in community settings (Pinto et al., 2024), yet in the absence of guidelines concerning if and how practitioners should adapt programs, and what competencies therapists require to do so, many adaptations deviate from the evidence base (Moore et al., 2013), broadening the research-practice gap.

In the field of conduct problems, emerging research has targeted this gap by informing approaches to adapting evidence-based interventions based on the unique needs of a case (for a review see Andrade et al., 2022). Research aimed at decreasing the research-practice gap has included: examination of treatment effects associated with specific intervention elements or components (Garland et al., 2008; Leijten et al., 2019); development of transdiagnostic treatment components and modular models of delivery to address individual client needs related to complex comorbidities (Chorpita et al., 2005; Evans et al., 2021; Weisz et al., 2012); development of a framework for adaptations (Georgiadis et al., 2020); and interventions addressing caregiver factors affecting clinical engagement and benefit (Gonzalez et al., 2023; Jones et al., 2021). Such approaches have shown much promise in translational research. For example, the Modular Approach to Therapy for Children (MATCH; Chorpita & Weisz, 2005) has been found to improve both client outcomes and efficiency of services compared to treatment as usual (Chorpita et al., 2017; Merry et al., 2020; Weisz et al., 2012). Research into MATCH has highlighted the importance of better understanding therapist competencies to support optimal intervention delivery (Cecilione et al., 2021).

One novel and potentially important approach identified to further reduce this research-practice gap is to investigate practitioner perceptions of case complexity. Little is currently known about practitioner perceptions of the factors that contribute to case complexity among children with conduct problems, in terms of the specific features of a case

that are likely to complicate the delivery of evidence-based intervention and potentially cause practitioner deviation from evidence-based practice. These perceptions may be particularly important to understanding the demands that case complexity places on practitioners, and to understanding therapist competencies for the optimal delivery of evidence-based interventions with case complexity.

In implementation science, therapist competence has been conceptualised as a subcomponent of fidelity. Specifically, fidelity has been defined as comprising both adherence (i.e., implementation of program components as intended according to protocol) and competence (i.e., the quality with which this is done, including therapist skill and style of delivery) (Breitenstein et al., 2010; Martin et al., 2023). Notably, a recent systematic review found that fidelity was most consistently associated with parenting intervention outcomes when operationalised in terms of adherence, competence and knowledge, compared to studies in which it was operationalised only in terms of adherence or another single component (Basha et al., 2025). Associated outcomes included improved parenting behaviours and stress, and improved child behaviour, self-esteem, and adjustment. In addition to highlighting the significance of fidelity, this supports the importance of ongoing research into competence regarding the delivery of such interventions.

Therapist competencies for evidence-based practice have been subject to growing research in their own right across various fields of mental health. Drawing on the expert consensus (Delphi) method used to inform the Improving Access to Psychological Therapies (IAPT) initiative in the UK (Clark, 2018), Chapter 2 produced a comprehensive model of competencies for the evidence-based treatment of conduct problems. Such intervention was found to rely on a broad range of competencies, including 25 competencies related to general clinical practice in child mental health (e.g., knowledge of influence of cultural and racial factors on therapy); 27 specific to parenting interventions (e.g., use of experiential strategies

to teach skills); and 23 specific to the content of evidence-based interventions for conduct problems (e.g., nonviolent disciplining; caregiver-child relationship enhancement; see Chapter 2).

Therapist competencies may be particularly important to address complexity in treatment delivery. Practitioner perspectives on specific dimensions of case complexity, and what competencies may be particularly important to each, have not previously been examined. If practitioners perceive that case complexity has distinct dimensions, investigation of the specific competencies that are particularly important to each is also relevant, as these may differ between each and have implications for treatment adaptations. Whilst the term *case complexity* is used here for consistency with existing literature (Delgadillo et al., 2017; Hawes & Dadds, 2021a; Kazdin & Whitley, 2006), we wish to clarify that our use of the term refers to difficulties clinicians face due to the limitations of current clinical practices, rather than difficulties that are inherent in a client. The major aims of the current study were therefore twofold. First, we aimed to examine practitioner perceptions of the factors that contribute to case complexity among children with conduct problems. Specifically, we tested whether the model of key dimensions of case complexity proposed by Hawes and Dadds (2021) was supported by consensus among practitioners with high levels of experience in the delivery of evidence-based parenting interventions for conduct problems. Second, we examined practitioner perceptions of the therapist competencies necessitated by distinct features of case complexity when delivering these interventions. Of key interest was the relative importance that experienced practitioners place on specific competencies (see Chapter 2).

3.2 Methods

3.2.1 Participants

Participants consisted of an international expert practitioner panel, all currently practicing a social learning-based parenting intervention for conduct problems (hereby referred to as PIs), with at least 5 years of experience in PIs. 117 practitioners were invited by email, identified through relevant literature publications and recommendations from other practitioners who were recruited, including developers of established programmes. All interested eligible practitioners willing to complete the multiple rounds of data collection required (60 practitioners) were recruited with informed consent, with 49 participants completing the first round of data collection. The final sample, which was the same sample as that recruited for the Delphi study reported in Chapter 2, was demographically highly comparable to those initially approached regarding sex, nationality, profession, and research experience. Forty one participants completed all three main testing rounds, resulting in a high participant retention rate (84%) compared to similar Delphi studies (Morrison & Barratt, 2010; Spain & Happé, 2020). Twenty-eight participants completed the follow-up round (57% retention rate) – a comparable retention rate to similar Delphi studies that had fewer testing rounds, highlighting strong participant engagement (Bauer et al., 2019; Kim et al., 2021; Rubio et al., 2020).

Participants represented nine countries across three continents, including the United States of America (51% of participants), Australia (31%), Canada, New Zealand, England, Wales, Germany, Finland, and the Netherlands. Professions were predominantly psychology (73% of participants) and social work (10%), along with nursing, education, and psychiatry. Clinical experience spanned the major PIs for conduct problems (e.g., Parent-Child Interaction Therapy, 45% of participants practicing; Helping the Noncompliant Child, 24%; Triple-P, 24%; Incredible Years, 22%; Parent Management Training-Oregon Model, 22%;

Barkley's Defiant Child, 16%; Parent-Child Care, 14%). Practitioners had a mean of 18 years of experience in PIs, and 98% of participants reported working with case complexity in their current and/or previous positions. Varied settings were represented, including private practice, university/research clinics, community health including hospital-based care, and government child welfare agencies. All participants provided informed consent to participate and chose whether to be identified (see acknowledgements for names of identified participants).

3.2.2 Design

Practitioner perceptions regarding complex presentations of child conduct problems were examined through Delphi method consultation with the international expert panel. Data collection comprised three main testing rounds, undertaken in April-May, June-July, and September-October of 2022, with a follow-up round in July 2023 specifically to further examine competencies for complexity. Each round consisted of an approximately 30-50-minute questionnaire, for which participants were given two weeks to respond. Following Delphi method guidelines, consensus on proposed drivers of complexity, and competencies most vital for each, was developed through iterative questionnaire rounds in which participants provided qualitative responses and quantitative ratings (Chalmers & Armour, 2019). Participants remained anonymous to each other, whilst receiving summary feedback on panel responses in previous rounds, to encourage convergence of opinions. Participants could participate via videoconference (Zoom) interviews or via online questionnaires using the Qualtrics platform, whereby most chose the latter. Ethics approval was obtained from the University of Sydney Human Ethics Research Committee.

3.2.3 Procedure

The first round of testing consisted of three parts: (1) participant revisions to a preliminary model of core therapist competencies for PIs for conduct problems (reported in

Chapter 2); (2) participant revisions, including edits, additions, and omissions, to a proposed model of drivers of case complexity for conduct problems (Hawes & Dadds, 2021a); and (3) participant perceptions of what therapeutic competencies (from the proposed core competencies model or otherwise) they would draw on most, or see as most vital, to address each case-complicating dimension. These priority competencies for case complexity were developed alongside the model of drivers of case complexity to minimise testing rounds and hence optimise participant retention. In doing so, participants were asked to consider the term *complex* throughout the survey to mean “particularly challenging, demanding, or difficult to treat.”

Following Round 1, revisions were made to the model of case complexity for conduct problems by content analysis of participant responses. Round 2 focussed on obtaining participant perspectives on these revisions. Participants were asked to select whether they perceived further revisions necessary for each part of each model. Consensus support was received for the model of drivers of case complexity in Round 2 hence no further revisions were required. Round 3 therefore focussed on developing consensus on priority competencies specific to each driver of case complexity. For each driver, participants were presented with the priority competencies suggested in Round 1 and asked to identify those they perceived as most vital. A follow-up, Round 4, was implemented to refine consensus for priority competencies as consensus was not met in Round 3. In Round 4, participants were again asked to select which competencies they perceived as most important for each driver of case complexity and additionally, of those, rank their order of importance in addressing that driver. For each driver of case complexity, participants were informed of which competencies met consensus in the previous round, and which did not have agreement.

Content analysis of open-ended expert responses to Round 1 was conducted manually, to aptly revise the drivers of case complexity. Reliability of analysis was evidenced by the

researchers' agreement on content themes, drivers of case complexity, and wording of final competencies. Participant acceptability of the revised model showed the analysis had good validity (Chalmers & Armour, 2019). Data was deidentified to minimise bias. The criterion for consensus, consistent with recent Delphi studies, was 70% agreement for each individual driver of case complexity (Khazaie & Khan, 2020; Kim et al., 2021). For each priority competency, consensus required at least 70% of participants to both (a) rate the competency as "most" vital; and (b) rank the competency amongst the number most highly rated. This double consensus method was employed to optimise validity of consensus.

3.3 Results

3.3.1 Drivers of Case Complexity

Practitioners reached consensus regarding the factors that contribute to complex presentations of child conduct problems, and the grouping of these factors into seven dimensions, or drivers, of case complexity (see Table 3.1). 94% of experts agreed that the six-driver model proposed by Hawes & Dadds (2021a) was acceptable, that is, that it appropriately grouped factors associated with case complexity in child conduct problems. However, in Round 1, almost half of experts (42%) suggested revisions to this model. Consequently, each driver, except severity of child conduct problems, was revised by content analysis.

The final model of drivers contributing to complicating the delivery of PIs for child conduct problems consisted of seven drivers. Three drivers of case complexity concerned child-level factors: (1) conduct problem severity; (2) developmental history; and (3) comorbid child psychopathology and dispositional factors. Additionally, two drivers related to caregiver-level factors: (4) the caregiver-child relationship and parenting practices, and (5) parental characteristics; and two drivers related to ecological factors: (6) family context (e.g.

interparental conflict; cultural beliefs such as those that stigmatise mental health); and (7) broader social environment (e.g., legal system involvement; other systems involvement).

Experts reached consensus that factors related to parental characteristics, family context, and the broader social environment, always or almost always contributed to complexity among cases of conduct problems in early-to-middle childhood. Notably, practitioners also reached consensus regarding the cumulative nature of these drivers as they relate to overall level of complexity, with 94% of participants agreeing or strongly agreeing that “when more of these factors/dimensions are present, a case is likely to be more complex.” The remaining 6% of participants responded “neutral”; none disagreed.

3.3.2 Priority Competencies for Case Complexity

Expert practitioners also reached consensus on up to five competencies for each driver of case complexity that they endorsed as particularly important to achieve optimal outcomes when that driver is present (see Table 3.1). 508 priority competencies were initially identified by participants across the respective drivers of case complexity in Round 1. Following Round 4, experts reached consensus on 16 priority competencies across the drivers. Notably, consensus was not reached on all competencies, with additional competencies identified by 30-70% of participants as important. However, further rounds to reach more consensus were not possible due to attrition (Hasson et al., 2000; Sumsion, 1998).

The priority competencies identified by practitioner consensus for each driver of case complexity (Table 3.1) were adapted from those in the model of core therapist competencies described in Chapter 2. Of note, all priority competencies concerned generic therapeutic competencies and process skills/knowledge than specific parenting skills and techniques, and no priority competencies were identified for complexity driven by conduct problem severity. Competency regarding treatment planning was identified as important for the remaining two child-level drivers: for developmental history, this competency included adjusting treatment

plans for child factors including age, developmental needs, intellectual ability and other factors; whereas for comorbid child psychopathology and dispositional factors, this included helping the family prioritise the most significant concerns. Additional priority competencies were also identified for complexity driven by comorbidity and dispositional factors but not for developmental history. For each driver of case complexity beyond these child level-factors, a priority competency regarding the therapeutic relationship was identified.

Specifically, a focus on building the therapeutic relationship with primary caregivers before moving into active intervention was the only priority competency highlighted by practitioners for complexity driven by parental characteristics. For other drivers, additional priority competencies were also identified alongside those specific to the therapeutic relationship.

Priority competencies for ecological drivers of case complexity – family context and broader social environment – concerned assessment; culturally responsive and strengths-based practice; and the therapeutic relationship.

Table 3.1*Drivers of and Priority Therapist Competencies for Case Complexity in Conduct Problems*

Driver of complexity	Priority Therapist Competencies
<p><i>Severity of child conduct problems</i></p> <p>The frequency and range of problem behaviours/symptoms, and the range of settings in which symptoms create impairment (e.g., home, school, with peers)</p>	<p>No specific competencies were identified as particularly important above other competencies.</p>
<p><i>Child developmental history</i></p> <p>Developmental history as typically gathered in clinical assessment or reported in medical documentation. This includes language impairments, traumatic experiences etc</p>	<p>For treatment planning: Devise, implement, and revise treatment plans, collaboratively and flexibly, especially adjusting for child factors such as age, developmental needs, ability level and other factors (e.g., through additional modules/content)</p>

Comorbid child psychopathology and dispositional factors

Temperament, irritability, callous-unemotional traits, emotional dysregulation, ... internalising disorders like anxiety, depression and PTSD, neurodevelopmental disorders like ADHD

For assessment: Assess symptoms, developmental factors, and function of behaviour (functional analysis) including those related to comorbidities (e.g., self-injurious or repetitive behaviours in ASD), trauma and family histories, to identify most appropriate intervention(s) based on the child's needs

For treatment planning and delivery: Collaboratively and flexibly devise, implement, and revise treatment plans, helping the family prioritise the most significant concerns to address first in therapy, applying all parenting intervention skills in accordance with the needs of the individual child, to address what is possible for each presenting issue

For assessment, case formulation and goal setting: Use skills for evidence-based multi-method, multi-informant assessment to be very clear on the case formulation, diagnoses (including primary/secondary and disorder subtypes) and what factors are maintaining the problems, to therefore be clear on primary diagnoses or needs and consequent treatment goals and priorities

Caregiver-child relationship and parenting practices

Significant levels of: lack of warmth, engagement, positive affect, and sensitivity in caregiver-child relationship; permissive, harsh, or inconsistent discipline; parenting skill deficits

For therapeutic relationship: Build a collaborative therapeutic relationship with primary caregivers and repair any ruptures (e.g., by focusing on building rapport, showing empathy, seeking to understand the primary caregivers and prevent potential negative countertransference, and potentially engage them with additional techniques such as motivational interviewing); so that primary caregivers see the therapist as an ally, are willing to collaborate and build investment in the intervention including shared goals, and also can be challenged in their parenting without becoming defensive

For barriers to change: Support primary caregivers to overcome barriers to treatment & manage resistance to change (e.g., assess, formulate and manage barriers to engagement, including relational dynamics; apply motivational interviewing / motivational enhancement strategies)

For assessment: Assess quality and patterns of parenting and caregiver-child interaction, and drivers thereof, using valid methods of observation, interview and ongoing sessions

For strengths-based practice: Apply culturally responsive and strengths-based practices (e.g., acknowledging the unique experiences of families; recognising primary caregivers as experts on their child) – including to reduce negative countertransference

Caregiver-child relationship and parenting practices (cont.)

For goal setting: Collaboratively create and set concrete and measurable shared treatment and session goals with caregivers to encourage caregiver investment in the intervention and alignment with the therapist, even when addressing parenting deficits

Parental characteristics

Parental personality, mental health (e.g., depression, substance use), trauma history, or cognitive/affective processes (e.g., attributional biases, emotional flooding, poor self-regulation)

For therapeutic relationship: Develop and maintain a trusting therapeutic relationship with primary caregivers, with rapport and empathy, developing this before moving into active intervention, to engage primary caregivers as allies, gain access to information about family dynamics, reduce negative countertransference, and effectively intervene in parenting

<p><i>Family context</i></p> <p>Family structure and dysfunction (e.g., interparental conflict, parenting conflict with extended family); parental social and economic adversity (e.g., lack of social support, financial disadvantage); cultural beliefs, context and connectedness; intergenerational trauma; treatment history and experiences</p>	<p>For therapeutic relationship: Foster and maintain engagement with primary caregivers in a collaborative therapeutic alliance (e.g., identifying & inviting in the child’s parenting team; managing in-session conflict between caregivers; managing resistance and ruptures, including client challenges to the competence of the therapist)</p> <p>Culturally responsive & strengths-based practice: Apply culturally responsive and strengths-based practices, including recognising, understanding and clarifying the family’s unique perspectives, experiences and knowledge; integrating the value, role and influence of culture for the family into formulation, psychoeducation and discussions; and adapting interventions and specific techniques with cultural sensitivity and humility so that they’re in line with the family’s cultural beliefs and values</p> <p>For assessment: Conduct a thorough and broad assessment (including of intergenerational or historical trauma, family storyline, social support, the family’s ability to meet basic needs, culture, parental beliefs and cognitions, family dynamics such as responses to child behaviour, and other psychosocial factors), to understand the role of the broader context (including strengths and barriers) in the child’s presenting problems and develop realistic treatment expectations for planning and outcomes</p>
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Broader social environment

Historical and/or systemic oppression, systems involvement for the family (e.g., child protective services, juvenile justice, parental justice involvement)

For assessment: Conduct a thorough and broad assessment (including of intergenerational or historical trauma, family storyline, social support, the family's ability to meet basic needs, culture, parental beliefs and cognitions, family dynamics such as responses to child behaviour, and other psychosocial factors), to understand the role of the broader context (including strengths and barriers) in the child's presenting problems and develop realistic treatment expectations for planning and outcomes

Culturally responsive & strengths-based practice: Apply culturally responsive and strengths-based practices, including recognising, understanding and clarifying the family's unique perspectives, experiences and knowledge; integrating the value, role and influence of culture for the family into formulation, psychoeducation and discussions; and adapting interventions and specific techniques with cultural sensitivity and humility so that they're in line with the family's cultural beliefs and values

For therapeutic relationship: Foster and maintain engagement with primary caregivers in a collaborative therapeutic alliance (e.g., identifying & inviting in the child's parenting team; managing in-session conflict between caregivers; managing resistance and ruptures, including client challenges to the competence of the therapist)

Note. Competencies most frequently ranked most highly by participants are listed first for each driver. PTSD = post-traumatic stress disorder.

ADHD = attention-deficit/hyperactivity disorder

3.4 Discussion

Parenting interventions (PIs) for conduct problems are amongst the most well researched interventions in child and youth mental health, yet they appear to often fall short of meeting the complex needs of children and families. Little is known about practitioner perceptions of the factors that contribute to case complexity among children with conduct problems, that is, factors that make the treatment delivery process more difficult, or the therapist competencies necessitated by distinct features of case complexity. The current study is the first, to our knowledge, to examine practitioner consensus regarding these factors.

A model of drivers of case complexity originally proposed by Hawes and Dadds (2021), based on treatment outcome research, was acceptable to practitioners yet was found by the majority of participants to need revision, showing that it is not the model of best fit according to practitioners. The novel model produced here differs in both number and composition of these drivers and reflects consensus among expert practitioners from diverse practice settings and interventions, across nine countries. The current model therefore integrates treatment outcome evidence with the practitioner perspective, to provide a novel account of case complexity among children with conduct problems. These drivers of complex client needs include factors that complicate the treatment process but may not have a negative effect on outcomes of PIs, and, in the case of severity, may indeed have a positive effect on child conduct problem outcomes (e.g., Leijten et al., 2020), indicating that case complexity does not equate to nonresponse if intervention is delivered competently. Our findings also build on Chapter 2 regarding practitioner competencies for the delivery of evidence-based interventions for conduct problems, by identifying specific therapist competencies of key importance for each distinct driver of case complexity.

The first three drivers in this novel model of case complexity in child conduct problems relate to child-level factors: (1) conduct problem severity; (2) developmental

history; and (3) comorbid child psychopathology and dispositional factors. These largely reflect child-level features specified in current approaches to classifying disruptive behaviour disorders in DSM-5-TR and ICD-11, including diagnostic specifiers for high-risk subtypes therein. Interestingly, practitioners endorsed a model in which child characteristics such as irritability and callous-unemotional traits were represented on a dimension incorporating comorbid child psychopathology and dispositional factors, separate to a developmental history dimension. This represents a modification to the original Hawes and Dadds (2021) model, and is consistent with qualitative responses from participants indicating a perception that the implications of such characteristics for treatment are often more considerable than those associated with common risk factors in a child's developmental history (e.g., language delays), and that they can be difficult to distinguish from comorbid symptoms in clinical practice. This is also consistent with transdiagnostic accounts of these characteristics (Chin et al., 2025; Hawes et al., 2023).

Two caregiver-level drivers in the model of case complexity comprised (4) caregiver-child relationship and parenting practices; and (5) parental characteristics. This is consistent with literature showing that caregivers play a critical role as agents of change in evidence-based interventions for conduct problems, and that both the caregiver-child relationship and specific parenting techniques contribute to change processes in these interventions (Leijten et al., 2018). The final two drivers in the current model, family context and broader social environment, further highlight a distinction between case complexity arising from these two factors, which were considered one dimension in the previously proposed model (Hawes & Dadds, 2021a). These have both previously been found to impact adversely on engagement with clinical services and the translation of treatment delivery into enduring change in PIs (Piotrowska et al., 2017; Weisenmuller & Hilton, 2021).

In addition to characterising distinct types of factors that serve as drivers of case complexity, our results support a cumulative perspective on the contribution of these drivers to case complexity, consistent with models of complexity in physical health literature (e.g., Shippee et al., 2012). This does not preclude the possibility that a case may present as highly complex based on factors within a single domain (e.g., multiple comorbidities). Importantly, however, the emphasis here on high case complexity often spanning distinct risk-factor domains diverges considerably from research in which such complexity has been operationalised based on a single factor alone (e.g., comorbidity; Aitken et al., 2018; Dadds et al., 2012), or research that investigates multiple drivers of case complexity but neglects to explore the cumulative effect of these (e.g., Kazdin & Whitley, 2006; McMahon et al., 2021).

It is noteworthy that practitioners working in diverse settings demonstrate consensus regarding some of the competencies of distinct importance for responding to specific drivers of case complexity. Our findings can be seen to validate the distinction between the respective drivers, and to support the utility of this distinction in clinical practice. However, practitioner consensus on priority competencies for case complexity was not reached on all competencies in the current study, suggesting diversity among practitioners' responses to case complexity. This supports the need for further research, including implementation research (Pinto et al., 2024), and more specific frameworks for how and when to use adaptations (Georgiadis et al., 2020).

It is noteworthy that no priority competencies were identified for complexity arising from severity of child conduct problems. This suggests that practitioners may perceive all core competencies as equally important for highly severe presentations, consistent with literature showing that children with severe conduct problems benefit particularly well from existing PIs as delivered in standard practice (Leijten et al., 2018), and that adapting these interventions beyond their core components of caregiver-child relationship enhancement and

effective non-violent discipline may lead to reduced benefit for severe conduct problems (Leijten et al., 2022). Regarding other child-level drivers of case complexity, treatment planning appeared in priority competencies for both complexity due to child developmental history and that due to comorbid child psychopathology and dispositional factors. This focus on tailored treatment planning is consistent with literature highlighting the importance of formulation-driven practice (Andrade et al., 2022; Day et al., 2011; Hawes & Dadds, 2021a), and shows further support for modular models of intervention to which formulation and individual treatment planning is central (Chorpita et al., 2005; Weisz et al., 2012).

The current findings also emphasise the importance of process-related competencies, beyond competencies related to specific PI skills, when case complexity stems from caregiver-level and ecological factors. No priority competencies were related directly to the content of specific parenting skills or techniques in PIs for conduct problems. Rather, priority competencies for caregiver-level and ecological drivers of case complexity most frequently concerned generic therapeutic competencies, that is, competencies common across all child and family therapy settings (see Chapter 2). This focus on generic therapeutic competencies is consistent with longstanding evidence that common therapeutic factors, including therapeutic alliance, and agreed activities and goals, account for greater variance in outcomes than specific therapeutic techniques (Lambert & Barley, 2001). Literature on PIs specifically also supports this, emphasising the importance of therapeutic engagement competencies for program effectiveness (Piotrowska et al., 2017). Indeed, a PI developed specifically for families with complex child conduct problems, the Helping Families Programme, focuses substantially on such competencies (Day et al., 2011). In light of previous research, the current findings suggest that the effective use of clinical process strategies is particularly critical for supporting children and families with complex needs.

The current model of drivers of case complexity and corresponding therapist competencies point to key priorities for future research to reduce the research-practice gap highlighted in recent literature (Andrade et al., 2022). Most importantly, treatment process and outcome research is needed to better understand the processes by which these drivers of case complexity can affect treatment outcomes. We predict this may include at least four broad processes, the most common being disruption to parental engagement at any stage of treatment (e.g., attendance, implementation; Piotrowska et al., 2017). Secondly, when ecological-level drivers of case complexity also perpetuate the disruptive child behaviours (e.g., interparental conflict) they may continue doing so if not adequately addressed in an intervention; the same may be true for child-level drivers associated with risk mechanisms not typically targeted in standard intervention (e.g., callous-unemotional traits). Finally, therapists often respond to case complexity with treatment adaptations, which may improve outcomes for complex cases, but also have the potential to contribute to nonresponse when evidence-based components are modified or removed by practitioners unnecessarily (Hawes & Dadds, 2021a; Roach et al., 2022).

We predict that a consistent approach in research to characterising complex presentations, based on such a model, would enhance the quality of clinically applicable evidence available. Secondly, given that distinct competencies appear to be of key importance to these drivers, it is vital that intervention research addresses the significant heterogeneity that is known to characterise clinical populations of children with conduct problems (Andrade et al., 2022). Guidelines for adaptations based on this heterogeneity are nonetheless necessary to ensure their effectiveness (Hasson et al., 2023).

In clinical settings, consistent use of the current model to characterise complex presentations of conduct problems may support evidence-based practice in various ways. Firstly, this model suggests a key focus be placed on the early identification and assessment,

for each client, of the child and family factors represented by the respective drivers of case complexity. Likewise, these factors should be accounted for in formulation-driven treatment planning, such that the intervention delivery is adapted to meet the unique needs of the case and optimise clinical engagement where possible. Furthermore, this model offers multidisciplinary teams a shared language to facilitate communication at the service-level, where policy regarding referral, or the allocation of limited resources, may be based on criteria related to the complex needs of a case. Our findings likewise highlight that particular competencies may be beneficial to emphasise in practitioner training and supervision for complex client presentations, and that these may differ based on complexity profiles common to a particular service.

Our findings should be considered in light of some limitations. The current study focussed on the evidence-based treatment of conduct problems in early-to-middle childhood and may not be representative of case complexity and associated competencies necessitated by presentations of conduct problems in older ages. Additionally, despite a broad international sample, participants largely represented Western, educated, industrialised, rich, democratic (WEIRD) countries. The research team aimed for a more heterogeneous sample, with contact attempts to practitioners in other countries either unsuccessful or limited by availability of contacts. Therefore, findings may not be generalisable to other population groups. Intervention research in more diverse populations remains a high priority for the field of child conduct problems (Fairchild et al., 2019; Hawes et al., 2023). Finally, while widely used to establish consensus in health research, the Delphi method may restate received wisdom that may or may not be supported by other empirical data. Therefore, further research should test the relative contribution of identified priority competencies to treatment outcomes for families with various complex needs. This could support the development of clinical

practice guidelines to assist practitioners to make evidence-based adaptations, which may differ according to different drivers of complexity.

There is much to be gained by adopting a consistent approach to characterising the complex needs of children with conduct problems in research and practice, and our findings have the potential to inform such an approach. An expert panel identified therapist competencies of key importance to seven distinct drivers of case complexity among children with conduct problems, thereby supporting the differentiation of these drivers in clinical training and decision-making. The more that complexity arises from multiple drivers, especially those based in the family context and broader social environment of the child, the more likely it appears to be that optimal outcomes may rely on generic therapeutic competencies including process skills. There is a pressing need for coordinated, standardised, evidence-based approaches to complex presentations of child conduct problems. The current findings can inform further research, including into the development and implementation of formal practice and training guidelines to better meet the complex needs of children with conduct problems in real-world clinical settings.

CHAPTER 4: Development and Validation of a Competency-Based Tool for Therapists Delivering Parenting Interventions for Disruptive Child Behaviour

The following chapter has been submitted for publication to a peer-reviewed journal. Superficial modifications to wording and formatting have been made to the version below to fit the thesis.

4.1 Introduction

Disruptive behaviour problems (e.g., conduct disorder and oppositional defiant disorder) are the leading cause of mental health burden in children up to 14 years of age (Ferrari et al., 2022). As such, they are considered a mental health priority (Hawes et al., 2023). The interventions with the strongest evidence for disruptive child behaviour are social learning-based parenting interventions (PIs), which have been manualised and widely disseminated in several packaged programs (Kaminski et al., 2024; Leijten et al., 2025). Research based on the common elements of these programs has grown considerably in recent years and has highlighted the content and processes implicated in change during PIs (Eskandari et al., 2020; Garland et al., 2008; Leijten et al., 2019). Building on this work, Chapter 2 produced a model of the therapist competencies common to the delivery of PI programs by consensus-validation amongst an international panel of expert clinical supervisors. Emerging research of this kind has potential to inform novel approaches to competency-based training in PIs, which represents an important topic in its own right.

Competency-based training has been recognised as best practice for training mental health therapists (Gonsalvez et al., 2021). Such training focuses on identification of specific competencies (skills, knowledge and attitudes) and development of learning and assessment strategies to meet these (Falender & Shafranske, 2007). Competency-based training has become increasingly used since the early 2000's (Gonsalvez et al., 2021; Kaslow et al., 2004). Its growth in popularity has been in part driven by increasing regulation of training

programs and funding access (Fouad et al., 2009; Rodolfa & Schaffer, 2019), and rising expectations of therapist competence from consumers, regulators and policymakers (Hoge et al., 2005). Additionally, benefits of competency-based training compared to input-based training that relies on client hours and/or experience, have encouraged this shift.

Competency-based training has been successfully used internationally to upskill therapists at scale in both public services and low resource settings (Clark, 2018; Kohrt et al., 2024). It provides a clear structure both for ecologically valid evaluation and for skill progression, by identifying individually-tailored target learning areas (Gonsalvez & Calvert, 2014). Furthermore, competency-based training may better support therapists to respond to complex presentations by supporting them to use appropriate, evidence-based adaptations (as discussed in Chapter 3). This can allow greater flexibility within evidence-based interventions such that client outcomes may improve (Fonagy & Luyten, 2019). Collectively, these features highlight the broad utility of competency-based training.

This shift towards competency-based training has spurred the generation of various competency models in various fields of mental health, which map out therapist competencies for clinical practice. Some models outline general therapist competencies of broad relevance across multiple interventions and stages of training. One such example is the competency cube (Rodolfa et al., 2005), which identifies foundational competency domains, functional competency domains, and stages of professional development. General competency models also include those designed for post-graduate psychology training programs in Australia (Psychology Board of Australia, 2025) and the UK (The British Psychological Society, 2025). Other competency models also include intervention-specific competencies, or limited-domain or technical competencies, which pertain to skills and techniques needed to execute a specific intervention to a sufficient standard (Barber et al., 2007). A seminal example of an intervention-specific competency model is that constructed by Roth and Pilling (2008) for

cognitive behaviour therapy (CBT) in the UK's National Health Service (NHS) Talking Therapies Initiative (or IAPT; National Collaborating Centre for Mental Health, 2023). Using the same Delphi method as Roth and Pilling to attain expert consensus, intervention-specific competency models have also been produced for child and adolescent internalising problems (Sburlati et al., 2011), and more recently for PIs for disruptive child behaviour (see Chapter 2). The PI competency model in Chapter 2 outlines individual, operationalisable competencies, organised under 15 competency areas, across three domains: generic therapeutic competencies; parenting intervention competencies; and competencies for promoting specific parenting skills and techniques.

Core competency models and competency rating tools are a foundational component of competency-based practice (Rodolfa & Schaffer, 2019). However, to the authors' knowledge no consensus-validated competency models for specific child mental health problems, including for PIs, have been translated into competency rating tools. Tools for evaluating and supporting therapist competence in clinical practice are imperative for tracking skill development, identifying training needs, and promoting ongoing refinement of practice (Martin et al., 2021; Rice et al., 2025; Simons et al., 2013). For instance, one competency rating tool for CBT for psychosis has been shown to discriminate between therapists with different levels of training (Haddock et al., 2001). This suggests that competency rating tools may help identify if a therapist is sufficiently trained. Additionally, repeated clinical supervisor and trainee ratings on another CBT competency rating tool throughout training found that both trainee competence and trainee-supervisor agreement on competency ratings increased with training (Beale et al., 2020). These findings indicate that the process of competency assessment and feedback can support self-reflection and professional goal development (Epstein & Hundert, 2002). Evidence hence suggests that use of competency rating tools is beneficial to mental health therapist training and practice. The

recently developed core competency model for PIs (see Chapter 2) raises the question of whether such a model can be translated into a competency rating tool, to support training in the important area of disruptive child behaviour problems.

The major aim of the current study was to translate the PI core competency model in Chapter 2 into a training and supervision tool that is acceptable, appropriate and feasible for use in diverse clinical settings. This was done in two parts. The aim of the first part was to co-design the tool—the Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour rating tool (CoPPI)—with clinical supervisors in PIs. The second part then aimed to examine the validity and implementability of the tool with supervisors and supervisees, including comparative tests of versions that differed in number and breadth of ratings.

Implementability was examined throughout the translation and design of the CoPPI because this is critical to producing a practical training tool. Proctor et al. (2011) identified eight implementation outcomes relevant to mental health interventions—acceptability, adoption, appropriateness, cost, feasibility, fidelity, penetration, and sustainability—which have been previously applied specifically to PIs (Pinto et al., 2024). Among these, acceptability, appropriateness and feasibility are partially assessable by survey of stakeholders based on preliminary tool use, without full implementation of the tool, and were accordingly examined in the current study. Research suggests that competency rating tools for clinical practice must be user-friendly, brief, simple, and resource-efficient (Hatcher et al., 2013; Muse & McManus, 2013). However, existing tools in other interventions often demand extensive training, such as the 30 to 76 hours required for rating the Cognitive Therapy Scale–Revised (CTS-R; Blackburn et al., 2001; Muse & McManus, 2013), placing further strain on stretched supervisory resources. Roth & Pilling (2008) similarly highlighted the need for brevity, recommending that their model be simplified, or select competencies used,

if it were translated into a competency rating tool. To enhance implementability of tools, co-design approaches, such as focus groups and iterative methods, have been previously employed in developing competency rating tools (Böhm et al., 2022; Kohrt et al., 2015; Rice et al., 2022). Thus, co-design is a core strategy for informing the development of implementable tools.

4.2 Method

4.2.1 Participants

Participants in the initial co-design interviews were clinical supervisors of therapists delivering PIs for disruptive child behaviour, invited to participate via professional networks. Recruitment was international, with sixteen supervisors participating from five countries (Australia, United States of America, New Zealand, Netherlands, United Kingdom), with a mean of 18.8 years' experience in PIs ($SD = 13.7$). Supervisors spanned major PIs, including Triple P, Parent-child Interaction Therapy (PCIT), Integrated Family Intervention (IFI), Incredible Years, Barkley's Defiant Child, Helping the Non-Compliant Child (HNCC), and Parent Management Training–Oregon (PMTO).

For the validity and implementability sample, clinical supervisors and supervisees in PIs for disruptive child behaviour were invited to participate. Supervisees were defined as any therapists currently, or within the last 12 months, receiving individual supervision specifically in a PI, on a routine basis. Participants were again recruited via professional networks, with individuals and services contacted in 36 countries across seven continents (full list in supplementary materials). Seventy completed questionnaires were received from participants across several PI programs, including all programs in Part 1 and some additional (e.g., Kazdin's parent training model). Three participants were excluded due to missing data ($n = 2$) and ineligibility ($n = 1$; disruptive child behaviour not primary to their intervention), resulting in 36 supervisor and 31 supervisee responses. Supervisees had a mean of 3.2 years'

experience in PIs ($SD = 4.3$). Supervisors had a mean of 18.1 years' experience in PIs ($SD = 10.2$), with demographics similar to Part 1. Demographics for participants in both parts are shown in Table 1.

Table 4.1

Participant demographics

Variable	Co-design (<i>n</i> = 16) <i>n</i> (%)	Validation – supervisors (<i>n</i> = 36) <i>n</i> (%)	Validation – supervisees (<i>n</i> = 31) <i>n</i> (%)
Hold relevant postgraduate qualification	14 (87.5)	34 (94.4)	24 (77.4)
Cis-gender female	11 (68.8)	29 (80.6)	26 (83.9)
Country of practice			
Australia	11 (68.8)	13 (36.1)	20 (64.5)
United States of America	2 (12.5)	13 (36.1)	7 (22.6)
Other (New Zealand, Netherlands, United Kingdom, Germany, Hong Kong, Iceland, Japan, Lebanon, South Korea, Turkey)	3 (18.8) ^a	10 (27.8)	4 (12.9)
Profession			
Psychologist (incl. provisional)	15 (93.8)	32 (88.9)	28 (90.4)
Other (nurse, social worker, counsellor, paediatrician)	1 (6.3)	4 (11.1)	3 (9.7)
Workplace setting			
University/research clinic	11 (68.8)	18 (51.4)	22 (71.0)
Private practice	7 (43.8)	8 (22.9)	7 (22.6)
Community health incl. hospital	2 (12.5)	9 (25.0)	5 (16.1)
Other government	1 (6.3)	6 (17.1)	1 (3.2)
Other (e.g., NGOs, non-profits, training facilities, schools)	1 (6.3)	4 (11.1)	3 (9.7)

Note. NGO = non-government organisation.

^a This participant also practiced across several low- to middle-income countries in Africa, South American and Southeast Asia.

4.2.2 Materials

Competency Rating Tool (CoPPI)

Part 1 prototype. The 75-item competency rating tool prototype developed from the core competency model for parenting interventions in Chapter 2 was used in Part 1. In the prototype, participants were asked to rate each competency on a 5-point Likert scale adapted from a previously developed competency measure for mental health clinicians (0 = *no evidence [of appropriate contextual use of competency]*, 1 = *sometimes shows evidence*, 2 = *half the time*, 3 = *most of the time*, 4 = *almost always*; Moskoei et al., 2017). A *not applicable* option was also provided as per a related supervision measure (Hamilton et al., 2022). This option allowed flexibility in use of the tool so that scores may account for therapeutic context, stage and complexity, which previously developed competency rating tools have not supported (Muse & McManus, 2013; Waltz et al., 1993).

Part 2 versions. Based on Part 1 findings, two versions of the CoPPI were developed to examine therapist preferences for each: a short version consisting of higher-level domain ratings (15 items, rating competency areas); and a long version providing greater depth in competency ratings (77 items, rating individual competencies). Each of these versions used a 7-point rating scale with description to rate each item, with competence levels *not yet competent* (0 to 1), *novice* (1 to 2), *advanced beginner* (2 to 3), *competent* (3 to 4), *proficient* (4 to 5), and *expert* (5 to 6). This response format is adapted from the Cognitive Therapy Scale-Revised (CTS-R; Blackburn et al., 2001), which has been shown to have high internal consistency and adequate inter-rater reliability (Blackburn et al., 2001). The CTS-R is used to assess competency-based training in the NHS (Clark, 2018; Liness et al., 2019b), and is based on the seminal Dreyfus model of competency acquisition (Sharpless & Barber, 2009). Some adaptations were made in the CoPPI ratings compared to the CTS-R: *incompetent* was revised to *not yet competent* to promote constructive supervision discussion and learning, as

per another measure of therapist competence (Rice et al., 2022), and an additional *insufficient evidence* option was included to support flexibility and interpretation of scores.

Other revisions to the Part 1 CoPPI prototype were also made based on findings prior to Part 2. Firstly, Part 2 versions included a downloadable *Frequently Asked Questions* document and a discussion scaffold for supervision (see supplementary materials) to support its utility. Secondly, on-page text was reduced and simplified by addition of links for further information; revision of wording, inclusion of definitions for specific terms; and addition of examples for specific competencies, available through hover icons. Thirdly, three competencies were also revised (see supplementary materials), such that 77 competencies were included, as shown in Figure 1. Competencies otherwise remained consistent with those developed in the original competency model in Chapter 2. Fourthly, a “focus” feature was introduced, which allowed respondents to select specific competencies to re-rate on subsequent completions (exemplified to participants but not used given the single timepoint in the current study). Finally, a new summary page was developed that included graphs with summary scores for each competency area and type; a table summary of ratings with corresponding competency level to support interpretation; and a list of any selected focus competencies.

Validity

The Therapist Self-efficacy Scale (T-SES; Gori et al., 2022) was used to measure the convergent validity of the CoPPI. It was initially designed to assess confidence of psychologists and psychotherapists in their skills (Gori et al., 2022), although strongly overlaps with the construct of competence and has been used previously to measure convergent validity of a competency measure for psychological intervention (Rice et al., 2022). The T-SES is a 21-item measure with a 5-point Likert scale (1 = *completely disagree* to 5 = *completely agree*). The respondent responds “during psychotherapy sessions, I am able

to...”, with items including “express verbal interventions effectively”; “promote therapeutic alliance”; and “be welcoming.” For the purposes of this study, “psychotherapy” was changed to “parenting intervention,” and “I am able to” was changed to “my supervisee is able to” for supervisors; no item wording was changed. The T-SES is reported to have good internal consistency ($\alpha = 0.93$; Gori et al., 2022), which the current study upheld ($\alpha = 0.92$).

Additionally, face validity was measured by participant agreement with the statement “the CoPPI items measure practitioner competencies” on a Likert scale (1 = *strongly agree* to 5 = *strongly disagree*).

Implementability

Acceptability, appropriateness and feasibility were measured using Weiner and colleagues’ (2017) scales (the Acceptability of Intervention Measure [AIM]; Intervention Appropriateness Measure [IAM]; and Feasibility of Intervention Measure [FIM]). Each scale included four items rated on a 5-point Likert scale from 1 (*completely disagree*) to 5 (*completely agree*), with items such as “the [CoPPI] meets my approval,” the [CoPPI] seems fitting,” and “the [CoPPI] seems implementable.” The AIM, IAM and FIM have all shown good structural validity, test-retest reliability and discriminant validity, and have been widely used including within mental health interventions (e.g., Grønlie et al., 2024). Cronbach’s alphas in the current study for the AIM, IAM and FIM were .84, .93 and .86, respectively, similarly to previously reported (Weiner et al., 2017). Sustainability and intent to adopt were also assessed, through agreement on the same 5-point Likert scale to two statements: “It would be sustainable for me to maintain use of the CoPPI as a routine tool,” and “I would be interested in adopting the CoPPI for my clinical practice.”

Figure 4.1. Core Therapist Competencies Indexed in the CoPPI

Generic Therapeutic Competencies	Parenting Intervention (PI) Competencies	Specific Parenting Skills/Techniques
A. Practicing professionally 1. Codes of conduct 2. Supervision and development 3. Research evidence 4. Reflective practice 5. Systems knowledge 6. Limits of expertise	E. Understanding relevant theory and research 1. Behavioural theories 2. Implementation based on theory 3. Additional theoretical perspectives 4. Risk, maintenance and protective factors 5. Adult mental health strategies	H. Psychoeducation 1. Child development 2. Caregiver-child interactions
B. Understanding relevant child and family factors 1. Child development 2. Culture and race 3. Family structure, experiences, dynamics 4. Child psychopathology and individual differences 5. Adult psychopathology	F. Family-based formulation and treatment planning 1. Formulation 2. Treatment planning 3. Communication of formulation 4. Treatment goals 5. Roles in treatment 6. Engagement of wider network 7. Progress monitoring 8. End of treatment planning 9. Limits of treatment	I. Reinforcement of positive behaviour 1. Social rewards 2. Tangible rewards J. Nonviolent disciplining 1. Time-out 2. Planned ignoring 3. Natural/logical consequences
C. Building a therapeutic relationship 1. Engaging primary caregivers 2. Maintaining engagement with primary caregivers 3. Inclusive practices 4. Hope and optimism 5. Therapeutic alliance with child 6. Age-appropriate engagement 7. Partnerships and stakeholders 8. Culturally responsive and strengths-based practices 9. Therapist modelling	G. Collaboratively conducting caregiver-focused sessions 1. Session goals 2. Communication of rationale 3. Client feedback 4. Flexible technique implementation 5. Experiential strategies 6. Technique monitoring and shaping 7. Sensitivity to parental factors 8. In-session family collaboration 9. Strategy implementation between sessions 10. Between-session activities 11. Information sharing 12. Family boundaries and routines 13. Barriers to treatment and resistance to change 14. Technology use	K. Proactive parenting 1. Effective commands 2. Rule setting 3. Child monitoring and supervision 4. Structuring the environment
D. Conducting a thorough assessment 1. Assessment method 2. Integration of reports 3. Diagnosis 4. Assessment areas 5. Assessment of violence and risk 6. Parental assessment skills		L. Relationship enhancement 1. Quality caregiver-child time 2. Empathic responding 3. Active listening
		M. Skills for caregivers to improve their own wellbeing 1. Emotion regulation and stress-management skills 2. Problem-solving and conflict management skills 3. Partner/social support 4. Self-care skills
		N. Skills caregivers teach children 1. Child emotion regulation skills 2. Child problem-solving skills 3. Child social skills 4. Child general learning and life skills
		O. Coordination of parenting skills/techniques 1. Technique coordination and consistent implementation

Note. Figure adapted from Chapter 2. CoPPI = Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour rating tool.

Other participant perceptions were also investigated. Firstly, perceptions of use of supervisor-report and sharing of scores were examined (see Table 4.2 for specific questions). Secondly, perceptions about the length of the scale were also investigated, given this was raised as a barrier during Part 1. Additionally, therapist preference for CoPPI version (short or long); interest in a printable PDF version of the tool; and interest in other features of the tool (e.g., graphs, item detail), were also assessed through multiple choice questions. Finally, participants were given the option to leave any additional comments.

4.2.3 Procedure

Part 1 involved completing the CoPPI online and then partaking in a semi-structured interview either online or in-person about the experience of completing the CoPPI. Participants received a link to an online survey hosted through *RedCap*, which first required them to complete informed consent and demographic questions, then the CoPPI prototype, to which participants were asked to respond based on competence of a specific supervisee. Participants then selected interview time and format preferences (group versus individual; in-person or online). Nine individual interviews and two focus groups were conducted online via *Zoom*; one focus group was conducted in person [location masked]. Semi-structured interviews focused on implementability of the CoPPI. Questions assessed acceptability (e.g., what participants liked and disliked about the tool); appropriateness (e.g., what rating scale and what specific competencies felt most relevant); and feasibility (e.g., how frequently participants would consider using the tool). Sample questions are available in supplementary materials.

Part 2 (validation) assessed convergent validity, face validity and implementability of the CoPPI through an online anonymous survey. Participants completed informed consent, then were alternately assigned (separate alternation for supervisors and supervisees) to either complete the short or long version of the CoPPI. Each participant completed the assigned

CoPPI version, followed by the validity and implementability measures and then demographic questions. Supervisors completed the CoPPI and T-SES regarding a supervisee, whereas supervisees completed self-report. Names and emails were stored separately to study data and only collected from participants who consented to contact for study results or future research.

4.2.4 Analyses

Part 1 interviews and focus groups data were analysed by framework analysis as per Gale et al., (2013). Data transcription was completed using *Trint* (Trint Limited, 2022), an AI transcription software (ISO 27001 and Cyber Essentials certified), and revised by the primary researcher to ensure accuracy. Transcripts were deidentified and all words and clear utterances were transcribed. Subsequent qualitative data analysis was completed in *NVivo* (Lumivero, 2023). After preliminary coding by the first author, codes were confirmed in consultation with another member of the research team to develop a working analytical framework, against which all transcripts were then coded; some secondary coding was also completed by this team member, with discrepancies between coders discussed and resolved. An inductive approach to coding was used to determine three frameworks: uses and benefits; barriers to use; and recommended changes to optimise the tool's utility in routine practice settings. Themes and codes within each framework were then developed deductively from data.

Part 2 (validation) data were analysed with inferential statistics using SPSS. On visual inspection of histograms, CoPPI and T-SES total scores were not normally distributed, hence Spearman's correlation coefficients were calculated to measure convergent validity of the CoPPI to the T-SES. These correlations were performed for each version of the CoPPI (long and short), and for each participant type (supervisors and supervisees). Internal consistency of each of the three competency types within the CoPPI was calculated by Cronbach's alpha.

Mann Whitney U tests were used to examine differences between conditions for face validity, AIM, IAM and FIM scores. For sustainability and intent to adopt, response frequencies are reported. A Fisher exact test was used to investigate differences in preferences between for each version of the CoPPI.

4.3 Results

4.3.1 Part 1: Co-design of the tool

Responses in co-design focus groups and individual interviews were broadly captured under three topics, including: 1) *uses and benefits* of the CoPPI; 2) *barriers* to its use; and 3) *recommended changes* to the prototype. Themes and codes under each topic are shown in Figure s1 and detailed in full in supplementary materials. Two themes were identified regarding *uses and benefits*: framework and implementation, with codes under each. Results showed that strengths of the CoPPI lay in its use as a framework for supervision and training. The CoPPI was found to offer a specific, detailed structure to support supervision, including through aiding assessment and tracking. It was also identified as a potential support for clinical supervisors, to help reflect on specific competencies of a supervisee and therefore to identify potential blind spots about the supervisee's competence. Participants found that the CoPPI could also therefore provide a focus for practice by identifying specific learning needs, hence encouraging supervisee reflective practice. Finally, codes under *implementation* highlighted that the CoPPI was perceived as relevant, helpful and usable, and that the ability to tailor the tool was helpful.

The second topic, *barriers*, included three themes: acceptability, appropriateness and feasibility. Codes under *acceptability* highlighted that the assessment-like design of the CoPPI prototype could be perceived as uncomfortable in employment settings; that wording in parts was unclear or imprecise; and that the interface was difficult to navigate. Findings regarding *appropriateness* barriers included that some competencies were not relevant for

particular training or supervision contexts; that the frequency-based rating scale could be difficult to use meaningfully; and that guidance on interpretation of scores and appropriate subsequent actions was not provided. Finally, *feasibility* barriers included length and time needed to complete the CoPPI; and insufficient opportunity for clinical supervisors to accurately rate supervisee competencies.

Themes within *recommended changes* included *content*, *process* and *context*, where findings largely addressed barriers identified above. The current study focused on *content* and *process* as these relate to design of the tool. Firstly, findings highlighted a need for minor changes to content of the tool. Specifically, findings included a need for improved clarity of instructions, minor adjustments to wording for clarity or inclusivity (e.g., “parent” to “primary caregiver”), and addition of detail to individual competencies including examples. Another main finding was that a more relevant and detailed scale, highlighting quality over frequency of implementation, was needed to ensure meaningful ratings.

Second, *process* findings indicated a need to refine certain features of the CoPPI prototype in order to support its utility in routine clinical practice. For instance, supervisors highlighted that respondents should be able to selectively focus on specific competencies. Participant perspectives varied as to whether the “focus” should be based on (a) guidelines of particularly vital competencies, (b) expectations at a particular level of training, or (c) individual needs of the supervisee. Another *process* finding was that summary feedback provided following tool completion should be supportive rather than directive, with graphs of summary scores particularly recommended. Furthermore, a need for amendments to the tool interface was also identified, particularly to increase flexibility. Specific recommendations included briefer response options; ability to tailor to the individual supervisee (such as through the “focus” feature above); and different tool formats (e.g., checklist rather than rating). Finally, analysis found that more scaffolding on completing and reflecting on the

CoPPI would improve its utility. The CoPPI was revised prior to Part 2 according to these findings for *recommended changes*, as detailed in the methods.

4.3.2 Part 2: Validity and Implementability

Total score on the CoPPI was positively correlated with total score on the T-SES for both the CoPPI long version ($r_s = .61$, one-tailed $p < .001$) and short version ($r_s = .54$, one-tailed $p < .001$). Across both versions, the CoPPI was positively correlated with the T-SES for supervisors ($r_s = .66$, one-tailed $p < .001$), and for supervisees ($r_s = 0.43$, one-tailed $p = .008$). There were no significant demographic differences between participants who completed each version of the CoPPI.

Face validity was high across both versions. Significantly more participants who completed the short version agreed or strongly agreed that “the CoPPI items measure practitioner competencies” (94.1%), compared to those who completed the long version (78.1%; $U = 409$, one-tailed $p = .023$). Cronbach’s alpha for each subscale of the CoPPI (0.93 generic therapeutic competencies; 0.94 parenting intervention competencies; and 0.97 specifics skills/techniques competencies) showed high internal consistency.

AIM, IAM and FIM scores did not significantly differ between versions of the CoPPI, nor did they differ between supervisors and supervisees. Mean scores were 3.70 ($SD = 0.62$), 3.88 ($SD = 0.68$), and 3.73 ($SD = 0.72$), respectively, with scores above 3.00 (out of 5) representing positive perceptions of the CoPPI’s acceptability, appropriateness and feasibility. Preferences for CoPPI version significantly differed between participants who completed the short versus long version ($F = 9.99$, two-tailed $p = .006$). Specifically, most who completed the short version preferred it to the prospect of a longer in-depth version (79.4% preferred the shorter version; 11.8% preferred longer; 8.8 reported no preference), whereas participants who completed the longer version did not show the same preference

(41.9% preferred shorter; 41.9% preferred longer; 16.1% no preference). Table 4.2 shows results for other implementability outcomes for the short CoPPI version.

Other participant perception outcomes included the following. Firstly, the majority of participants (65.2%) stated it would be helpful to have a printable PDF version. Secondly, 77.3% of participants stated they liked the availability of additional competency information and examples via hover icons, rather than on-screen. Thirdly, most participants (78.8%) stated they found summary graphs helpful. Fourthly, regarding the “focus” competencies feature introduced in Part 2, most participants (80.3%) stated they preferred to select focus competencies during completion of the CoPPI (10.6% preferred selecting them after reviewing the summary page; and 9.0% preferred not to answer). Finally, 42.4% of participants stated they would like the option of a frequency-based rating scale.

Regarding user experience questions, the majority (65.2%) of participants stated it would be helpful to have a printable PDF version of the CoPPI. Further, 77.3% of participants stated they liked having access to additional information for competencies via hover icons, which included examples and minimised on-page text; and there was a strong positive response to the suggestion to include summary graphs (78.8% stated they liked them). When asked whether they would like to choose “focus” competencies during or after completion of the tool (that is, competencies that they could re-rate on subsequent completion of the CoPPI), 80.3% of participants preferred during, and 10.6% preferred after (nine percent preferred not to respond). Finally, 42.4% of participants stated they would like the option of an alternative rating scale, which focused on frequency rather than quality of use of a competency.

Table 4.2*Participant Responses Regarding Implementability of the CoPPI*

	Agree / strongly agree (%)	Neutral (%)	Disagree / strongly disagree (%)
Sustainability “It would be sustainable for me to maintain use of the CoPPI as a routine tool (e.g., every X weeks/months)”	50.0	26.5	23.5
Adoption “I would be interested in adopting the CoPPI for my clinical practice”	58.8	26.5	14.7
Acceptability – supervisee ^a “I would be willing to share my scores on the CoPPI with my supervisor”	75.0	25.0	0
Acceptability – supervisor ^b “I would be willing to share my scores of my supervisee on the CoPPI with my supervisee”	83.3	11.1	5.6
Appropriateness – supervisee ^a “It would be helpful for my supervisor to use the CoPPI regarding my competencies”	75.0	18.8	6.3
Appropriateness – supervisor ^b “As an experienced practitioner, it would be helpful for my own supervisor to use the CoPPI regarding my own competencies”	55.6	27.8	16.7
Feasibility “I found the current tool too long”	55.9	26.5	17.6

Note. Responses above are from participants who completed the 15-item CoPPI ($n = 34$).

CoPPI = Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour rating tool.

^a Only supervisees responded to this question ($n = 16$).

^b Only supervisors responded to this question ($n = 18$)

4.4 Discussion

This study aimed to develop, validate and test the implementability of the Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour rating tool (CoPPI). Regarding development of the tool, we found that it was possible to translate a consensus-validated core competency model into a competency rating tool. Furthermore, the CoPPI is the first competency-based tool that highlights the common elements of PI programs (Garland et al., 2008; Leijten et al., 2019), making it the first to be relevant across this family of interventions. Based on results of the current study, the CoPPI was co-designed as a 15-item competency rating tool, with the option for therapists to expand this to rate up to 77 competencies individually (see supplementary materials for printable version). Therapists can also select competencies on which to focus, which can be re-rated on subsequent completions of the CoPPI (the online CoPPI automatically creates an additional version with only the respondent's focus competencies, which they can choose to use for subsequent completion). This "focus" feature offers a briefer way to interact with the tool, which can support supervisees and their clinical supervisors to set and review professional development goals. Furthermore, selecting specific competencies to aid reflective practice is consistent with recommendations of competency model authors (Roth & Pilling, 2008). This expandable format of the CoPPI thus allows therapists to interact with the tool flexibly to support their practice.

The second aim of the study was to validate and test the implementability of the CoPPI. We found the CoPPI to have good basic psychometric properties. It showed high internal consistency, adequate face validity, and strong convergent validity, both when therapists rated 15 competency areas, and when all 77 individual competencies were rated. We also found perceived acceptability, appropriateness and feasibility to be promising. Further results specifically supported the expandable 15-item CoPPI format. Firstly, face

validity was significantly higher for 15-items compared to the longer version. Secondly, more participants preferred the short version, although the preference was driven only by those who completed the short version. Thus, findings support the brief format, but also reflect interest of a subset of practitioners in a longer, more detailed version.

The interest of a subset of participants in rating individual competencies conflicted with results that suggested difficulty disseminating a longer version. Results highlighted that inclusion of detailed, specific competencies, with examples, was a major benefit of the CoPPI, but also that the CoPPI should be shortened. Participants reflected that they are often time-poor and struggle with “administrative burn-out” (i.e., exhaustion due to significant time spent on administrative processes), consistent with resource constraints identified in community settings (McPherson et al., 2016). Brevity to meet these constraints compromises detail, hence these findings highlight the challenges of developing a measure that meets juxtaposing stakeholder interests. The final length of the CoPPI is consistent with other competency rating tools that are 12-15 items long (Blackburn et al., 2001; Kohrt et al., 2024; Rice et al., 2022). This suggests that the CoPPI may be sufficiently brief and implementable, but that further research should now examine its dissemination in routine practice settings.

4.4.1 Significance and Implications

The CoPPI is the first intervention-specific competency rating tool designed for use across a range of PI programs, which is translated from a consensus-validated PI-specific core therapist competency model. Extending on previous research on core competencies (see Chapter 2; Allen et al., 2021; Hawes & Dadds, 2021) and on competency rating tools (Blackburn et al., 2001), the CoPPI is a proof of concept that a therapist competency model can be translated into a competency rating tool. This therefore offers important implications for research and clinical practice.

The CoPPI provides a framework for competency-based training and supervision. Previous research has highlighted a need for PI training supports that can be adapted based on the needs of specific settings (Doyle et al., 2023; Kohrt et al., 2024; Turner et al., 2011). Current findings suggest the CoPPI supports this need as it offers a framework for developing competency-based goals and learning. Accordingly, the CoPPI has been designed as a training tool that can be used alongside existing PI programs. Features that support this include: the supervision discussion scaffold (see supplementary materials); comment boxes for reflections; options to select *not applicable* or *insufficient evidence*; and the focus feature to selectively rate specific competencies based on goals. As such, the CoPPI can flexibly support individual therapist training needs.

Provision of a competency-based PI training support, as offered by the CoPPI, could improve PI delivery in several ways. Firstly, competency-based training can provide ongoing support beyond initial training. Lack of ongoing support has been identified as an important barrier to use of PIs in routine practice settings (Turner et al., 2011), hence the CoPPI could decrease this barrier to PI delivery. Secondly, para-professionals in low-resource settings (Kohrt et al., 2024), and professionals without formal PI training (Sanders, 2023), are often expected to deliver PIs. The CoPPI could help equip therapists to deliver PIs if specific training therein is otherwise unavailable. In this way, the CoPPI could improve availability and quality of PI delivery, which competency-based training tools have done in other interventions (Clark, 2018; Kohrt et al., 2024). Thirdly, competency-based training support can guide clinicians to meet complex client needs through evidence-based adaptations to manualised programs (Barker & Hawes, 2025), which may be associated with superior outcomes (Fonagy & Luyten, 2019; Georgiadis et al., 2020). Thus, the CoPPI could support improved PI delivery for complex presentations. In brief, the CoPPI could improve clinical

training and therefore reach and quality of PI delivery, including through informing curriculum guidelines.

The CoPPI also presents significant implications for research related to clinical practice, training, and supervision. First, it comprehensively outlines both general and intervention-specific competencies needed for PIs. The effect of individual competencies and overall competency ratings on clinical outcomes can therefore be tested, which has been previously limited for PIs (Leijten et al., 2025; Martin et al., 2021). General and intervention-specific competence have been identified as distinct concepts (Cecilione et al., 2021), with few studies examining both (Sharpless & Barber, 2009), and no such studies known in PIs. The CoPPI could therefore offer novel perspectives on the effect of therapist competence on clinical outcomes in PIs, as it includes both general and intervention-specific competencies. Second, the CoPPI could be used to examine the level of competence with which PIs are being delivered (Waltz et al., 1993), therefore supporting research to improve quality of PI training and delivery. Third, the CoPPI provides a method by which other competency models could be translated into competency rating tools. Several models of therapy that are recommended by NICE guidelines do not currently have related competency rating tools (Barlow & Brown, 2020), and literature has identified a need to better understand therapist competence (Gonsalvez et al., 2021; Simons et al., 2013). The current research provides a blueprint for how such tools could be developed, which could subsequently lead to increased ability to measure and understand therapist competence.

Some limitations of the current study must be acknowledged. The sample consisted of predominantly psychologists. As such, implementability and validity of the CoPPI should be further investigated with other professional groups delivering PIs. The distribution of PI therapists across professions is unknown and a worthy subject of future research that could support dissemination of the CoPPI. Additionally, the response format of the CoPPI allowed

respondents to rate *not applicable* or *insufficient evidence*, which deemed the data unsuitable for further psychometric validation such as factor analysis with the current sample size.

Inclusion of these response options was an intentional design decision, allowing flexibility of the CoPPI, to support clinicians with learning. Further research would therefore be needed to progress the utility of the CoPPI as a competency assessment measure. Overall, future research could examine whether the CoPPI: (a) reliably measures competencies; (b) can be disseminated across routine practice settings; and (c) improves therapist self-efficacy and reflective practice capacity of therapists, which could therefore support competency development and delivery of PIs (Lilienfeld & Basterfield, 2020; Turner et al., 2011).

In conclusion, the construction of the CoPPI represents the first instance of a consensus-validated intervention-specific core competency model being translated into a competency rating tool. The CoPPI specifically offers new opportunities for competency-based training in PIs for disruptive child behaviour, which can support therapists to learn beyond specific program manuals and apply interventions to complex presentations. Furthermore, the CoPPI may serve as a blueprint for developing competency-based training tools in other fields. Ultimately, it therefore has potential to support therapists delivering PIs across a broad range of programs and settings, and to inform ongoing research into clinical training.

CHAPTER 5: Competency-Based Supervision in Parenting Interventions for Child**Conduct Problems****5.1 Introduction**

Disruptive child behaviour disorders, such as oppositional defiant disorder and conduct disorder, have long term detrimental consequences to the families they affect and high social cost, with conduct disorder the leading cause of burden in mental health for children up to 14 years of age (Ferrari et al., 2022). Fortunately, interventions for disruptive child behaviour problems have decades of research supporting their effectiveness, with social learning-based parenting interventions (PIs) being the gold-standard (Eyberg et al., 2008; Kaminski et al., 2024). PIs have been subjected to extensive research, including examining its implementation in routine care settings (e.g., Ma et al., 2023; Pinto et al., 2024; Shenderovich et al., 2019). However, little research exists on the training and supervision of therapists delivering such interventions, which is critical to intervention implementation.

5.1.1 Competency-based Training and Supervision

Training, including supervision, is the cornerstone to ensuring mental health therapists are competent to deliver evidence-based interventions (Kohrt et al., 2024). Competency-based training is an increasingly popular type of training that aims to meet these needs (Gonsalvez et al., 2021). In such training, specific professional competencies (including skills, knowledge and values) required for delivery of evidence-based interventions are identified, and learning and assessment strategies are developed to meet them (Falender & Shafranske, 2007). Competency-based training emphasises use of reliable and valid competency ratings tools (Gonsalvez & Calvert, 2014; Kaslow et al., 2009), which is aligned with recommendations for best practice supervision (O'Donovan et al., 2011). It has been used to support intervention delivery in broad contexts, including public health settings (Clark, 2018), and low and middle-income countries (Kohrt et al., 2024). Offering more

flexibility than manualised training and supervision, competency-based training and supervision is aligned with professional codes of conduct (Gonsalvez & Calvert, 2014), aiming to better support practitioners to meet individual client needs. Hence, developing competency-based training in PIs may be important to supporting high quality intervention delivery.

Research in other mental health interventions suggests that competency-based training can benefit therapists, supporting the rationale for exploring this in PIs. For instance, a competency-based intervention for post-graduate clinical psychology students developing skills in use of CBT for depression improved therapist competencies, according to the Cognitive Therapy Scale (CTS; Young & Beck, 1980), compared to supervision as usual (Weck et al., 2021). The intervention involved students receiving qualitative and quantitative feedback over 20 therapy sessions regarding their competence based on an independent expert's observation of sessions and ratings on the CTS. Additionally, a manualised competency-based supervision intervention for CBT was also shown to be effective in improving supervisee competencies as measured by the CTS-R in a single-case experimental design (SCED; $N = 6$) with multiple baselines (Alfonsson et al., 2020). Furthermore, a SCED with multiple baselines study of 7 experienced CBT therapists using a self-practice/self-reflection program showed that the program could lead to improvement in intervention-specific competencies and therapeutic alliance competencies (Davis et al., 2015). Thus, as competency-based training has shown benefits in other areas, it could be useful in PIs too.

Reflective practice is a cornerstone of competency-based therapist training (Gonsalvez et al., 2021; A. S. Lane & Roberts, 2022). It is here defined as a therapist's reflection on their therapeutic competence, experience, actions and thoughts, with the aim of improving their clinical practice (Nguyen et al., 2014; Ooi et al., 2023; Schön, 1992).

Reflective practice allows one to identify areas of focus for learning (Mann et al., 2009). It is

therefore core to effective supervision (Watkins, 2012), and a core foundational competency necessary for building other competencies (Epstein & Hundert, 2002; Kaslow & Ammirati, 2020; Ooi et al., 2023; Rodolfa et al., 2005). Reflective practice is understood to be central to high quality intervention delivery (Ooi et al., 2023; Sadosky & Spinks, 2022), allowing a therapist to work dynamically to address various and complex client needs. Reflective practice may also appropriately moderate therapist self-efficacy – that is, confidence in one’s competence (Lilienfeld & Basterfield, 2020). As research has found only a modest association between self-efficacy and actual competence (D. J. Miller et al., 2015), moderation of self-efficacy by reflective practice is important to avoid therapist overconfidence (Lilienfeld & Basterfield, 2020). For this reason, reflective practice is central to competency-based therapist training, supporting training through both competency development and accurate understanding of one’s own competencies. Nevertheless, no studies in PIs are known to have examined whether competency-based training improves therapist reflective practice, thus this should be directly investigated.

Several models of core competencies have been developed to support competency-based therapist training. For psychologists specifically, the Competency Cube was developed (Rodolfa et al., 2005): a three-dimensional model that describes both foundational and functional competencies, how these types of competencies inter-relate, and how they relate to each stage of professional development. Competency benchmarks were then developed from the model, to further describe each competency and expectations for each at different stages of training (Fouad et al., 2009). The Competency Cube is a model of generic therapeutic competencies, meaning it is relevant across different types of psychological interventions. Other generic therapeutic competency models are available both for psychologists (Psychology Board of Australia, 2025; The British Psychological Society, 2025) and other mental health therapists (Böhm et al., 2022).

Whilst generic therapeutic competencies are important, core competency models that include intervention-specific (or technical) competencies are also critical as they provide more specific information and guidance for a particular intervention. Consequently, comprehensive core competency models, which include both generic and intervention-specific competencies, are needed. For CBT specifically, a comprehensive model of core therapist competencies has been developed for treating adult anxiety and depression (Roth & Pilling, 2008). Roth and Pilling's (2008) model was validated by expert consensus and developed for the NHS Talking Therapies initiative (previously called IAPT), aiming to upskill therapists from a range of professional backgrounds in CBT specifically for anxiety and depression (Clark, 2018). Similarly, comprehensive competency models have since been developed for other therapies, such as psychodynamic and systemic therapies for adult mental health (Lemma et al., 2009; Roth et al., n.d.); CBT for child and adolescent anxiety and depression (Sburlati et al., 2011); and interpersonal psychotherapy for adolescent depression (Sburlati et al., 2012).

5.1.2 Competencies for the Treatment of Conduct Problems

More recently, a comprehensive competency model has been developed in PIs for child conduct problems (see Chapter 2). The model, developed by expert consensus validation using the Delphi method, includes generic therapeutic competencies, PI competencies, and competencies in specific PI skills and techniques, with a total of 77 competencies under 15 competency areas. Furthermore, recommendations for using the competency model with different types of case complexity have been explored, supporting the model's use with complex presentations (see Chapter 3). This core competency model hence provides an opportunity to develop competency-based training suitable across PI programs for child conduct problems.

In addition to a core competency model for PIs, a corresponding competency rating tool is also needed. Competency ratings tools allow for tracking and assessment of competencies and are therefore central to competency-based training (Gonsalvez et al., 2021). Valid and reliable competency assessment tools have been called for in the literature (Barlow & Brown, 2020; Simons et al., 2013). Furthermore, authors of one of the aforementioned core competency models themselves have recommended the development of a self-assessment tool from their model, to support reflective practice and a focus for ongoing professional development (Sburlati et al., 2011). Thus, the importance of developing competency rating tools is clear.

Competency rating tools have been developed in other psychological interventions (Blackburn et al., 2001; Hatcher et al., 2013; Kohrt et al., 2015) and have been the basis of competency training programs (Clark, 2018; Kohrt et al., 2024). Recently, the first comprehensive competency rating tool for PIs that is not program-specific has been developed (see Chapter 4). The Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour (CoPPI) is the first competency rating tool known to be translated from a consensus-validated competency model that includes both general and intervention-specific competencies, showing that it is possible to translate a comprehensive therapist competency model into a tool. The CoPPI has shown high internal consistency and good convergent validity, whilst still showing divergence from a measure of self-efficacy, a related construct (see Chapter 4). Therefore, the CoPPI shows promise as a tool to support competency-based training and supervision in PIs and assessment of therapists, although its utility as the basis of a competency-based training program is yet to be tested in PIs.

5.1.3 Current Study

The current study aimed to examine whether the CoPPI enhances the foundational competency of reflective practice when used as the basis of a competency-based training

program for trainee therapists in PIs. Reflective practice is understood to be a cornerstone of competency-based training, and has been increased by competency-based training in nursing (Khalil & Abou Hashish, 2022) and medicine (Sobral, 2000). However, research on competency-based training and reflective practice in mental health interventions is still in its infancy. Only two of 18 studies in a systematic review on therapist supervision investigated reflective practice competence (Wheeler & Richards, 2007); and only four of 29 studies in a systematic review on reflective practice for other professionals investigated whether reflective practice can be developed (Mann et al., 2009); with no more recent reviews identified. As such, although two studies found reflective practice competence (or self-awareness) can improve through supervision (Wheeler & Richards, 2007), it is unknown whether competency-based training improves reflective practice in therapist training as theorised (Ooi et al., 2023; Sburlati et al., 2011). The current study aims to address this important gap in the literature by investigating the effect of competency-based supervision on therapist reflective practice.

The current study aimed to investigate whether a new competency rating tool specifically for PIs is effective in increasing reflective practice competence. We investigated this in PIs specifically given the need in this area and opportunity granted by the new competency rating tool therein. As the CoPPI is the first therapist competency rating tool translated from a comprehensive competency model, this facilitated investigation of competency-based supervision in PIs and allowed novel examination of whether such a tool could increase reflective practice. We examined the effect of completing and discussing the CoPPI in supervision fortnightly on reflective practice for newly practicing therapists (post-graduate students) in a parenting intervention for disruptive child behaviour. We hypothesised that use of the CoPPI to structure supervision would increase reflective practice competence of PI therapists compared to supervision as usual. We also hypothesised that

improvements in competencies, professional self-efficacy and the process of supervision may be associated with improvements in reflective practice competence.

Finally, implementability according to therapists was assessed, including acceptability, feasibility and appropriateness in typical therapist contexts. Implementation outcomes such as these are recommended to be included for intervention studies to support ultimate utility of interventions in routine care settings (Pinto et al., 2024), and are also typically measured in training programs (Valenstein-mah et al., 2020). Thus, given the current study relates to a training program to support a clinical intervention, examining implementation outcomes is valuable. We hypothesised that the CoPPI would be perceived as acceptable, appropriate and feasible by practitioners.

5.2 Methods

5.2.1 Design

A SCED with multiple baselines was used in the current study, consistent with previous studies on therapist training programs (Alfonsson et al., 2020; Davis et al., 2015). Participants were randomised to a baseline period of either four, five, six or seven weeks, and then participated in the competency-based supervision intervention for the remainder of a 16-week period (i.e., 9-12 weeks of intervention). Multiple baselines allowed causal inferences to be made about the intervention (Alfonsson et al., 2020; Kratochwill & Levin, 2015), with primary outcome data collected weekly from each participant during both baseline and intervention periods. The sample size ($N = 7$) and study duration were designed to detect a moderate effect size as per a previous study of similar design (Alfonsson et al., 2020). This study received approval from the Human Research Ethics Committee of [masked] [approval number], and all participants provided consent in line with this.

5.2.2 Materials

Competencies for Application of Parenting Interventions for Disruptive Child Behaviour (CoPPI)

The CoPPI is a competency rating tool that aims to enhance supervision and reflective practice among practitioners of parenting interventions for disruptive child behaviour problems (see Chapter 4). It was developed from a model of core competencies developed for the same intervention type (see Chapter 2), and offers self-report or supervisor-report on 15 competency areas spanning three competency types: generic therapeutic competencies; parenting intervention competencies; and competencies for promoting specific parenting skills and techniques. Practitioners have the option to more specifically rate each competency within competency areas, with a total of 77 competencies. Respondents rate their perception of competencies based on available evidence (including e.g., live video, discussion, attitudes, feedback from others), on a 13-point scale from 0 (*not yet competent* – absence of feature, or highly inappropriate performance) to 6 (*expert* – excellent performance, or very good even in the face of patient difficulties). Respondents may also rate *not applicable to current practice*, or *insufficient evidence to assess*. During completion, the respondent can select specific “focus” competencies to re-rate on subsequent completions, to support a focus on specific competencies in their training or professional development. Participants are presented with a summary page of ratings, graphs thereof, focus competencies, and any comments made during completion, to support reflection. The CoPPI has shown strong internal consistency and convergent validity (Cronbach’s alphas of 0.93, 0.94 and 0.97 for each competency type subscale; see Chapter 4).

Reflective Practice Questionnaire (RPQ)

The RPQ is a measure of self-reported reflective practice and related constructs, including confidence, stress and work satisfaction, developed for professionals across

settings, including psychology, nursing and education (Priddis & Rogers, 2018). The revised 10-item version of the RPQ was used in the current study (Rogers et al., 2024). Participants answer questions on a 6-point scale from 1 (very rarely), to 6 (almost always), with questions such as “during interactions with clients I recognize when my pre-existing beliefs are influencing the interaction” and “after interacting with clients I think about how things went during the interaction.” The RPQ has shown good discriminant validity and strong internal consistency, with Cronbach’s alphas of 0.83 to 0.89 (Priddis & Rogers, 2018; Rogers et al., 2024). In the current study, the RPQ was also adapted for supervisor-report, with items remaining unchanged other than to update text to third person wording. The supervisor adaptation of the RPQ showed strong internal consistency (Cronbach’s alpha 0.97).

Therapist Self-Efficacy Scale (T-SES)

The T-SES was developed to assess professional self-efficacy of practitioners delivering therapy online via video conferencing (Gori et al., 2022). The T-SES has one-factor that consists of 21-items rated on a 5-point Likert scale from 1 (*completely disagree*) to 5 (*completely agree*). Respondents self-rate whether during sessions they can: “promote therapeutic alliance”; “use clinical reasoning”; and other similar items. The T-SES has shown good reliability and convergent and divergent validity (Gori et al., 2022).

Generic Supervision Assessment Tool (GSAT)

The GSAT assesses competencies of supervisors, both by self-report (GSAT-SR) on a 26-item scale, and supervisee-report (GSAT-SE) on a 21-item scale (Hamilton et al., 2022). The GSAT uses a visual analogue rating scale (0 to 100), where 0 to 19 represents absence or inappropriate application of essential skills, and 90 to 100 represents expert level. A *not applicable* option is also available. Both versions have items that include “gives accurate, constructive and timely feedback”; “encourages reflection on process as well as content in client and professional interactions”; and other similar items. The GSAT-SE is a two-factor

scale, including foundational competencies enabling effective feedback; and fundamental accountability, safety, and awareness processes; whereas the GSAT-SR has four factors: foundational feedback processes; goals and tasks; respect; and enabling supervisory practices. The GSAT has shown good internal consistency and convergent validity (Hamilton et al., 2022).

Supervisory Working Alliance Inventory (SWAI)

The SWAI measures the relationship in therapist supervision (Efstation et al., 1990). The SWAI includes a 19-item supervisee version (SWAI-Supervisee) and a 23-item supervisor version (SWAI-Supervisor). Respondents estimate the frequency with which each item occurs within supervision, on a 7-point Likert scale from *almost never* (1) to *almost always* (7). Both scales include subscales of rapport (e.g., “I make an effort to understand my supervisee”; “my supervisor makes the effort to understand me”) and client focus (e.g., “I help my supervisee stay on track during our meetings”; “my supervisor helps me stay on track during our meetings”), with the supervisor scale additionally including a subscale of identification (e.g., “my supervisee consistently implements suggestions made in supervision”). The SWAI has shown adequate internal consistency (Cronbach’s alphas ranging from .71 to .90 for each subscale), and adequate convergent and divergent validity (Efstation et al., 1990). Low correlations between supervisor and supervisee scores suggest that each view the relationship differently (O’Donovan & Kavanagh, 2014) and hence that the SWAI-Supervisor and SWAI-Supervisee offer differential and important information about the supervisory relationship.

Implementation Outcome Measures

The Acceptability of Intervention Measure (AIM), the Intervention Appropriateness Measure (IAM), and the Feasibility of Intervention Measure (FIM) were used in the current study to measure implementation outcomes. Developed together, these are each 4-item

questionnaires that have shown good structural validity, test-retest reliability and discriminant validity (Weiner et al., 2017), and have been widely used in psychosocial intervention implementation studies (Stahmer et al., 2024; Studts et al., 2022; Zingg et al., 2024). Each scale uses a 5-point Likert scale from 1 (completely disagree) to 5 (completely agree), including items such as “the CoPPI meets my approval” (AIM); “the CoPPI seems fitting” (IAM); and “the CoPPI seems implementable” (FIM). Two additional implementation outcomes, adoption and sustainability (Pinto et al., 2024), were measured with hypothetical questions (“I would be interested in adopting the CoPPI for my clinical practice”; and “It would be sustainable for me to maintain use of the CoPPI as a routine tool”, respectively). Acceptability and appropriateness around the process of sharing of scores and supervisor-report was also examined with similar questions.

Semi-structured interviews

Brief (15-minute) interviews focused on participant experiences of using the CoPPI and included six questions. Three questions focused on impact of the tool on self-reflective practice (e.g., “what aspects of the tool were most helpful/unhelpful to your reflective practice?”). Three further questions concerned ongoing use of the CoPPI, with questions about barriers to use, what they would change if continuing to use it, and if they would endorse any further changes to make it relevant to practitioners in ongoing practice.

5.2.3 Participants & Procedure

Prior to the SCED, a pilot phase of the study was first completed with four post-graduate Clinical Psychology students (i.e., supervisees) conducting PCIT in the USA [location masked], which aimed to test implementability of using the CoPPI over a 12-week intervention period, so as to adjust the design following this if needed. Supervisees completed the training intervention as per Table 5.1 but without a baseline period and with more extensive review of CoPPI ratings fortnightly, for a full 12 weeks for all participants.

Following this, two supervisees and one supervisor completed an optional interview to give feedback on the process. From this feedback, the in-supervision CoPPI review process was revised (shortened) to form that used in the subsequent procedure.

Following the pilot, the SCED was completed, which aimed to examine the effect of the CoPPI on reflective practice. Participants were seven post-graduate clinical psychology students (i.e., supervisees) and their supervisors (total of five supervisors) at a university training clinic specialising in PIs for disruptive child behaviour problems in Australia [location masked]. All students had been delivering parenting interventions for less than one year and 57.1% were female. Student ages were varied: four were aged 18-26 years; two were 26-35 years; and one was 46-55 years. Supervisors were all psychologists and held post-graduated qualifications in clinical psychology. Students' supervisors had a mean of 12 years' experience practicing PIs, and all supervisors also had experience in community health settings and/or private practice.

Interested participants were sent a link to a survey hosted on REDCap at the University of Sydney (Harris et al., 2009, 2019), in which participants first gave informed consent to participate, and then proceeded to complete pre-baseline questionnaires as per Table 5.1. Supervisees did not complete the CoPPI pre-baseline to prevent it informing their practice during baseline. Following completion of pre-baseline questionnaires, supervisees were randomised to a baseline period of four, five, six or seven weeks, consistent with previous research seeking to improve therapist training (Alfonsson et al., 2020; Davis et al., 2015). Baseline and then intervention proceeded as per Table 5.1, until each supervisee had completed 16 weeks of the study overall (i.e., intervention duration = 16 weeks – baseline length). Regardless of intervention length, all supervisees completed post-intervention measures 12 weeks after baseline ended, which aligned with the final week of placement for supervisees with the longest baseline period. To measure adherence to the procedure,

supervisees were asked fortnightly during the intervention period whether (a) ratings on the tool were discussed in supervision as recommended, and (b) how long they spent discussing the competency tool in the current supervision session. Supervisors met with the project coordinator prior to study commencement to ensure their understanding of the procedure.

5.2.4 Statistical Analyses

Weekly baseline and intervention measures for reflective practice competence for each supervisee, as measured by the RPQ, were compared visually and using non-overlap of all pairs (NAP) as outlined by Parker and Vannest (2009). For each supervisee, the NAP was calculated by determining the proportion of all comparisons between baseline and intervention data points that did not show overlap. Literature suggests that a NAP less than .65 represents a small effect size; .66 to .92 represents a medium effect size; and .93 to 1.0 is a large effect (Alfonsson et al., 2020; Parker & Vannest, 2009). A modified Brinley plot was also used for reflective practice competence and secondary outcomes, as a reliable method of visual analysis (Tanious & Manolov, 2025). Descriptive statistics are provided for secondary outcomes, with insufficient sample size for t-tests to be meaningful.

Table 5.1

Study Procedure

Baseline	Supervisee	Supervisor
Week 1	Pre-baseline questionnaires (demographics, T-SES, GSAT-SE, SWAI-Supervisee) RPQ	Pre-baseline questionnaires (demographics, RPQ-adapted, GSAT-SR, SWAI-Supervisor, CoPPI)
Weeks 2-7	RPQ	Nil
Intervention	Supervisee	Supervisor
Week 1	Pre-intervention questionnaires (T- SES, GSAT-SE, SWAI-Supervisee) RPQ CoPPI	Pre-intervention questionnaires (RPQ-adapted, GSAT-SR, SWAI- Supervisor) CoPPI
Week 2	In-supervision review of CoPPI: Discuss strengths & areas for development; select focus competencies; identify specific goals; set agenda for current supervision session RPQ	
Week 3	CoPPI focus competencies RPQ	-
Week 4	Brief in-supervision review of CoPPI: Identify any issues arisen or goal changes; set agenda for supervision RPQ	
Week 5	CoPPI focus competencies RPQ	-

Intervention	Supervisee	Supervisor
Week 6	Brief in-supervision review of CoPPI	
	RPQ	
Week 7	CoPPI	CoPPI
	RPQ	
Week 8	In-supervision review of CoPPI	
	RPQ	
Week 9	CoPPI focus competencies	-
	RPQ	
(Week 10)	Brief in-supervision review of CoPPI	
	RPQ	
(Week 11)	CoPPI focus competencies	-
	RPQ	
(Week 12)	Brief in-supervision review of CoPPI	
	RPQ	
All participants	Post-intervention questionnaires (RPQ, T-SES, GSAT-SE, SWAI-Week 12	Post-intervention questionnaires (RPQ-adapted, GSAT-SR, SWAI-Week 12
	Supervisee, CoPPI, implementation outcome measures)	Supervisor, CoPPI, implementation outcome measures)

Note. T-SES = Therapist Self-Efficacy Scale; GSAT = Generic Supervision Assessment Tool; SE = supervisee version; SR = supervisor version; SWAI = Supervisory Working Alliance Inventory; RPQ = Reflective Practice Questionnaire; CoPPI = Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour rating tool.

5.3 Results

Supervisees are referred to as Participants 1-7 to support interpretation of results. Prior to statistical analyses, data quality checks were completed. All supervisee completed all components of the study. Supervisees took a mean of 23 minutes to complete the full CoPPI in-supervision review in Intervention Weeks 2 and 8, and a mean of 13 minutes to prepare for this; they took a mean of 17 minutes to complete the brief CoPPI review. Checks showed that most supervisees completed the study as intended, with all full CoPPI reviews completed during supervision. However, the brief CoPPI review was completed following rather than during supervision once by each of Participants 6 and 7. Furthermore, the supervisor of Participant 6 did not complete the CoPPI prior to the first in-supervision review.

5.3.1 Primary outcome: Reflective practice competence (RPQ)

Table 5.2 shows change in RPQ score and NAP scores by supervisee; Figure 5.1 shows time series data of RPQ scores; and Figure 5.2 shows a modified Brinley plot of the data. On visual analysis of time-series graphs, RPQ scores were relatively stable across baseline (within 1 point) from Week 2 onwards. NAP-values were statistically significant ($p = 0.003-0.009$) for three of seven supervisees (Participants 1, 2 and 4), showing that reflective practice scores during the intervention period were higher than those during baseline, with a large effect size. These supervisees were of different genders, age groups and levels of experience. NAP-values for three other supervisees also showed that reflective practice was more often greater during the intervention period than during the baseline period, although these were not statistically significant. For one supervisee, the NAP-value showed that reflective practice scores were on average lower during the intervention period compared to baseline, although this was not statistically significant. Despite varied results, combining all supervisee scores showed statistically significant improvement in reflective

practice scores during the intervention period compared to baseline, with a moderate effect size.

Table 5.2

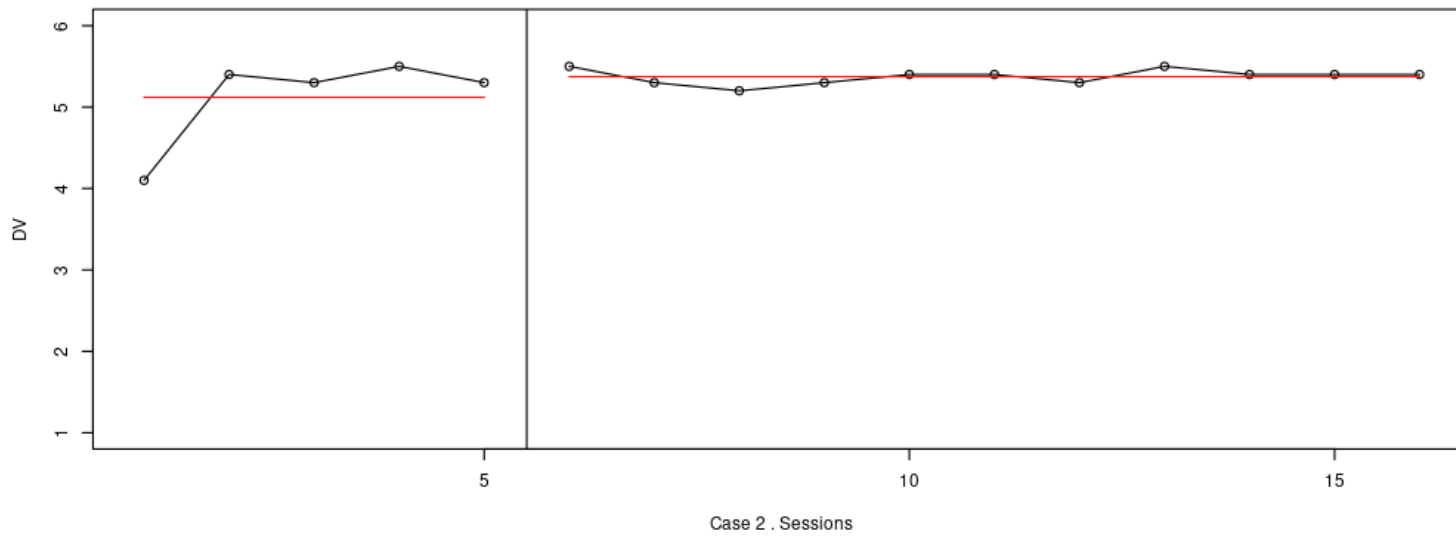
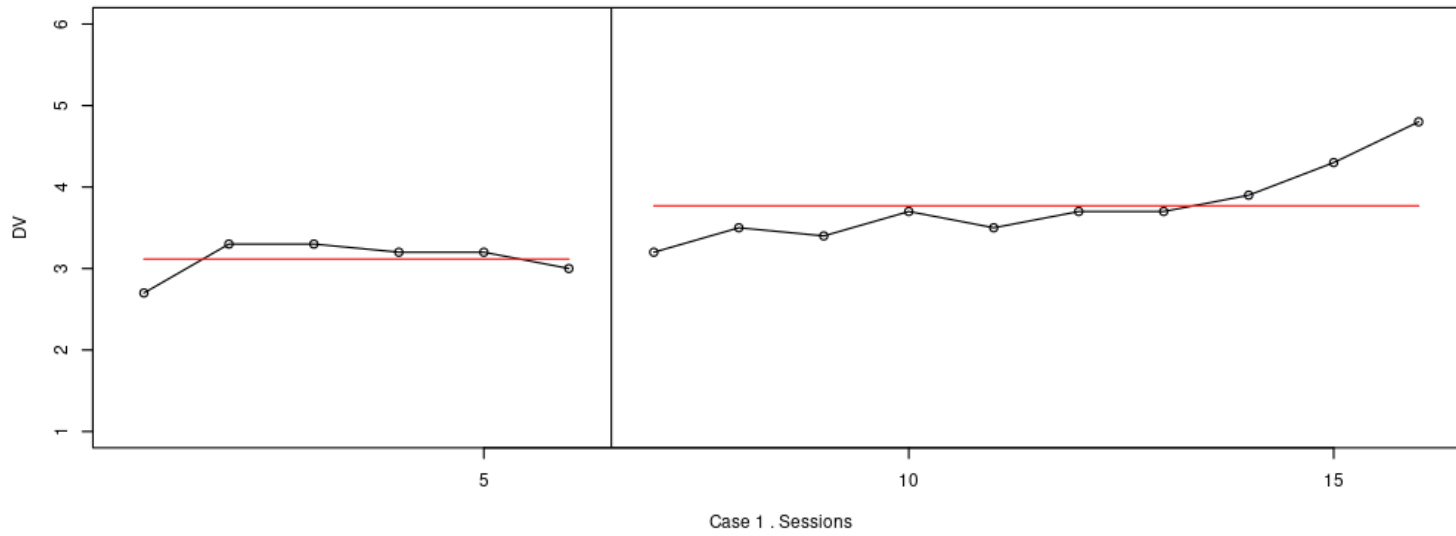
Non-Overlap of Pairs (NAP) Value for Reflective Practice Competence During Baseline Compared to Intervention Period of Competency-Based Supervision

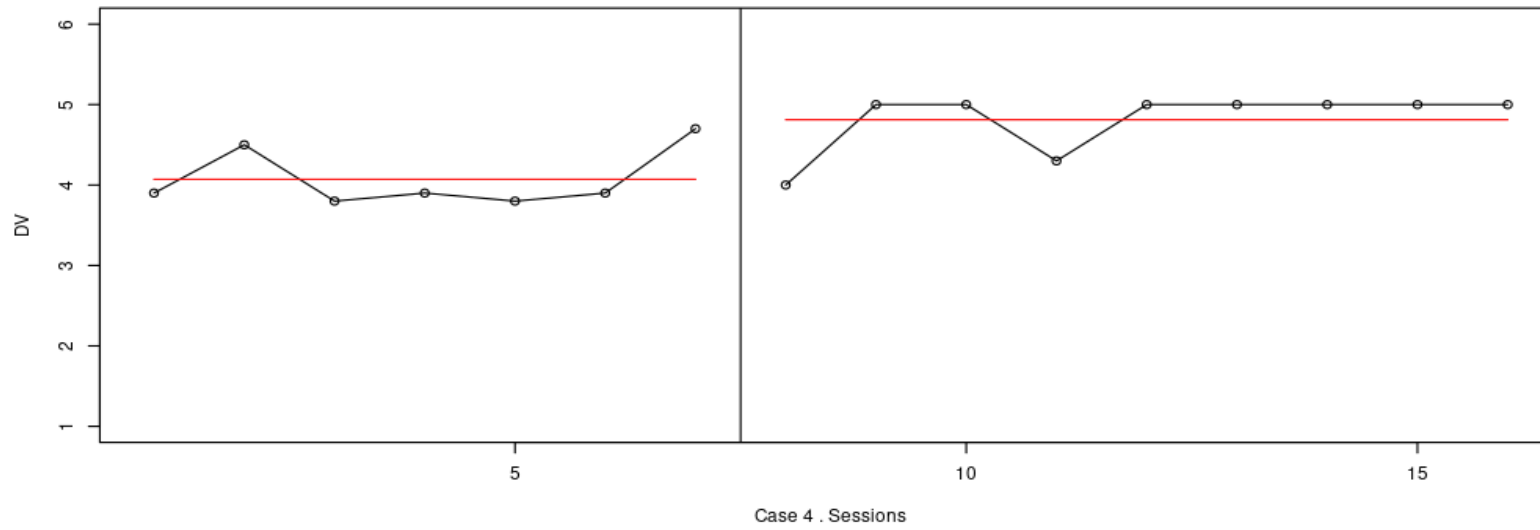
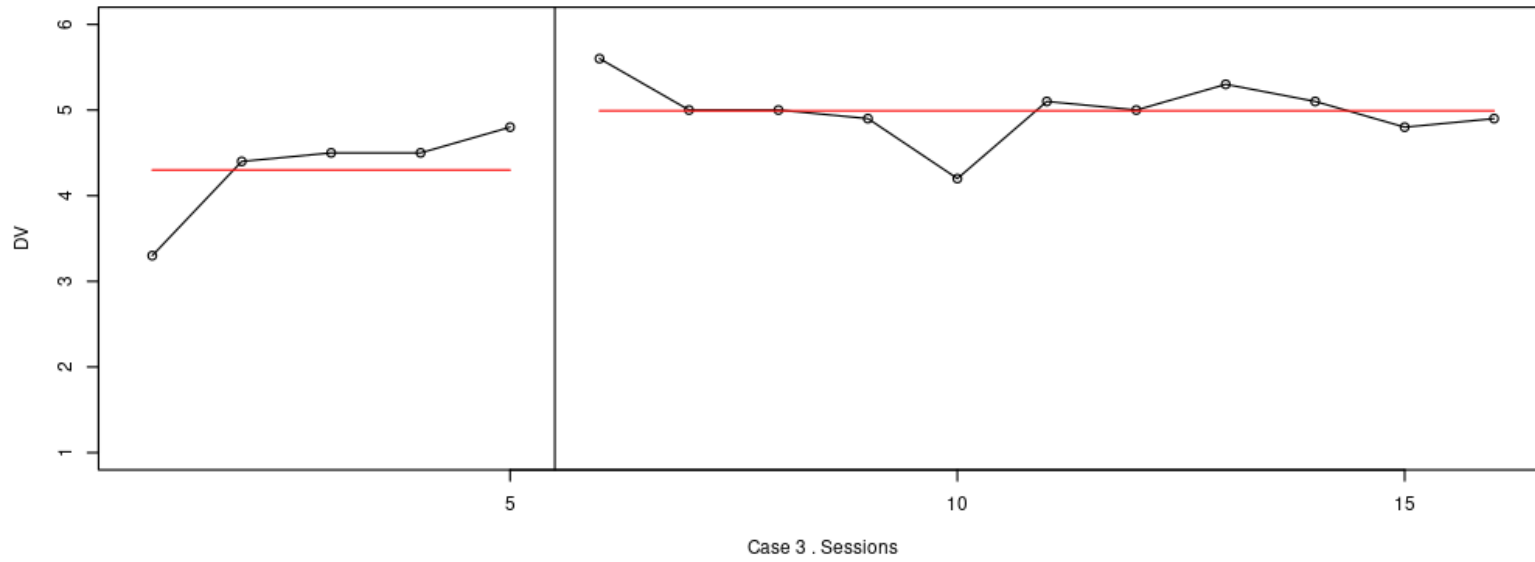
Participant	Baseline length Weeks	Intervention length Weeks	RPQ total score			NAP	p-value
			Mean (SD)		Change score		
			During Baseline	During Intervention			
1	6	10	3.12 (0.21)	3.77 (0.45)	0.65	.95*	.003
2	5	11	5.12 (0.52)	5.37 (0.09)	0.25	.61	.497
3	5	11	4.30 (0.52)	4.99 (0.33)	0.69	.92*	.009
4	7	9	4.07 (0.34)	4.81 (0.36)	0.74	.94*	.004
5	4	12	4.32 (0.24)	4.36 (0.22)	0.03	.54	.808
6	7	9	4.67 (0.21)	4.72 (0.27)	0.05	.56	.711
7	6	10	3.63 (0.33)	3.42 (0.09)	-0.21	.31	.212

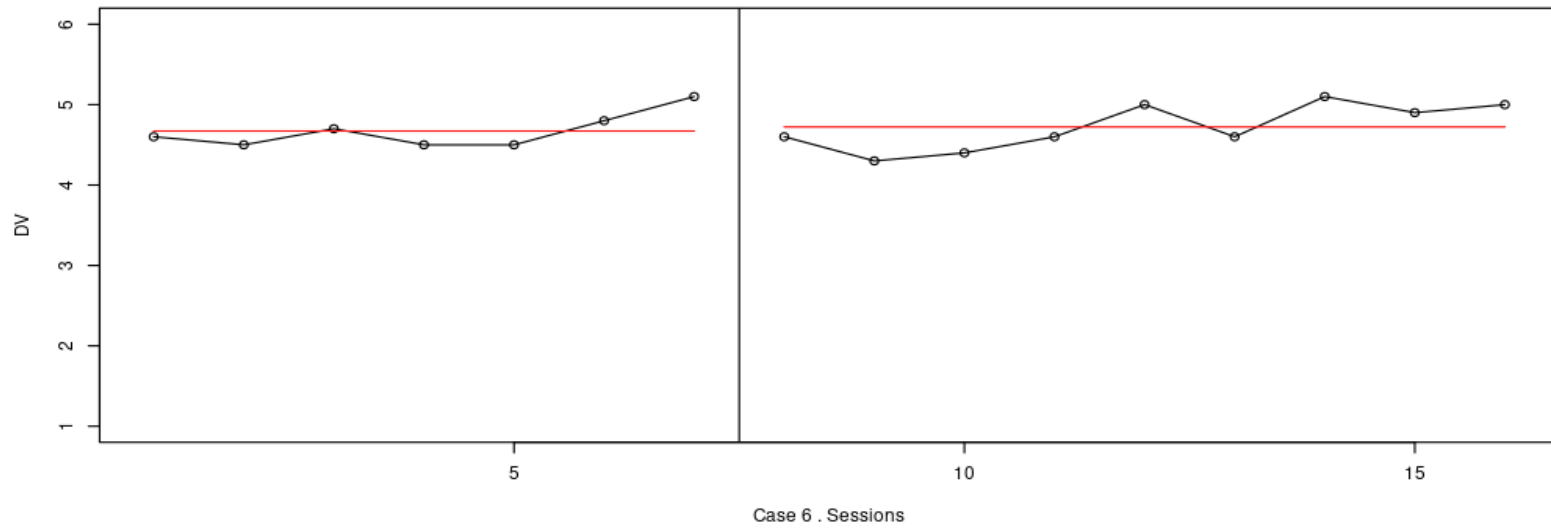
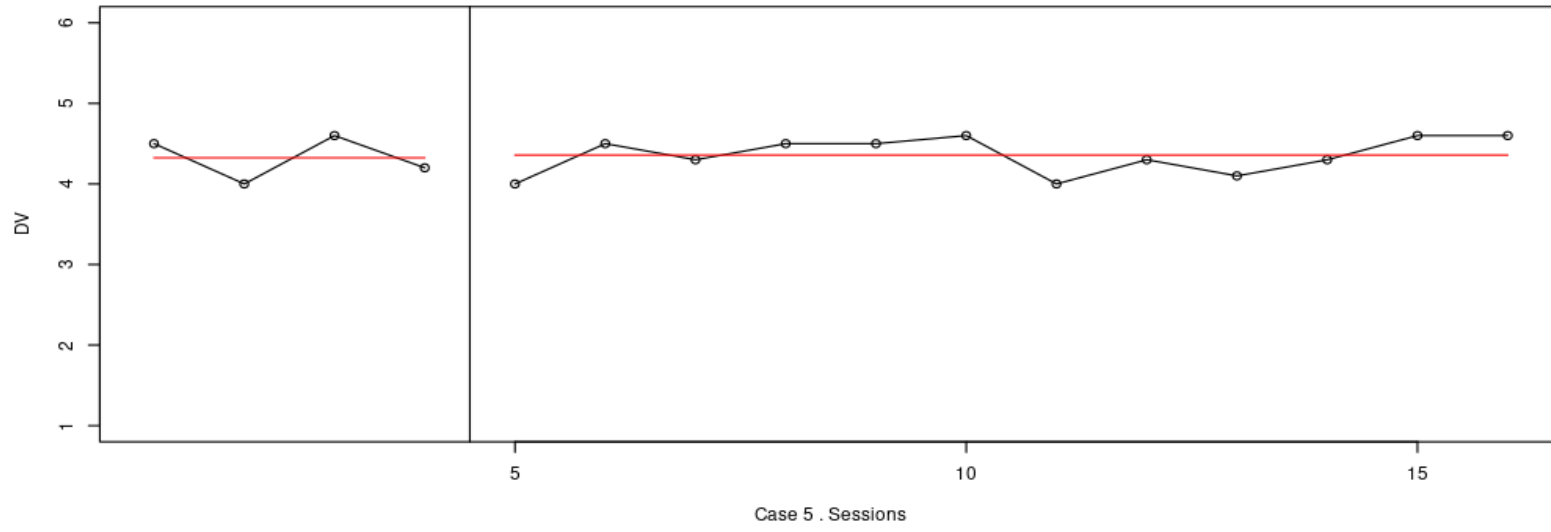
Note. RPQ = Reflective Practice Questionnaire; NAP = Non-overlap of pairs. * $p < .05$.

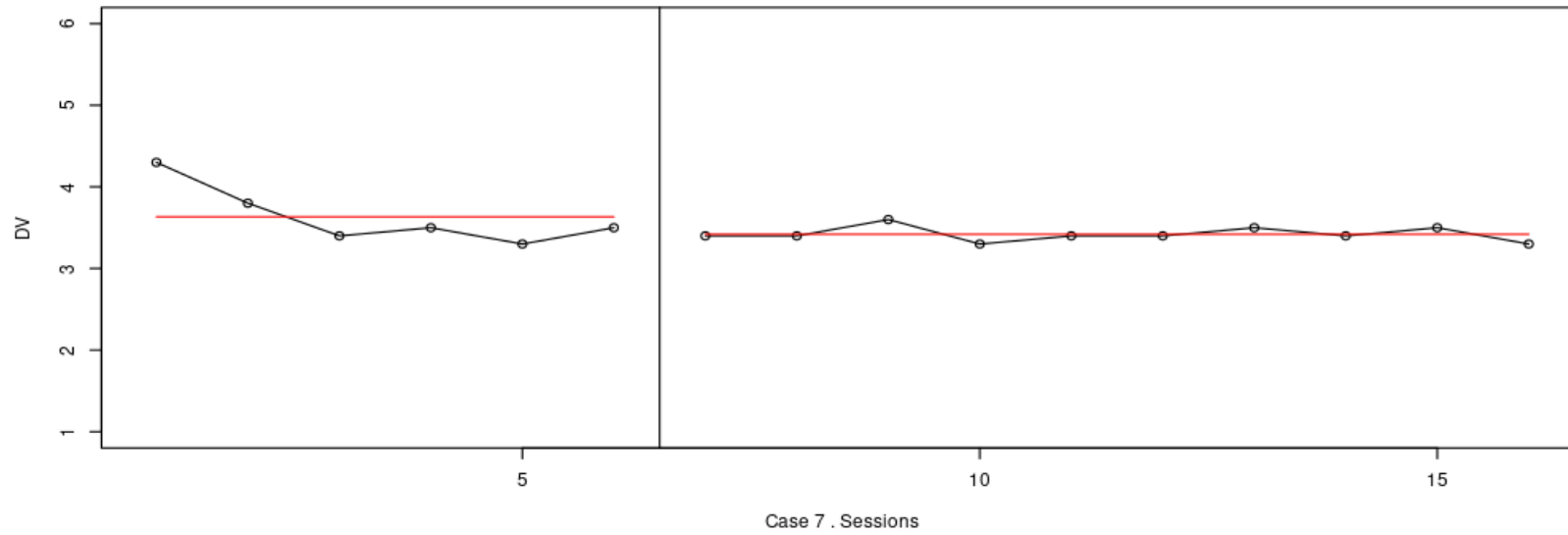
Figure 5.1

Time Series Graphs of Reflective Practice Competence of Supervisees









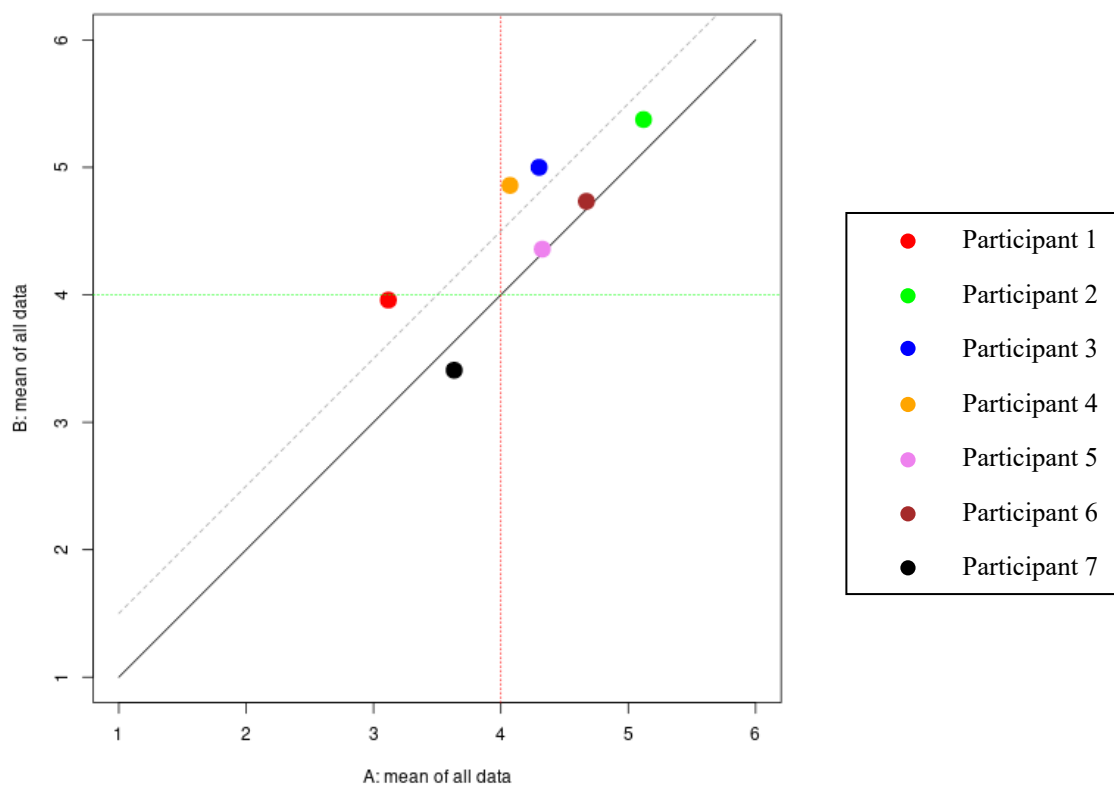
Note. The study week is represented on the x-axis. DV = Score on Reflective Practice Questionnaire (RPQ). Case = Participant.

5.3.2 Secondary outcomes

Secondary outcomes are descriptive only, as the current study was not designed for statistical analyses of secondary outcomes. Means and standard deviations for each outcome are shown in Table 5.3, and detail on trends for individual supervisees is shown in Table 5.4. Secondary outcomes did not show any consistent differences in trends between supervisees whose reflective practice improved compared to those whose did not.

Figure 5.2

Reflective Practice Competence of Supervisees During Baseline and Intervention Periods of Competency-Based Supervision



Note. X-axis (*A*) = mean RPQ score during the baseline period; Y-axis (*B*) = mean RPQ score during the intervention period. The solid black line represents no change; the dotted line represents an average improvement of 1 in RPQ score. Red and green lines represent an RPQ score of 4 (i.e., “often” engaging in reflective practice processes) during baseline and intervention, respectively. RPQ = Reflective Practice Questionnaire.

Table 5.3*Means and Standard Deviations for Secondary Outcomes*

Outcome measure	Mean (standard deviation)		
	Pre-baseline	Pre-intervention	Post-intervention
CoPPI Discrepancy between supervisor and supervisee	N/A	0.83 (0.91)	0.38 (0.29)
CoPPI Generic therapeutic competencies – supervisor rating	3.01 (0.88)	2.95 (0.67)	4.23 (0.62)
CoPPI Parenting Intervention competencies – supervisor rating	2.00 (0.67) ^a	2.81 (0.76)	4.05 (0.62)
CoPPI Specific skills/techniques competencies – supervisor rating	1.00 ^b	2.64 (0.61)	4.01 (0.54)
RPQ-adapted – supervisor rating	3.34 (0.69)	4.08 (0.75)	4.90 (0.95)
T-SES	70.14 (12.32)	78.67 (5.31)	83.71 (8.45)
SWAI-supervisee			
Rapport	4.87 (1.38)	5.61 (1.16)	5.51 (1.23)
Client focus	5.08 (1.32)	5.71 (0.88)	5.90 (0.58)
SWAI-supervisor			
Rapport	5.47 (0.54)	5.41 (0.51)	5.73 (0.57)
Client focus	5.57 (0.80)	5.49 (0.74)	5.51 (1.05)
Identification	5.02 (0.53)	5.22 (0.58)	5.33 (0.98)
GSAT-SE			
Feedback	79.47 (14.65)	82.11 (15.23)	84.79 (14.83)
Processes	76.95 (15.97)	82.29 (12.39)	83.92 (11.92)

Outcome measure	Mean (standard deviation)		
	Pre-baseline	Pre-intervention	Post-intervention
GSAT-SR			
Feedback	73.92 (10.08)	70.06 (14.53)	79.41 (8.01)
Goals and tasks	75.38 (10.57)	72.86 (11.71)	79.95 (7.36)
Respect	83.75 (10.08)	81.54 (10.90)	84.43 (7.55)
Enabling	79.14 (9.10)	74.71 (13.97)	82.63 (7.50)
AIM – supervisee	-	-	3.25 (0.58)
IAM – supervisee	-	-	3.64 (0.40)
FIM – supervisee	-	-	3.86 (0.20)
AIM – supervisor	-	-	3.85 (0.68)
IAM – supervisor	-	-	4.15 (0.82)
FIM – supervisor	-	-	3.45 (0.91)
AIM – pilot phase	-	-	3.92 (0.12)
IAM – pilot phase	-	-	4.00 (0.00)
FIM – pilot phase	-	-	3.33 (0.59)

Note. CoPPI = Competencies for Practitioners of Parenting Interventions for Disruptive Child

Behaviour rating tool; RPQ = Reflective Practice Questionnaire; T-SES = Therapist Self-

Efficacy Scale; SWAI = Supervisory Working Alliance Inventory; GSAT = Generic

Supervision Assessment Tool; SE = supervisee version; SR = supervisor version; AIM =

Acceptability of Intervention Measure; IAM = Intervention Appropriateness Measure; FIM =

Feasibility of Intervention Measure.

^a Ratings only completed for two participants.

^b Ratings only completed for one participant.

Table 5.4*Participants Whose Score Showed a Trend of Improvement for Secondary Outcomes*

Outcome measure	During baseline	During intervention
CoPPI Generic therapeutic competencies – supervisor rating	1, 2, 7	All
CoPPI Parenting Intervention competencies – supervisor rating	3, 7 ^a	1, 3, 4, 5, 6 ^b
CoPPI Specific skills and techniques competencies – supervisor rating	3 ^a	1, 3, 4, 5, 6, 7 ^b
RPQ-adapted – supervisor rating	5, 6, 7	2, 3, 4, 5, 7
T-SES	1, 2, 3, 5, 7	1, 4, 5, 6, 7
SWAI-supervisee		
Rapport	1, 2, 3, 4, 5, 6	1, 3, 6
Client focus	1, 2, 3, 4, 6, 7	1, 4, 6
SWAI-supervisor		
Rapport	2, 5, 7	1, 2, 3, 4, 5, 6
Client focus	2, 4, 5	1, 2, 6, 7
Identification	2, 5, 6, 7	2, 4, 5
GSAT-SE		
Feedback	1, 2, 4, 5	1, 3, 4, 6
Processes	1, 2, 4, 6	1, 4, 5

Outcome measure	During baseline	During intervention
GSAT-SR		
Feedback	5, 6, 7	1, 2, 3, 4, 7
Goals and tasks	7	1, 2, 3, 7
Respect	5, 6, 7	1, 2, 3, 4
Enabling	5, 6, 7	1, 2, 3, 4, 7

Note. CoPPI = Competencies for Practitioners of Parenting Interventions for Disruptive Child

Behaviour rating tool; RPQ = Reflective Practice Questionnaire; T-SES = Therapist Self-

Efficacy Scale; SWAI = Supervisory Working Alliance Inventory; GSAT = Generic

Supervision Assessment Tool; SE = supervisee version; SR = supervisor version.

^a Remaining participants excluded due to no pre-baseline score.

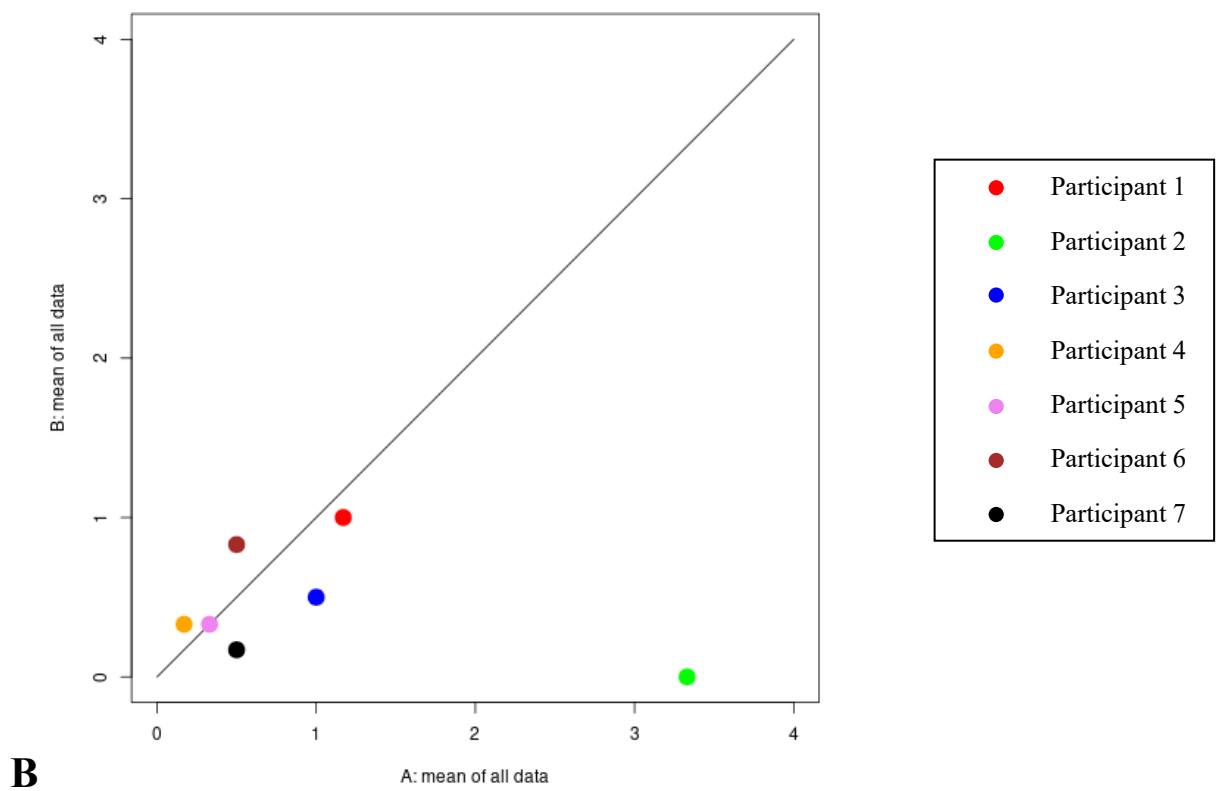
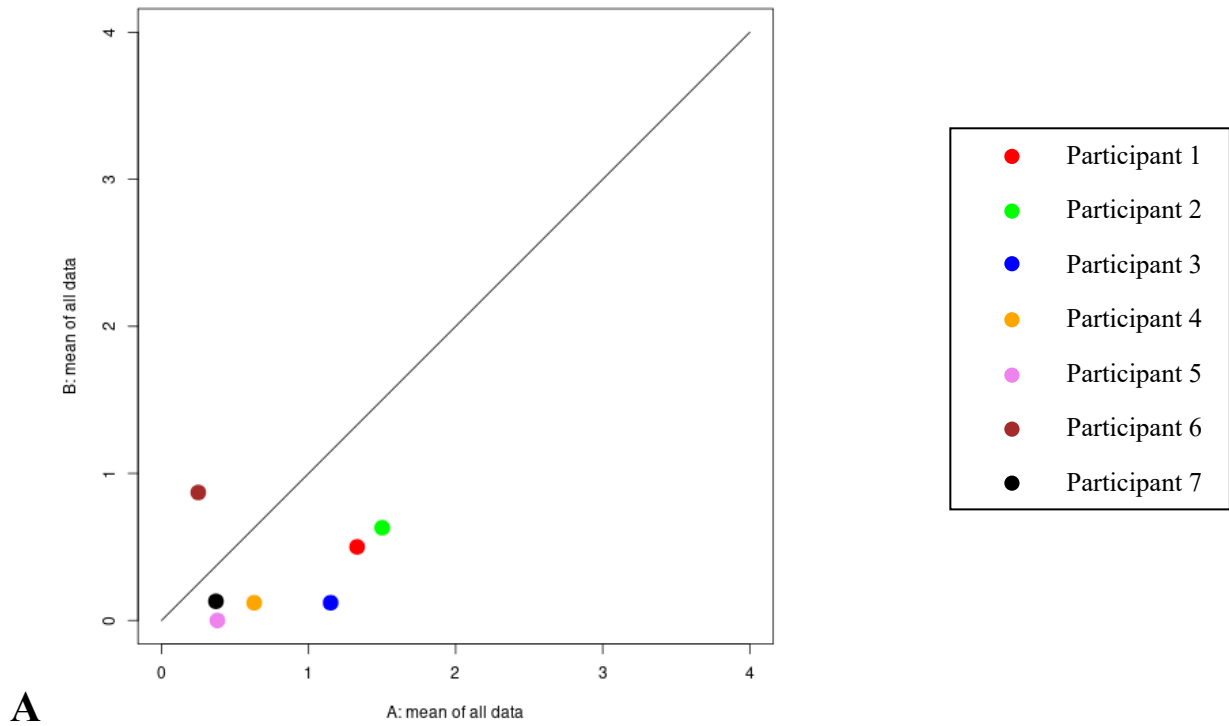
^b Participant 2 excluded due to no pre-intervention score.

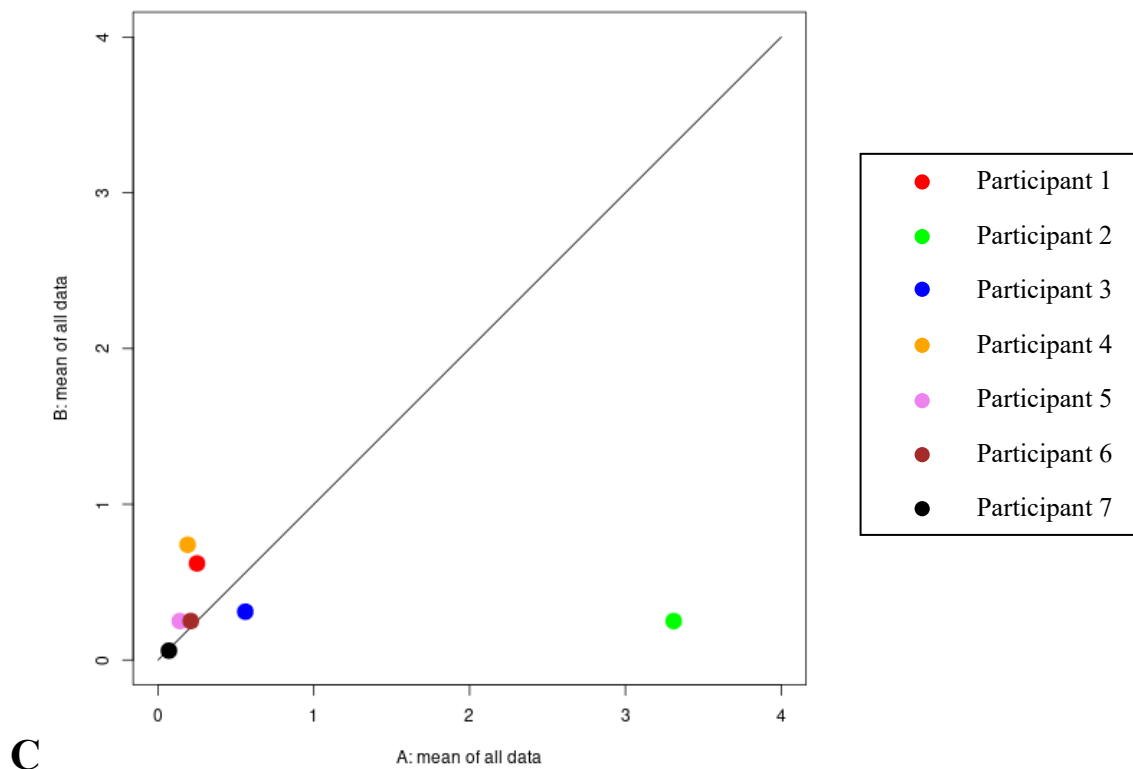
Accuracy of supervisee competency perception

Accuracy of supervisee competency perception was measured by the discrepancy between supervisor and supervisee scores on competencies. Individual participant analysis showed that supervisee-supervisor discrepancy was greater than 1 point difference at pre-intervention for at least one competency type for Participants 1, 2 and 3 (see Figure 5.3). However, following intervention, all supervisees rated within 1 point of their supervisor.

Figure 5.3

Discrepancy Between Supervisor and Supervisee Scores of Competency Ratings Pre and Post Competency-Based Supervision Intervention





Note. Each dot represents a participant, showing the discrepancy in CoPPI competency score between supervisor and supervisee prior to competency-based supervision (pre-intervention time point) on the x-axis (*A*), and after the competency-based supervision intervention on the y-axis (*B*). The solid black lines represent no change in discrepancy score, with data points below this line representing low discrepancy after compared to before competency-based supervision. Figure 5.3A presents generic therapeutic competencies, Figure 5.3B presents parenting intervention competencies, and Figure 5.3C presents competencies in specific skills and techniques. CoPPI = Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour rating tool.

Implementation outcomes

The AIM, IAM and FIM were used to measure acceptability, appropriateness and feasibility of the competency-based training, respectively. Five supervisees answered favourably on all measures (i.e., scale score of greater than three, representing overall

agreement over disagreement), whereas others had some lower ratings. Participant 1 scored 3.00 for acceptability and Participant 5 scored 2.25 for acceptability and 3.00 for appropriateness, where a score of 3 represents a neutral perception of implementation. For supervisors, all rated acceptability and appropriateness favourably, although only two of five supervisors rated favourably for feasibility, with two rating 3.00, and one rating 2.75.

Other acceptability and appropriateness questions were also examined. Two of seven interns agreed the CoPPI was easy to complete (four answered neutrally), whereas supervisors either disagreed that it was easy to complete (two) or answered neutrally (three). Regarding instructions specifically, six interns and two supervisors agreed instructions were easy to follow, with all others answering neutrally. Ratings for acceptability of sharing CoPPI scores with their supervision partner showed six interns and all supervisors were agreeable to sharing, with the remaining intern answering neutrally. Additionally, perspectives on supervisors rating of intern competencies were mixed, with three interns and three supervisors agreeing that supervisor ratings were helpful; two interns and one supervisor answering neutrally; and two interns and one supervisor disagreeing. Finally, five of seven trainees and all supervisors agreed that the CoPPI was too long.

Interview Responses and Participant Comments

Interview responses and qualitative comments at the end of the study further highlighted participant perspectives on the CoPPI and its use to structure competency-based supervision. Responses of one supervisor following the pilot phase described benefits of the CoPPI competency-based training, including that it helped them to reflect on what they are offering students; clarify assumptions; and fill gaps in knowledge. They also described it as flexible. However, they found some competencies irrelevant and felt that it could be completed less frequently. Interviews with two interns following the pilot phase highlighted that they found the CoPPI helpful for identifying new intervention components or detail therein, keeping

competencies front of mind, adjusting self-perception, and supporting structure in learning and supervision. Interns also noted that they liked the flexibility of the CoPPI. However, a theme between both interns was a preference for a shorter tool and/or less frequent use.

This theme of length and frequency was repeated in participant comments at the end of the study, with one intern requesting a shorter version, and a supervisor stating that fortnightly completion was too frequent and hindered implementation of change, but that less frequent use could be meaningful. Another intern also reiterated this sense that, especially with few clients during internship, completing rating fortnightly was too frequent. A further supervisor response highlighted that the administrative burden of the CoPPI was too much in addition to an existing general competency rating tool designed for post-graduate psychology students in Australia, but that the CoPPI “is much more applicable and useful than [other rating tool].” Finally, one supervisee stated that rating descriptors for the CoPPI did not seem to match labels of *advanced beginner* versus *competent*, and could therefore make rating difficult.

5.4 Discussion

This is the first known study to directly examine whether therapist reflective practice increases during competency-based therapist training in PIs. The current study specifically investigated whether the CoPPI, a competency-based rating tool, can improve reflective practice of trainee psychologists when used as the foundation for competency-based training in PIs for child conduct problems. Results show that competency-based training in PIs, using the CoPPI, can be effective at increasing reflective practice competence for trainee psychologists in different age groups, genders and levels of experience. The multiple baseline design allows for causal inferences to be made about the intervention compared to baseline (Alfonsson et al., 2020; Kratochwill & Levin, 2015), suggesting that the current competency-based training may improve reflective practice competence more than supervision as usual. However, statistically significant improvements were only achieved in three of seven cases, without any patterns in

secondary outcomes seeming to distinguish between these supervisees compared to others. Importantly, reflective practice did not significantly worsen for any supervisees. Furthermore, secondary outcomes showed that participants found the CoPPI somewhat acceptable, appropriate and feasible, and supervisees consistently became more accurate at rating their generic therapeutic competencies from pre- to post-intervention.

Three of seven supervisees demonstrated significant improvements in reflective practice as a result of using the CoPPI, partially supporting our hypothesis. This increase in reflective practice competence due to competency-based training is consistent with literature on competency-based training in nursing and medicine (Khalil & Abou Hashish, 2022; Sobral, 2000), and hence broadens evidence on reflective practice development to the field of psychology. Additionally, this finding is consistent with the aim of competency-based training, to increase reflective practice competence so as to subsequently build other competencies (Epstein & Hundert, 2002; Kaslow & Ammirati, 2020; Ooi et al., 2023; Rodolfa et al., 2005).

However, four supervisees did not show significantly higher reflective practice scores in the intervention compared to baseline period. Participants 6 and 7 showed lower adherence to the intervention, to which poorer outcomes may be attributed, meaning that most supervisors (three of five) who adhered to the intervention had an increase in reflective practice competence. However, poor adherence does not explain scores of Participants 2 and 5. Their lower RPQ scores may be explained by other factors that could be important to development of reflective practice, although this was beyond the scope of the current study to examine. Nonetheless, despite insignificant NAP-values, three of the four remaining supervisees (all except Participant 7) trended towards an increase in reflective practice following competency-based supervision, with NAP-values higher than those in a similarly designed supervision study (Alfonsson et al., 2020).

Our second hypothesis, that increased reflective practice would be associated with improvements in secondary outcomes, including competencies, therapist self-efficacy and the process of supervision, was not supported by the current findings. The current data did not show consistent differences in trends between supervisees who did versus did not improve in reflective practice. GSAT scores across both supervisors and supervisees pre-intervention were within or above the range of 60-79, which represents “proficient level of skill with consistent level of practice.” Therefore, supervisors appeared to have a high level of competence prior to the intervention, suggesting that supervisor competence was unlikely a barrier to supervisee learning or competency improvement, and that a ceiling effect may have prohibited significant improvements in supervisor competence. Secondly, T-SES scores in the current study were comparable to previous research, with the original T-SES development study showing a mean of 78.10 (Gori et al., 2022), suggesting that T-SES scores in the current study were likely valid. Similarly, SWAI scores were comparable to scores in previous research on clinical supervisors in psychology training programs (Efstation et al., 1990), suggesting supervisory alliance was adequate. Hence, despite these secondary outcomes suggesting that design quality or validity did not interfere with data, no clear pattern in secondary outcomes was identified that differentiated supervisees whose reflective practice competence significantly improved during competency-based training, and those whose reflective practice competence did not. Accordingly, experimental research could further investigate the effect of competency-based supervision and reflective practice competence on other competencies, self-efficacy, supervisory competence and supervisor alliance.

Finally, our third hypothesis, regarding implementation outcomes, was that supervisors and supervisees would perceive the CoPPI as appropriate, acceptable and implementable. AIM, IAM and FIM mean scores were within the range of other studies on psychosocial interventions (Abbott et al., 2025; Dahiya et al., 2025) and supervision interventions in

teaching (Huffhines et al., 2024), although in the lower end of that range. This suggests that implementation outcomes were within an acceptable range but may benefit from being improved. Participant scores also reflected some strengths of the CoPPI's use as a competency-based training tool, including that supervisory teams were willing to share scores and supervisees found the instructions easy to follow. Furthermore, supervisors and supervisees both highlighted that the CoPPI was helpful for the purposes for which it was intended and which were highlighted during its development (see Chapter 4), including for building structure in supervision and learning, and identifying blind spots.

However, implementation outcomes suggest that dissemination of the measure into routine clinical practice may require further research. Two of seven supervisees were interested in adopting the CoPPI following the study, and two viewed its use as sustainable. The average time taken for the brief in-supervision review was considerably longer than anticipated: 17 minutes compared to 5 minutes expected, which was marginally briefer than the full in-supervision review. The duration of the in-supervision reviews and the length of the CoPPI itself may both have worsened implementation outcomes and may indicate a need to make the review process more concise and/or completion of the CoPPI briefer. Alternatively, participants may have been considering their experience of completing study outcome measures when responding to implementation outcome measures, without differentiating this from their experience of the competency-based training intervention. As outcome measure completion was a major component of study participation, this could have increased their perception of the time taken to engage in the competency-based training, and consequently negatively affected implementation outcomes. Responses to implementation questions and supervisor comments support that participants perceived study completion as time consuming, and suggest that the CoPPI may better meet therapist needs if (a) it is implemented less frequently; (b) it replaces other similar tools rather than being used simultaneously, and if (c)

therapists can use a shorter version more frequently. Further research may therefore seek to implement the CoPPI less frequently over a longer study period (e.g., every three months over a year), where therapists may additionally re-rate competencies at desired intervals, and separate intervention components (i.e., completion and review of the CoPPI) from outcome measure completion for participants.

Contextual constraints represent a limitation of the current study and an opportunity for future research. The current study took place in a university training clinic for post-graduate clinical psychology students, in which students see clients for approximately 22 weeks. This short duration precluded examination of the CoPPI over a longer study period, or commencement of the study later in therapist training. Additionally, supervision was of high quality prior to introduction of the CoPPI competency-based training. Improvements in secondary outcomes during baseline, which may have been due to the above factors, made it harder to establish a stable baseline, and to therefore identify trends in secondary outcomes related specifically to competency-based supervision. A further challenge related to commencement of the study only four weeks after students commenced placement was that pre-baseline competency ratings from supervisors were based on limited information. Consequently, to further examine benefits of competency-based supervision compared to supervision as usual, future research should examine use of the CoPPI over a longer period, within more established supervisory relationships, as well as with more experienced practitioners.

Another limitation of the current study is that causal inferences are somewhat limited. A single-case experimental design with multiple baselines was employed to support the study being conducted in a controlled setting, in which other variables around supervision (e.g., frequency, content, intervention being taught) were consistent. However, only a small sample was available. A SCED offers lower generalisability than experimental studies (Alfonsson et

al., 2020; Kratochwill & Levin, 2015), and statistical analyses were limited due to violations of the assumption of normality related to small sample size. Resultingly, whilst causal inferences can be made about the increase in reflective practice for three supervisees, no inferences can be made about what factors resulted in this increase. Interestingly, this is a parallel process to research in PIs itself, with research only more recently focused on understanding factors that moderate effectiveness of PIs (Leijten et al., 2018; Mejia et al., 2017).

Ultimately, the current study found that reflective practice competence significantly improved for three of five supervisees training in PIs when competency-based supervision using the CoPPI was adherently implemented over a 9- to 12-week period. This is the first study testing the use of a comprehensive common elements-based measure of core competencies in PIs as a training tool, and thus provides preliminary evidence for the benefits of the CoPPI. This study provides support for the CoPPI to be implemented in supervision for PIs, to enhance reflective practice outcomes. Additionally, the current data provides evidence that competency-based supervision has potential to improve reflective practice. As reflective practice is core to learning (Mann et al., 2009; Schön, 1992), its improvement through competency-based supervision could therefore support therapists to continue to learn, including following periods of competency-based supervision. In this way, other competencies may also be improved. However, further research would need to investigate whether competency scores are correlated to improvement in reflective practice competence, and whether these outcomes can be replicated in larger therapist samples, including in other intervention areas. If competency-based supervision can more effectively improve reflective practice than current supervision methods in PIs, then competency-based supervision could be used more broadly to improve quality of supervision, accessibility of supervision outside of manualised programs, and therefore quality of delivery and availability of psychosocial interventions (Pinto et al., 2024; Turner et al., 2011).

In summary, this study presents promising preliminary evidence for the use of the CoPPI in supervision for therapists training in PIs to promote reflective practice competence, which may subsequently promote development of other competencies and quality of PI implementation. The CoPPI is the first comprehensive measure of competencies for PI therapists and its utility therefore creates further avenues for research to develop competency-based training in PIs. Further research should investigate whether reflective practice competence and other competencies could be improved by more prolonged use of the CoPPI, whether this generalises to broader samples of therapists, and whether its use improves long term use of PIs by therapists.

CHAPTER 6: General Discussion

The current research aimed to build the foundational components for competency-based supervision and training in social learning-based parenting interventions for child conduct problems (PIs). In this project, a comprehensive core therapist competency model and a competency rating tool thereof were constructed through a Delphi study, co-design focus groups, an online validation survey and a pilot case series. This is the first consensus-validated core competency model and corresponding rating tool designed to be used across various social learning-based PI programs and also encompassing both general and PI-specific competencies. The output from this project therefore supports improved understanding of core competencies and enables important opportunities for competency-based practice in PIs that were not previously possible.

The first major contribution of the current research project was the construction of the model of core therapist competencies and its application to the drivers of case complexity. This novel competency model for PI therapists has been designed for use across various PI programs, and includes both generic therapeutic and intervention-specific competencies. Through the Delphi method, consensus was established amongst an international panel of expert PI therapists on a model of core therapist competencies as well as a model of drivers of case complexity that complicate the treatment process for child conduct problems. Previously proposed competencies were revised and validated (Allen et al., 2021; Hawes & Dadds, 2021a), and integrated with empirically derived competencies (Leijten, 2021; Roth & Pilling, 2008). Additionally, consensus was reached on competencies particularly important for higher overall complexity, and some competencies that are particularly important when each driver of case complexity is present. As such, the models developed in the current research build on previous research, further growing the understanding of therapist competencies and case complexity in treatment of conduct problems.

The second major contribution of the current research was the construction of the Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour (CoPPI), developed and validated through co-design, a survey of therapists, and a single-case experimental design (SCED). To the author's knowledge, the CoPPI is the first comprehensive competency rating tool designed for use across all major PI programs and the first comprehensive competency rating tool translated from a consensus-based core competency model. It offers a means for assessing and reflecting on core therapist competencies with basic psychometric properties established, such as convergent validity and face validity. Furthermore, to the author's knowledge the SCED study was the first study in psychology to directly examine whether reflective practice competence can be increased by competency-based supervision. Using the CoPPI as the basis for competency-based supervision in PIs, findings showed that competency-based supervision can improve reflective practice in some trainee psychologists, thus showing preliminary evidence for the CoPPI's utility. Overall, this project has thus produced a novel model of core therapist competencies, a novel model of drivers of case complexity, and a novel competency rating tool, which collectively support competency-based training and practice in PIs.

6.1 General Reflections

Reflecting on the process and findings of the current research as a whole, some observations were noteworthy. Firstly, in its production of a novel core competency model and corresponding rating tool, this research project develops new understanding by marrying disparate fields of literature. Traditionally, literature on competency development (e.g., Gonsalvez et al., 2021; Roth & Pilling, 2008; Sburlati et al., 2011) and on assessment of competencies (e.g., Blackburn et al., 2001; Kohrt et al., 2015; Rice et al., 2022) has been largely distinct from other supervision and training research (e.g., McPherson et al., 2016; Valenstein-mah et al., 2020). For instance, research on common elements and modular

treatment models (e.g., Garland et al., 2008; Leijten et al., 2019; Weisz et al., 2012) focuses little on competence directly. Furthermore, the above bodies of literature have traditionally been largely removed from literature on implementation science, which focuses on factors important for translating interventions into practice (e.g., Glasgow et al., 2019; Proctor et al., 2011; Shelton et al., 2018). Additionally, research on intervention implementation in routine care, including fidelity and adaptations (e.g., Anyon et al., 2019; Basha et al., 2025; Forgatch et al., 2005; Moore et al., 2013; Peters-Corbett et al., 2024; Rodrigo, 2016), has only recently been linked to implementation outcomes identified in implementation science literature (Pinto et al., 2024). Finally, literature on responses to case complexity (e.g., Delgadillo et al., 2017; Hawes & Dadds, 2021a; Kazdin, 2022; Leijten et al., 2020; Shippee et al., 2012), and on the capacity of the workforce to deliver evidence-based interventions effectively (e.g., Patterson et al., 2002; Prguda et al., 2020; Weisenmuller & Hilton, 2021), have previously also had little overlap with each other. The siloing of these related fields of literature has been in spite of research recognising the importance of training and therapist competence for effective intervention implementation (Roth et al., 2010) and subsequent workforce capacity to deliver evidence-based interventions. This siloing has consequently slowed progress on improving therapist training through competency-based approaches.

Contrastingly, the current project draws on each of these fields of research to clarify how each contributes to effective delivery of an evidence-based intervention. Integrating insights from each of these fields, the current project highlights that: (1) training must teach therapists to competently but flexibly deliver evidence-based care; (2) such training must be both implementable and responsive to complex client needs; and that (3) these above training conditions are necessary to attract therapists and encourage their ongoing use of evidence-based interventions post-training. It is also highlighted that such training is important because (4) there is a substantial burden of child conduct problems, and hence (5) it is important that

the workforce capacity to deliver evidence-based PIs better meets demand. This project is thus novel in its placement of competency-based training as an important piece of the puzzle in decreasing the research-practice gap in PIs.

Another reflection of note was that expert PI therapists from diverse settings and backgrounds were able to reach some consensus. Agreement was reached Over 70% of 41 therapists, practicing in nine countries across five professions and all the major PI programs, were able to agree on each of 15 areas of core competencies and seven drivers of case complexity. Furthermore, this consensus was reached after only two rounds, which is the minimum number of rounds for a Delphi study (Chalmers & Armour, 2019) and highlights that experts reached consensus swiftly. Hence, results suggest expert practitioners have a strong shared understanding of core competencies and drivers of case complexity in treatment of child conduct problems. Future research can consequently build on this shared understanding amongst experts, using shared language to further evolve models and training.

Finally, another salient observation pertained to the challenges inherent in designing a therapist training tool of practical utility. Challenges related to tensions between specificity and implementability, and between the tool's functions of assessment and supporting training process. Stakeholders expressed interest in detail and precision, whilst also noting time constraints to be one of the main barriers to use of a tool in routine practice. Modest ratings for acceptability, appropriateness and feasibility for the CoPPI in the current project reflect this tension, which has been recognised in translation of earlier core competency models (Roth & Pilling, 2008). Given the CoPPI fills an important gap by providing a means to reflect on PI-specific competencies common across PI programs, further research could focus further on its dissemination and utility as an assessment tool.

Also related to implementability, competing functions that a competency rating tool can serve in training and ongoing professional development complicated design of the CoPPI.

There is a demand for valid and reliable competency assessment measures (Gonsalvez & Freestone, 2007; Martin et al., 2021; Simons et al., 2013), yet there is also a demand for usable measures that can be flexibly applied in routine care settings (Böhm et al., 2022). A competency rating tool is ideally both reliable and implementable, yet often these two aspects come at odds. Flexibility (and subsequent appropriateness and feasibility) is often forgone to allow a tool to be psychometrically validated; and necessity to train to administer a tool reliably and validly naturally decreases the tool's implementability. In the current project, tool flexibility was prioritised given the focus on supporting the training process and in turn strengthening workforce capacity to deliver PIs. Thus, its psychometric properties should be further investigated if the CoPPI is to be used for competency assessment purposes.

6.2 Implications

6.2.1 Growing Recognition of Process-Related Competencies

Findings in the current research project add to previous research highlighting the importance of process-related competencies. The present core therapist competency model for PIs, like previously proposed frameworks of clinical competence, assigns significant weight to process-related competencies. Previous models generally identify three to five competency types (Roth & Pilling, 2008; Sburlati et al., 2011, 2012). The structure of CBT-related models summarised in a more recent publication (Muse et al., 2022), and the current competency model, have also mirrored this. Muse and colleagues define competency types as: (1) generic therapeutic knowledge, (2) generic therapeutic skills, (3) broader therapeutic practitioner competencies, (4) basic CBT competencies, (5) CBT meta-competencies, (6) specific CBT techniques, and (7) problem-specific CBT skills. Each of these is encapsulated in the current competency model: generic therapeutic competencies integrate the first three types identified by Muse and colleagues; PI competencies capture competencies equivalent to the next two; and specific PI skills and techniques parallel the final two competency types.

Thus, process-related competencies, including generic therapeutic competencies, meta-competencies and intervention-specific process competencies, represent a large proportion of core competencies, highlighting their importance to intervention delivery.

The emphasis on process-related competencies in the current core competency model, in addition to specific PI skills and techniques, highlights the demand for evidence-based tailoring of the process of treatment. Processes such as engaging parents, formulating, and treatment planning may vary to meet individual client needs. Clinicians may, for example, make cultural adaptations (Asiimwe et al., 2022), or address parental attributions (Sawrikar & Dadds, 2018), to attempt to support treatment success. Ultimately, effective tailoring and adaptations support engagement and effective intervention delivery (Hawes & Dadds, 2021b; Macneil et al., 2012; Weisenmuller & Hilton, 2021). As part of this individual tailoring, the core competency model recognises need for integration of theories beyond social learning theory on which PIs are based (e.g., integration of attachment theory). This need for integration aligns with published practitioner recommendations, especially to address case complexity (Scott & Dadds, 2009). The importance of these broader process-related competencies has also been investigated in broader psychological intervention research on common factors. Such factors that have been found to influence treatment outcomes include therapeutic alliance, therapist empathy, therapy expectations, cultural adaptations and therapist effects (Lambert & Barley, 2001; Wampold, 2015).

Notwithstanding the importance of process-related competencies, the importance of specific skills and techniques is also recognised. Previous empirical research has shown that specific competence is a distinct construct to general competence (Cecilione et al., 2021), and has identified key PI skills and techniques for program effectiveness (Leijten et al., 2019). As such, the inclusion of specific skills and techniques in the current PI competency model is also important to both research and clinical practice.

6.2.2 Supporting a Shift Towards Competency-Based Training

The research in this project provides the necessary components to support competency-based training in PIs: a comprehensive, consensus-based core competency model and a tool by which to assess and structure learning of competencies. Research is moving beyond the assumption that manualised interventions represent optimal care (Mazzucchelli & Sanders, 2010; Simons et al., 2013), although research on the most effective components of therapist training is still limited (Frank et al., 2020). In PIs specifically, identification of competencies has been recognised as a way to better understand and also improve training (Leijten et al., 2025). The foundational components for competency-based training produced in this project could form the basis of requested guidelines for training, treatment, and adaptations thereof, to better support therapists (H. Hasson et al., 2023). In this way, they could support a timely shift towards a competency-based training model across various PI programs, in line with other areas of mental health care (Gonsalvez et al., 2021).

Additional to supporting training in PIs, the current research supports progression of competency-based training in other areas of psychosocial intervention. Competency-based training and supervision has been increasingly encouraged across mental health care (Falender & Shafranske, 2017; Gonsalvez & Calvert, 2014), and several comprehensive competency models have been produced (Quick, 2011; Roth & Pilling, 2008; Sburlati et al., 2011). Despite this, no other competency models have been translated into a competency rating tool. CBT training programs often instead use the Cognitive Therapy Scale-Revised (CTS-R; Blackburn et al., 2001) to rate competencies (Kühne et al., 2020), with the items therein not empirically derived (Young & Beck, 1980). For other intervention areas, competency measures are often not available, with several therapy models recommended by NICE guidelines lacking relevant and validated competency measures (Barlow & Brown, 2020). By providing a blueprint for the translation of a competency-based model to a

competency rating tool, the current research offers the opportunity to progress competency-based training and practice in other mental health interventions.

Also critical to competency-based training is the conceptualisation of drivers of case complexity and an understanding of how these relate to competencies. Importantly, case complexity was defined as the complication of the treatment process, rather than by the occurrence of poorer client outcomes. That is, if case complexity is appropriately accounted for in treatment, it can exist without poorer outcomes. Based on the current findings, it was proposed that case complexity may worsen outcomes by (1) disrupting parental engagement (Piotrowska et al., 2017), (2) being driven by ecological factors or child-level drivers (e.g., callous-unemotional traits) that are not directly addressed by intervention, and/or (3) leading a practitioner to make non-evidence-based adaptations (Hawes & Dadds, 2021a; Roach et al., 2022). These three processes can all be addressed by competency-based training.

Firstly, process-oriented competencies in the current model can support disrupted parental engagement. Secondly, an understanding of which competencies are particularly important for each driver of case complexity can support therapists with when intervention should be adapted or not. In this way, an additional benefit to understanding and developing shared language around drivers of case complexity is that referral pathways could be made for specialized care based on case complexity. As such, clients could access therapists with specialised training to support the relevant competencies. Hence, while further research is needed to deepen the understanding of how competencies relate to case complexity, the current research provides some groundwork for better supporting therapists in responding to complex presentations.

6.2.3 Benefits of Competency-based Training

Growing interest in competency-based training is grounded in its potential to improve training and therefore workforce capacity and outcomes, with promising recent examples of

competency-based training. The UK's Talking Therapies initiative (IAPT) has trained over 10,500 therapists in the UK, improving both workforce capacity and quality of care (Clark, 2018; Liness et al., 2019b). Subsequently, similar programs have been rolled out in other countries and found to be economically effective (O. R. F. Smith et al., 2025). Additionally, in low-resource settings, competency-based training has been successfully used to upskill para-professionals and subsequently increase availability of evidence-based interventions in such settings (Kohrt et al., 2015, 2024). Ultimately, competency-based training programs such as these have improved workforce capacity to implement evidence-based intervention on large scales. This suggests that the use of competency-based training in PIs could also support improved workforce capacity to effectively deliver PIs.

Competency-based training is also related to modular approaches and as such may offer similar benefits. A well-known modular treatment model is the Modular Approach to Treatment for Children with Anxiety, Depression, Trauma and Conduct Problems (MATCH-ADTC), which is designed to address lack of flexibility in standard treatment protocols and therefore better meet variable client needs (Chorpita & Weisz, 2005; Lucassen et al., 2015). MATCH has been shown to improve clinical and functional outcomes compared to treatment as usual (Chorpita et al., 2017; Weisz et al., 2012), and shown to improve adherence to evidence-based interventions (Merry et al., 2020). Similarly, a modular approach for social service practitioners has been created, the Adaptation and Fidelity Tool (A-FiT), to improve guidance for adaptations (H. Hasson et al., 2023). Modular treatment approaches such as MATCH and A-FiT are flexible, guided by assessment and formulation of each individual client. These aspects were also highlighted as central to competency-based practice in the core competency model constructed in this project, particularly to address complex client needs. Like modular treatment training, competency-based training allows the therapist to flexibly tailor intervention and simultaneously maintain adherence to the evidence base. In

this way, competency-based training has the potential to improve therapist use of evidence-based intervention and subsequently improve client outcomes.

Competency-based training could better support therapists than manual- and input-based training models (e.g., hours of practice following a set training course), by providing structure for flexibility. Intervention adaptations are common in routine care settings, with 40% of therapists making adaptations (Moore et al., 2013), and parenting programs adapted for routine care settings in 40% of studies (Pinto et al., 2024). There is recognition that flexibility is important (Fonagy & Luyten, 2019; Mazzucchelli & Sanders, 2010), with therapists needing to adapt approaches according to cultural needs (e.g., Mejia et al., 2017), complex symptoms (e.g., Fleming et al., 2022), and varied trauma histories (e.g., Roach et al., 2022).

At the same time, there is concern that many adaptations are not evidence-based (Anyon et al., 2019; Moore et al., 2013). Such concerns are well-founded because it is important to maintain fidelity to foundational principles of the evidence-base, such as social learning theory for PIs, in order for interventions to be effective (Morawska & Sanders, 2011; Scott & Dadds, 2009). Indeed, multiple studies have found fidelity to a PI program to be associated with greater improvements in disruptive child behaviour (Hukkelberg & Ogden, 2013; Thijssen et al., 2017). Furthermore, fidelity has been found to predict improvement in parental engagement (J. D. Smith et al., 2013), parenting practices and parental psychopathology (Thijssen et al., 2017). Nonetheless, flexibility has been shown to improve program fit if adaptations are aligned with key program principles (Anyon et al., 2019), suggesting flexibility can be beneficial if fidelity is maintained. As such, better support is needed that aids practitioners in differentiating evidence-based adaptations from non-evidence-based adaptations (e.g., additional modules for severe conduct problems, Leijten et al., 2022; or removal of specific behaviour management strategies, Roach et al., 2022;

Woodfield et al., 2022). Competency-based training offers such support and is therefore well suited for training in routine care settings, including for scaling up intervention use (Clark, 2018).

In addition to providing guidance for evidence-based intervention adaptations, competency-based training could also better support practitioners by improving their reflective practice competence. The current research has shown that use of the CoPPI as the basis for competency-based supervision can improve reflective practice for some trainee psychologists. This is consistent with the purpose of the CoPPI: to anchor the reflective process by guiding the focus of training and supervision based on the individual therapist's skill set. Several benefits to reflective practice competence have been identified, including promoting accurate self-assessment (Kaslow & Ammirati, 2020), improving professional self-efficacy and independence in learning (Curtis et al., 2016), and improving other therapist competencies (Lilienfeld & Basterfield, 2020; Muse et al., 2022). Hence, the competency-based training for PIs tested in this project may improve reflective practice competence, with potential widespread benefits for therapist learning and practice.

Competency-based training may improve workforce capacity to deliver PIs by supporting reflective practice, development of competencies, and flexible evidence-based implementation of interventions. Social learning-based PIs have been shown to have the strongest evidence base for improving conduct problems according to research and guidelines (Kaminski et al., 2024; National Institute for Health and Clinical Excellence, 2013). Conduct problems are critical to address as they are responsible for the largest burden of any mental health concerns globally in children up to 14 years of age (Ferrari et al., 2022). However, literature consistently points to inadequate availability of PIs (Doyle et al., 2023; Prguda et al., 2020; Weisenmuller & Hilton, 2021). Given few formal education opportunities for therapists to train in PIs (Sanders, 2023), a shortage of therapists trained in PIs is likely a

significant barrier to their availability. Competency-based training has supported increased reach and quality of delivery for other psychological interventions (Clark, 2018; Kohrt et al., 2024), suggesting that competency-based training for interventions addressing conduct problems may be able to similarly do so. It could improve the availability of and interest in PI therapist training and ongoing professional support compared to standard manualised training, thus improving workforce capacity and, subsequently, intervention availability.

6.2.4 Generation of Avenues for Further Research

The products of the current project also provide important tools for research, enabling novel research opportunities. Firstly, the operationalisation of competence in PIs into specific core competencies allows the effect of specific competencies to be investigated. Previously, there have been inconsistent research findings on the relationship between competence and client outcomes, hindered by a lack of measures of competence (Collyer et al., 2020; Simons et al., 2013). Now, the current core competency model and CoPPI can help deepen our understanding of how competence, including specific competencies, affects outcomes. Additionally, the CoPPI could be further validated and revised by such a process, to optimise its use for improving client outcomes. In this way, operationalisation of specific competencies may also shed light on the discrete mechanisms that drive therapist effects (Wampold, 2015). In this way, the current core competency model and rating tool provide a means for further research on the relationship between therapist competence and client outcomes.

Secondly, the current project broadens opportunities for further research due to the conceptualisation of distinct drivers of case complexity in PIs. The development of language around different drivers of case complexity allows research to now examine distinctions between drivers in terms of how each effects the treatment process and treatment outcomes. Previous research has acknowledged different ways in which intervention can be

complicated, and ways to address these (Piotrowska et al., 2017; Schoemaker et al., 2020; Scott & Dadds, 2009; Weisenmuller & Hilton, 2021), yet PIs still cannot accurately distinguish between families who benefit from treatment and those who do not (Leijten et al., 2025; McMahon et al., 2021). This limitation suggests that a more standardised approach to conceptualising case complexity, as offered by the current model, could improve understanding of the effects of distinct profile of case complexity on treatment outcomes. Related to this, further research on what adaptations improve versus worsen outcomes for each driver of case complexity is afforded by the current conceptualisation of case complexity.

The current model of drivers of case complexity could support emerging models of evidence-based adaptations, such as strategic flexibility. The strategic flexibility model is a model aimed at supporting therapists to determine the parameters for tailoring intervention, including who to tailor for, what to tailor, when to tailor, where (in what settings), and why or for what goal (Georgiadis et al., 2020). Strategic flexibility outlines that there are baseline tailoring factors that should determine if adaptation or tailoring should occur so that proactive modifications in treatment delivery—in specific settings and at specific timepoints—can be made. The model stipulates that the effectiveness of these should then be monitored through ongoing observation and data collection, to determine if further modification is needed (Georgiadis et al., 2020). The drivers of case complexity conceptualised in the current model could support practitioners to outline baseline tailoring factors, to which they could then apply proactive modification to improve intervention effectiveness for individual clients. In this way, the current model supports the “who” of strategic flexibility. Further research can subsequently now explore what, when and where intervention adaptations are effective for these clients whose presentation is complex.

Thirdly, the current results could support further research on mechanisms of supervision and training, for which there is an identified need (Garbacz et al., 2014). Supervision has long been recognised as core to training and ongoing skill maintenance (Garbacz et al., 2014; Moncher & Prinz, 1991; O'Donovan et al., 2011), yet there has been limited research and hence understanding on the effect of supervision on client outcomes (Falender & Shafranske, 2017; O'Donovan et al., 2011). The current operationalisation of competencies could support research that compares different supervision approaches. For instance, research could examine the effectiveness of teaching different subsets of competencies, to determine what competencies are particularly important for improving therapist competencies and subsequently client outcomes. The products of the current project therefore promote further pertinent research on improving therapist training and intervention delivery in several ways.

6.3 Limitations and Future Research

6.3.1 *Generalisation of Findings*

Despite the strengths of the current research, important limitations must be acknowledged about the generalisability of findings, with further research required to address these. Firstly, the current findings require further empirical support before their implementation to inform training would be appropriate. The methods used in the current research included a Delphi study, co-design, a small experimental study and a single case experimental design. These were chosen as the most appropriate methods to construct preliminary models and tools. Indeed, strengths supporting generalisation of the current findings included high participant retention across Delphi rounds and considerable consensus drawn from the “wisdom of crowds” in the Delphi study (Jorm, 2015). The current methods were also those that were feasible within the context of PhD in which all data was collected by the author without project funding beyond scholarship. Despite strengths of the current

research methods, further research questions require different methods. Empirical research methods should be used to test the effectiveness of these models in training; examine further psychometric properties of the CoPPI to support its reliability and validity (Simons et al., 2013); and refine the models and tool accordingly. This future research could ultimately optimise training and subsequently client outcomes.

Specifically, whilst the current research established consensus amongst an international expert therapist panel on core therapist competencies and drivers of case complexity, consensus was not entirely established regarding which core competencies are particularly important for different drivers of case complexity. This outcome highlights differing perspectives amongst practitioners as to how to address case complexity, which warrant further examination. The current research could not address this as another round in the current Delphi study was likely to result in high attrition that could bias outcomes (Chalmers & Armour, 2019). Hence, further research should seek to establish more consensus regarding pertinent competencies for addressing complex client needs.

Understanding of core therapist competencies may also be improved by inclusion of client perspectives, which was beyond the scope of the current research. While clients need not be aware of the specifics of therapist training beyond perceiving their therapist as competent, they may have distinct perceptions regarding the competencies that make a therapist effective. Building competency-based training that includes competencies that clients value could improve engagement and therefore program reach and outcomes (Piotrowska et al., 2017). Consequently, further research examining client perceptions of important therapist competencies could be beneficial to intervention delivery.

One important finding of the current study was that therapist reflective practice can be improved by a competency-based training intervention. However, the effects of this on competency development or client outcomes was beyond the scope of the current research.

The current single case experimental design study addressed an important gap in the research: no previous known studies have examined improvement in reflective practice via competency-based training in mental health therapists. Other research on therapist reflective practice development is also limited (Ooi et al., 2023), despite reflective practice a recognised core therapist competency internationally (Kaslow & Ammirati, 2020; Lilienfeld & Basterfield, 2020). Therefore, the current study was an important step towards understanding the relationship between reflective practice and competency-based training, which now allows future research to extend to the relationship between reflective practice and other outcomes. In light of this, further research exploring whether improvement in reflective practice competence is related to improvement in other competencies and subsequent client outcomes would be timely.

Notably, reflective practice competence did not improve for all therapists in the current research, suggesting further research is also needed to understand factors that affect a therapist's development of reflective practice within PIs. Understanding factors affecting development of reflective practice was beyond the scope of the current research, yet is important to determine effective methods to improve reflective practice. The current research also did not examine whether reflective practice is the mechanism through which competency-based training improves competencies. Furthermore, it also did not assess other potential effects of improved reflective practice, such as on self-efficacy, supervisory working alliance, supervisor competence, or therapist ongoing use of intervention. Each of these relationships should be investigated in further research to understand supervision processes and the effectiveness of competency-based training.

Further research is also needed to examine if competencies and findings effectively generalise with different populations. Findings regarding increase in reflective practice in response to a competency-based training intervention were limited to a small sample of

trainee psychologists. Participants in studies 2, 3 and 4 consisted largely of psychologists as well. Therapists with various professional backgrounds deliver PIs, and different core competency areas may be particularly pertinent to therapists with different backgrounds and experience. Future research should hence examine consensus on core competencies, consensus on competencies that are particularly important for different areas of case complexity, and dissemination of the CoPPI in broader populations. This should include PI therapists from different professional backgrounds (social work, nursing, medicine, education), different countries and cultural settings, and at different levels of training. Additionally, the current research was focused on PIs for child conduct problems, where other psychosocial interventions could benefit from similar research to create competency models and measures. Thus, the current research offers preliminary findings to support competency-based training, with significant further research needed to support generalisation thereof.

Finally, it is important to acknowledge that most PI research has been developed in predominantly WEIRD contexts—Western, educated, industrialised, rich, democratic (Maciel et al., 2023). Resultingly, the field has evolved around values and priorities that reflect WEIRD cultural norms. As such, PIs may not be relevant to some cultural contexts in which PI outcomes, such as child compliance, are not valued. For instance, WEIRD cultures often value children sleeping independently and PIs may be used to manage child behaviour around sleep with this goal in mind, whereas independent sleep is not universally valued. Future research investigating the validity of the core competency model in non-WEIRD contexts may highlight such boundaries of the model, and/or language adaptations that could enhance its applicability across diverse cultural contexts. Furthermore, the self-determination of each family as to whether they engage in PIs must be respected. I wish to contribute to research with the aim to deepen understanding rather than impose a singular worldview. Ongoing

acknowledgement of the origins and limitations of PIs, alongside support for research into other approaches to parenting, with a range of research methods, is important to continue decolonising psychology.

6.3.2 Contributions to Training Programs

As discussed above, the current research has produced the prerequisites for a competency-based training program for use across various PI programs for child conduct problems. However, more research is needed to construct an implementable training program. Firstly, a comprehensive training structure, including benchmarks, resources and clinical decision making tools, needs to be created. The current research has produced an important first step in the construction of a consensus-validated core therapist competency model for PIs, although it does not offer specific guidance on minimum competency benchmarks nor ways to improve competencies. Similarly, the current research does not offer guidance on how frequently use of a competency rating tool would be beneficial for training, nor does it offer different ways of interacting with core competencies beyond a rating tool. Further research could therefore work towards building a comprehensive training program by focusing on (1) design of a competency checklist; (2) recommendations for competencies of particular importance; (3) construction of benchmarks for competencies; (4) and recommendations on methods to improve competencies.

Secondly, the CoPPI must be disseminated in order to support competency-based training effectively. Implementation outcomes of the CoPPI, including acceptability, adoption, appropriateness, feasibility and sustainability were modest. Accordingly, whilst the CoPPI has been shown to be useful, further research is needed on how to effectively disseminate it in various practice settings, based on the needs and resources of those settings. For instance, revisions to the CoPPI, including shorter or other alternative versions, may support its dissemination, such that more clinicians can engage in competency-based training.

Additionally, alternative interfaces for the CoPPI should also be examined to encourage its dissemination. The CoPPI is currently available on REDCap, a research platform with suboptimal user interface. Hosting the CoPPI on a more user-friendly platform, and which offers a portal system that allows users to track their progress, could make it more accessible in routine care settings. Findings from Study 3 also suggest that a checklist design, without ratings, could support competency-based training and supervision in some settings. Therefore, further research should examine whether alternative CoPPI interfaces could support its dissemination and subsequently support more widespread use of competency-based training in PIs.

Further research should also examine use of the CoPPI in other clinical settings, to support its widespread dissemination. It was evident from data collection throughout the current project that despite some overlap, many therapists in non-research settings are isolated from research. Therapists working in public health settings were challenging to contact due to minimal public contact information available, and private therapists were less likely to participate in research than therapists working in university or other research settings. For example, in the CoPPI validation study ($N = 66$), 71% of supervisees and 51% of supervisors recruited worked in a university or research clinic, despite the vast majority of participants contacted via non-research contact pathways. This low representation of non-research settings despite concerted efforts to engage therapists therein suggests that practitioners in private practice and public settings may be disconnected from research, and/or that few may be providing evidence-based PIs. If indeed few therapists outside of research settings are providing evidence-based PIs, this would be consistent with lack of policy supporting their use (Doyle et al., 2023). This difficulty recruiting therapists from non-research settings also raises concerns about the quality of practice in non-research settings; the perceived relevance of research to therapists therein; and whether current research on PIs

is representative of needs in diverse settings. To examine these concerns, efforts need to be made to establish better connections between clinical research settings and other clinical settings. Further research that involves practitioners in diverse settings will ensure that competency-based training is widely implementable and available and therefore effectively supports PI delivery.

6.3.3 *Personal Bias*

Finally, my personal bias in conducting the current research and interpreting the meaning and significance thereof must be noted. Secondly, I have a research-dominant background in PIs. As a psychologist, I have clinically trained in a PI (integrated family intervention) during my PhD candidature to better understand the context of my research. I acknowledge, however, that I do not have extensive clinical experience in PIs, the application of PIs in diverse cultural populations, nor the intricacies of each specific PI to which this research project pertains. I also do not have personal experience as a parent or caregiver. I therefore could not bring these perspectives to the research, and endeavoured to include different perspectives in my project to account for this. Secondly, I also acknowledge that I am passionate about improving the capacity of the workforce to deliver evidence-based PIs so early intervention is available to more families. Accordingly, I have completed my PhD with the goal to ultimately contribute to this improvement. Thirdly, I am Caucasian and have grown up in Australia in a privileged context, which has shaped my personal experience of being parented. It is important to recognise these perspectives that I bring to the research, as each individual researcher introduces some bias to qualitative data analysis and interpretation of data. Supervisors were involved in reviewing interpretation of data and qualitative themes to minimize the effect of my individual bias, although the current results could also benefit from further research to consolidate and broaden findings. For this reason and to address other aforementioned limitations, research on design of competency-based training would

benefit from additional researcher perspectives to ensure it has a meaningful impact on both quality and availability of training.

6.4 Conclusion

Ultimately, this project represents key progress on research regarding competency-based training specifically in social learning-based parenting interventions for child conduct problems (PIs). Output of the current project includes: a core therapist competency model; a model of drivers of case complexity; therapist recommendations on how therapist competencies relate to drivers of case complexity; and a competency rating tool capable of improving reflective practice competence (the CoPPI). The products of this research therefore represent foundational components necessary for competency-based training across various PI programs for child conduct problems. Findings from the current research open up new research avenues to examine how competency-based training can be optimally used to improve availability and quality of therapist training. By progressing competency-based therapist training, the aim is to improve availability of PIs and quality of their delivery, in turn improving important outcomes for families of children with conduct problems.

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Appendices

Appendix A – Published Manuscript for Study 1

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Practitioner Review: A core competencies perspective on the evidence-based treatment of child conduct problems

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Background: The effective treatment of child conduct problems is understood to rely on a range of therapist competencies, yet these have rarely been an explicit focus of research. In this practitioner review, we examine core competencies for the delivery of evidence-based parenting interventions for conduct problems in early-to-middle childhood. These are examined in light of research into the common elements shared by these interventions, literature regarding common challenges in these interventions, and conceptualisations of such competencies in other fields of mental health. **Methods:** We report on the development of a novel consensus-based model of core competencies for evidence-based practice in this field, based on consultation with an international expert panel. This includes competencies as they apply to complex presentations of conduct problems. **Results:** Despite considerable variation among widely disseminated programmes in terms of content, format and skills-training practices, there is strong consensus among practitioners regarding core competencies. These relate to three broad domains: (a) generic therapeutic competencies; (b) parenting intervention competencies; (c) specific parenting skills/techniques. **Conclusions:** Practitioners working with conduct problems, particularly complex presentations thereof, require competencies for engaging not only mothers, but fathers and diverse/non-traditional caregivers and other stakeholders, in evidence-based parenting interventions. Moreover, the successful delivery of these interventions necessitates competencies that extend beyond behaviour management and encompass broader aspects of the family system and the wider ecology of the child. **Keywords:** Conduct problems; parenting interventions; therapist competencies; evidence-based practice.

Introduction

Compared to many other fields of mental health, evidence regarding the treatment of child conduct problems (CPs) is particularly extensive. The interventions with by far the strongest support are parenting interventions based on social learning theory, delivered in early-to-middle childhood (Kaminski & Claussen, 2017). The packaging of these interventions into highly disseminable evidence-based programmes can be considered one of the major achievements of mental health science in the last century. The rollout and transportation of such programmes around the world has supported research into a broad range of questions concerning their effectiveness, mechanisms of change, novel adaptations for specific populations and innovative modes of delivery to improve engagement and reach (e.g. eHealth; Hawes et al., 2023).

Important strengths of this field have included an emphasis on treatment fidelity (for a review see Garbacz, Brown, Spee, Polo, & Budd, 2014), and a widespread availability of training resources and support attached to key examples of these programmes, such as Parent–Child Interaction Therapy (PCIT; McNeil & Hembree-Kigin, 2010), the Triple P Positive Parenting Program (Triple P; Sanders, Markie-Dadds, & Turner, 1999) and Incredible Years

(IY; Webster-Stratton & Reid, 2017). However, while the effective delivery of these interventions is understood to rely on a range of therapist competencies, these competencies have rarely been an explicit focus of research. In this practitioner review, we examine emerging theory and research into core therapist competencies for clinical practice in mental health and report on the development of a model of core competencies for the delivery of evidence-based interventions to families of children with CPs. Of key interest are competencies common to established programmes of this kind, as well as competencies most relevant to clinical practice with complex cases of child CPs.

The competency-based movement in mental health

Definitions of competencies in the clinical literature encompass ‘the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community served’ (Epstein & Hundert, 2002, p. 227). Competency-based practices have had a sweeping impact on training and professional development in diverse fields of health in recent years, reflecting a growing emphasis on the identification, teaching and assessment of these competencies. This movement has also played a key role in the promotion of evidence-based practice in mental health.

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Roth and Pilling's (2008) seminal model of competencies for delivering cognitive behaviour therapy (CBT) to adults with depression and anxiety disorders, was instrumental to the implementation of the Improving Access to Psychological Therapies (IAPT) initiative in the United Kingdom (Clark, 2018) and noteworthy for the intensive methods through which the model was developed. Through multiple rounds of consultation with a reference group of expert practitioners, consensus regarding these competencies was achieved, thereby allowing for the conceptualisation of a core competencies model comprising clusters or domains of (a) generic competencies, used in all psychological therapies; (b) basic CBT competencies, common to both low and high-intensity interventions; (c) specific CBT techniques; (d) problem-specific competencies; (e) meta-competencies, used to guide intervention implementation (Roth & Pilling, 2008). Models for other adult-focused interventions, such as CBT for psychosis (Morrison & Barratt, 2010), subsequently emerged through similar methods.

Child and adolescent mental health competencies

This approach to model building has also been applied to widespread interventions in child and adolescent mental health, although to a lesser extent. As in the adult literature, anxiety and mood disorders have been a predominant focus, while nonetheless reflecting the developmental and ecological considerations that make child mental health unique. For example, Sburlati et al.'s (2011) model of core competencies for CBT with child and adolescent internalising disorders differentiates similar domains, but incorporates additional competencies related to knowledge (e.g. typical developmental processes in these periods; risk processes in family and peer contexts relevant to formulation-driven treatment planning; understanding of the unique legal and ethical requirements relating to the provision of therapy to children and adolescents), as well as process skills for building positive therapeutic relationships with parents; collaboratively involving parents in treatment; implementing child/adolescent CBT-specific techniques (e.g. friendship skills, dealing with bullying skills); and modifying the family environment (e.g. parent contingency management, family communication). Other examples of core competency models for child and adolescent mental health include those regarding interpersonal psychotherapy for adolescent depression (IPT-A; Sburlati, Lyneham, Mufson, & Schniering, 2012) and CBT for autism in young people (Spain et al., 2023).

In addition to intervention-specific models of this kind, there has been growing interest into competencies spanning broader areas of practice. This reflects growing evidence that a therapist's capacity to flexibly adapt treatment to the client, integrating components of distinct interventions as appropriate,

may be associated with superior outcomes (Fonagy & Luyten, 2019). Adherence flexibility of this kind is particularly relevant to complex presentations, such as those with comorbid diagnoses. This is reflected in modular approaches to the management of comorbid psychopathology, such as the MATCH intervention method (Weisz et al., 2012). Rief (2021) proposed a global framework for categorising intervention components according to mechanisms and subgoals addressed, whereby competencies map on to these categories. Interventions were organised according to their relative emphasis on (a) skills acquisition; (b) working with relationship patterns and modifying them through the therapeutic relationship; (c) clarification of goals and motives. Within each of these categories, core competencies may include (a) scientific knowledge about relevant treatment processes and mechanisms; (b) competencies for addressing and modifying mechanisms and processes (e.g. engaging clients in skills training); (c) personal competencies to become a successful therapist (e.g. the therapist's own skills in communication, empathy, perspective taking and emotion-regulation; Rief, 2021).

Global models have also begun to emerge for child and adolescent mental health specifically, such as the unified model of competencies for family-based intervention for child and adolescent psychopathology, proposed by Allen, Hawes, and Essau (2021). The three broad domains specified in this model comprise (a) generic therapeutic competencies for practice across child and family settings; (b) competencies in treatment planning and delivery, including knowledge and abilities to plan and flexibly implement evidence-based treatment components according to the unique considerations and needs of the family and clinical setting; (c) competencies for targeting specific ecological domains, including the therapist's ability to deliver the content of therapeutic components (e.g. psychoeducation, exposure to reduce anxiety, skills training in parenting strategies) in a specific treatment plan. The conceptualisation of this final domain reflects an ecological perspective on the multiple levels potentially targeted within family-based interventions (e.g. individual child/adolescent, dyadic relationships, family level).

The overarching frameworks provided by these global models are valuable given the breadth of training and professional development typically undertaken by mental health practitioners. However, they rely heavily on the availability of in-depth models of competencies related to specific populations and interventions. Although the family-based model of Allen et al. (2021) was designed to encompass a broad range of disorders and interventions, it is important to note that only a relatively small number of these have been subjected to the consensus-based investigation that has been regarded as best practice for building in-depth

models of therapist competencies (i.e. the Delphi method; e.g. Sburlati et al., 2011). Child conduct problems (CPs) are among one of the major areas of practice neglected by such research to date. This omission is striking considering that conduct disorder is the leading cause of burden among all mental disorders in children aged 0–14 years (Ferrari et al., 2022), and that most children with CPs do not receive evidence-based treatment (Johnson, Lawrence, Sawyer, & Zubrick, 2018).

A core competency perspective on conduct problems

Considerable theory and evidence is available to inform research into core competencies for the treatment of CPs, with two bodies of literature particularly germane. First is research into the common elements (e.g. content, components, programme features) shared by the most effective parenting interventions for CPs (social learning theory-based parenting interventions; SLT-PIs). This perspective is important, given that there is considerable variation between SLT-PIs in terms of content, format and skills-training practices (e.g. use of video materials; in-vivo coaching with the child; role play) and integration of other theoretical principles (e.g. attachment theory; family systems theory).

An earlier Delphi study identified four categories of common elements among general interventions for conduct problems in children and adolescents, including therapeutic content; treatment technique; aspects of the working alliance; treatment parameters (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008). Subsequent meta-analytic work by Leijten et al. (2019) identified 19 parenting skills/techniques commonly targeted across 386 trials of SLT-PIs, the most common of which were praise (97% of interventions), time-out (87%), natural or logical consequences (85%), ignoring (77%) and direct and positive commands (77%). Stronger effects, in both prevention and intervention settings, were associated with the inclusion of natural or logical consequences as a nonviolent limit-setting technique, and positive reinforcement for desired behaviours, especially through praise. Additionally, in intervention settings, programmes that included time-out were significantly more effective than those that did not (Leijten et al., 2019). Interestingly, such research has shown that the combination of such components does not always enhance benefits. For example, a recent network meta-analysis of the collective effects associated with targeting various types of parenting techniques found that interventions with behavioural management, psychoeducation and relationship enhancement techniques were significantly less effective than interventions with behavioural management alone (Leijten, Melendez-Torres, & Gardner, 2022). Earlier meta-analytic research also tested the effects of these components

on externalising behaviour outcomes, finding that parent practice of skills with their child, positive parent-child interactions, time-out and consistent responding, all contributed significantly (Kaminski, Valle, Filene, & Boyle, 2008). Leijten et al. (2022) further found that interventions are likely to be more effective when content is focused and tailored to the needs of the individual family. This points to the potential importance of competencies for formulation-driven practice, including family assessment and collaborative treatment planning.

Second, a growing body of clinical literature has addressed factors that have the potential to complicate the delivery of such intervention to families of children with clinic-referred CPs. Hawes and Dadds (2021a) proposed that these factors relate largely to six domains, which were conceptualised as key dimensions of case complexity among such families. These pertain to (a) the severity of the child's CPs; (b) developmental and dispositional factors (e.g. language impairments, forms of temperament such as negative reactivity, fearlessness, callous and unemotional traits); (c) co-morbid child psychopathology (e.g. internalising disorders, neurodevelopmental disorders); (d) highly dysfunctional or adverse caregiving (e.g. harsh or inconsistent discipline, skill deficits in age-appropriate caregiving); (e) parent risk factors (e.g. personality and mental health, parental attributions); (f) family system and social environment risk factors (e.g. interparental conflict, lack of social support, financial disadvantage, differing cultural beliefs). Many of these factors covary with CPs (Fonagy & Luyten, 2018; Hawes et al., 2023), while at the same time increasing risk for poor engagement and resistance to change among parents, and placing additional demands on therapists (Miller & Prinz, 1990; Patterson & Chamberlain, 1994; Piotrowska et al., 2017).

Some SLT-PIs have been developed specifically for multi-stressed families, wherein related therapist competencies have been proposed and operationalised (e.g. 'genuine respect for multi-stressed families living in complex circumstances'; 'humility about what intervention can achieve'; 'resolute and quiet enthusiasm'; Day et al., 2011). Other recommendations have focused on additional theory-driven competencies to employ in existing programmes when change is not occurring (Scott & Dadds, 2009). Competency recommendations have included those specifically for the clinical engagement of multi-stressed parents in these interventions (Piotrowska et al., 2017); the joint engagement of parents whose own relationship is in conflict (e.g. Burn et al., 2019); the enhancement of parent motivation (Pelham, Dishion, Shaw, & Wilson, 2017); and overcoming resistance to change (e.g. Hawes & Dadds, 2021b; Sanders & Burke, 2014). Also of relevance is emerging evidence regarding novel adaptations of SLT-PIs for presentations of CPs associated with

unique risk pathways. For example, existing programmes have been modified to include additional emotion-focused components for children with CPs and callous-unemotional (CU) traits, based on the unique neurodevelopmental characteristics exhibited by such children (e.g. Dadds, Cauchi, Wimalaweera, Hawes, & Brennan, 2012; Fleming et al., 2022).

A consensus model of core competencies for CPs

As outlined, the common elements of SLT-PIs for CPs have been characterised and studied extensively using meta-analytic methods, while literature attached to individual programmes has often addressed specific therapist competencies for approaching common challenges and complex presentations. There remains, however, the need for a consensus-based perspective on these competencies, such as that which has contributed significantly to practice with internalising disorders of childhood (Sburlati et al., 2011, 2012). Accordingly, we aimed to develop and validate a model of core competencies for the delivery of SLT-PIs for CPs in early-to-middle childhood, with an international panel of expert practitioners using the Delphi method. A further aim was to examine consensus regarding these competencies as they apply to complex presentations of CPs.

Method

International expert practitioner panel

Practitioners with expertise in SLT-PIs for child CPs were identified based on their publication of literature in the area. This included the developers of a number of established programmes. Individuals were contacted with invitations to participate and also asked to recommend other expert practitioners. Those who met inclusion criteria (currently practising in SLT-PIs; 5 years' minimum experience; a willingness to complete the multiple rounds of data collection required by the Delphi method), were recruited. A total of 117 practitioners were approached; 60 agreed to participate, 11 later withdrew and 49 completed the first round of data collection (42% response rate). The final sample was highly comparable to those initially approached, regarding characteristics such as sex, nationality, profession and research experience. The completion rate was 84%, with 41 participants completing the final round. A range of countries were represented, including the United States of America (51%), Australia (31%), Canada, New Zealand, England, Wales, Germany, Finland and the Netherlands. Professions were predominantly psychology (73%) and social work (10%), along with nursing, education and psychiatry. Clinical experience spanned the major SLT-PI programs currently found in the field (e.g. Parent-Child Interaction Therapy; PCIT: 45%; Helping the Noncompliant Child: 24%; Triple-P: 24%; Incredible Years: 22%; Parent Management Training-Oregon Model: 22%; Barkley's Defiant Child: 16%; Parent-Child Care: 14%). Mean years of experience was 18 years, and 98% of participants reported working with complex cases in their current and/or previous positions. A range of settings were also represented, including private practice, university/research clinics and community health. All

participants provided informed consent to participate and were given the option to be identified or remain anonymous (see Appendix S1).

Model development

A preliminary model of core competencies for SLT-PIs was drafted and presented to participants for feedback. This preliminary model was informed by a review of SLT-PI manuals, as well as literature regarding the common elements of these programmes (e.g. Leijten et al., 2019), accounts of core competencies in overlapping interventions (e.g. Allen et al., 2021; Sburlati et al., 2011) and literature in which competencies for clinical practice with complex presentations of CPs have been operationalised (e.g. Day et al., 2011; Hawes & Dadds, 2021a). Following Delphi method guidelines, this model was revised through iterative survey rounds in which participants provided qualitative responses and quantitative ratings of the model. Participants remained anonymous to each other, while receiving feedback about the responses of the panel in previous rounds, in order to encourage convergence. Participants were given the option to participate via videoconference (Zoom) interviews or online surveys via the Qualtrics platform, with the majority opting for the latter.

Data collection comprised three survey rounds, undertaken in April–May, June–July, and September–October of 2022. Each was approximately 30–50 min in duration, and participants were provided with approximately 2 weeks to respond. Across these rounds, participants were asked to consider the draft model and propose their own revisions, including edits, additions, and omissions. Survey 1 consisted primarily of open-ended questions regarding specific aspects of the model, while Surveys 2 and 3 consisted primarily of Likert scale ratings. For the purpose of addressing competencies for clinical practice specifically with complex presentations of CPs, participants were presented with the definition of such complexity proposed by Hawes and Dadds (2021a). Participants were asked to identify what competencies they considered most vital with clients high in such complexity, and how those competencies should be applied.

Model validation

Content analysis of expert responses was conducted manually, allowing for modifications to the clustering of competencies where appropriate. Deidentified data was used to minimise bias. Reliability of analysis was evidenced by author agreement on content themes and wording of final competencies, and validity of analysis was ultimately ensured by acceptability according to participants based on survey data (Chalmers & Armour, 2019). Criteria for consensus required at least 70% of participants to report being satisfied with how the respective competencies were operationalised. The majority of experts (88%) requested modifications to the preliminary model in the first round, and, following feedback of model revisions, expert consensus was attained on all 15 competency categories.

Results

The final model produced by the Delphi method is represented in Figure 1. The specific competencies identified through this process clustered into 15 categories, across three broad domains. This model spans the major phases of initial engagement, assessment, treatment planning and delivery, with specific and operationalisable competencies for the delivery of SLT-PIs by practitioners.

Generic therapeutic competencies (Domain 1)

Generic therapeutic competencies are those considered common to many psychological interventions, and here include those for understanding relevant child and family factors, conducting a thorough assessment, practising professionally and building a therapeutic relationship. The latter two can be considered important meta-competencies, in that they enable therapists to adapt the implementation of interventions to the needs of a case in a coherent and informed manner (see Table 1). Among these, three novel competencies were formulated, pertaining to limits of expertise (category: Practising professionally); adult psychopathology (category: Understanding relevant child and family factors); therapist modelling (category: Building a therapeutic relationship).

Parenting intervention competencies (Domain 2)

Parenting intervention competencies are those specific to parenting interventions, but common to parenting interventions for a broad range of problems. The three categories in this domain comprise (a) understanding relevant theory and research; (b) family-based formulation and treatment planning; (c) collaboratively conducting parent-focused sessions. Meta-competencies for formulation-driven practice with parents feature heavily here (see Table 2). Novel competencies in this domain were formulated regarding the integration of evidence-based strategies for adult mental health and

behaviour change (e.g. cognitive challenging, motivational interviewing) into parenting interventions for child mental health.

Specific parenting skills/techniques (Domain 3)

This domain comprises eight categories of competencies for delivering programme content largely specific to SLT-PIs for CPs, including that related to the specific parenting skills/techniques targeted in these programmes (see Table 3). Three novel competencies were formulated in this domain: structuring the environment (category: Proactive parenting); self-care skills for parents; child general learning and life skills (category: Skills parents teach children). A novel category was also formulated (Coordination of Parenting Skills/Techniques), regarding competencies for supporting parents' coordinated and consistent implementation of a range of techniques to optimise child outcomes (e.g. selecting, sequencing and combining techniques, as appropriate to the situation; being able to 'recover' after discipline). This reflects the importance of inconsistent parenting to the maintenance of CPs (Hawes et al., 2023), as well as cautions that targeting an excessive number of parenting skills can be counter-therapeutic (Hawes & Dadds, 2021b; Leijten et al., 2022).

Complex cases of child conduct problems

When asked to consider what competencies are particularly vital to practice with complex cases,

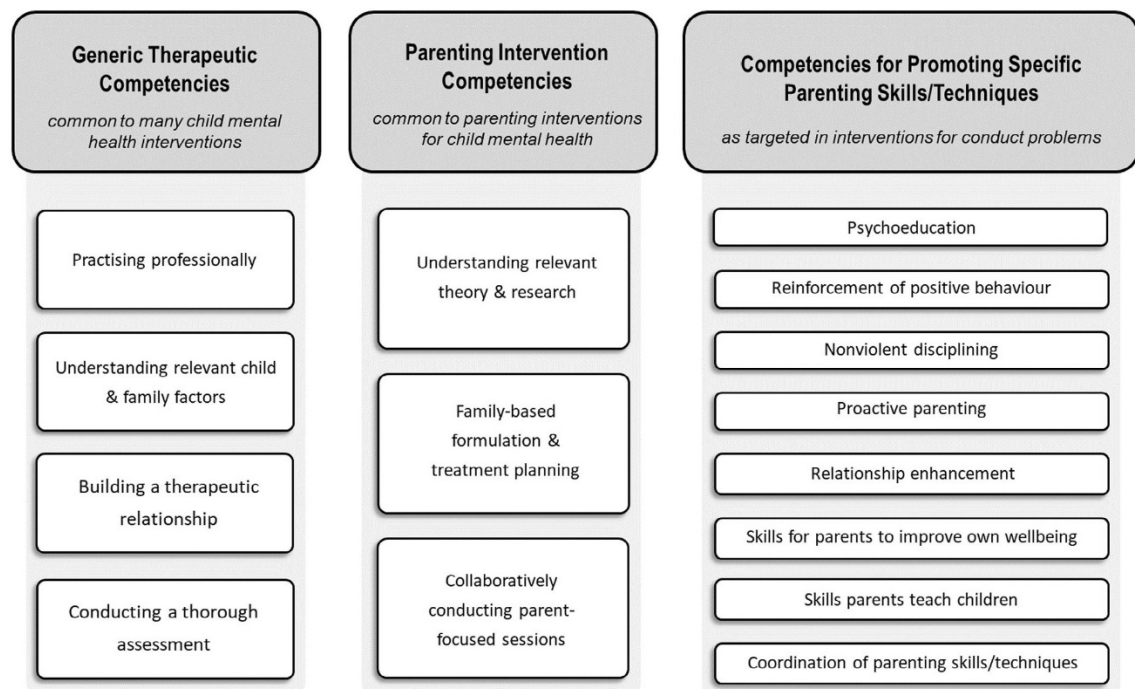


Figure 1 Core competencies for delivering evidence-based parenting interventions for conduct problems in early-to-middle childhood

Table 1 Descriptions of generic therapeutic competencies

Competency category	Description
<i>Practising professionally</i>	
Codes of conduct	Have knowledge of and ability to work within professional, ethical, legal codes of conduct relevant to children and families
Supervision and development	Actively participate in supervision or professional development/consultation
Research evidence	Have knowledge of the research evidence supporting interventions; be able to identify and critically evaluate available evidence of effectiveness and utilise this evidence to inform practice
Reflective practice	Engage in reflective practice (e.g. self-assess current competencies, process personal reactions, manage transference/countertransference)
Systems knowledge	Understand the role, purpose and responsibilities of key disciplines and institutional systems involved in the care of children/families, while supporting families to engage with such systems where appropriate
Limits of expertise	Be aware of the limits of one's own expertise and/or the interventions being provided and refer on as appropriate for out-of-scope issues
<i>Understanding relevant child and family factors</i>	
Child development	Have knowledge of child development and developmental stages, including age-appropriate behaviour, physical, cognitive, emotional and social maturation
Culture and race	Have knowledge and recognition of factors related to culture and race and their significance to therapy
Family structure, experiences, dynamics	Have knowledge of child and family structure, experiences, and relationship dynamics and how they can affect therapy
Child psychopathology and individual differences	Have knowledge of risk pathways to conduct problems, child psychopathology, comorbidity and other individual differences, and how these can affect therapy
Adult psychopathology	Have knowledge of adult psychopathology and substance abuse and how these can affect therapy
<i>Building a therapeutic relationship</i>	
Engagement with parents/caregivers	Foster and maintain engagement with parents/caregivers in a collaborative therapeutic alliance (e.g. identifying and inviting in the child's parenting team; managing in-session conflict between parents; managing resistance and ruptures, including parent challenges to the competence of the therapist)
Inclusive practices	Use practices inclusive of all genders, diverse family structures, cultural diversity, sexuality and gender identity when engaging parents/caregivers
Hope and optimism	Instil hope and optimism for change
Therapeutic alliance with child	Foster and maintain when appropriate
Age-appropriate engagement	Use age-appropriate methods/pacing when engaging children
Partnerships with stakeholders	Form partnerships with other family members/stakeholders where appropriate
Culturally responsive and strengths-based practices	For example, acknowledge the unique experiences of families, recognise parents as experts on their child
Therapist modelling	Model appropriate behaviours, reactions and emotion regulation consistently
<i>Conducting a thorough assessment</i>	
Assessment method	Use skills for evidence-based multi-method, multi-informant assessment
Integration of reports	Integrate reports from diverse informants along with clinical observations
Diagnosis	Determine diagnoses with consideration of differential diagnosis, including physical health problems
Assessment areas	Assess symptoms, function of behaviour, strengths, history, resilience, stage and intervention suitability
Assessment of violence and risk	For example, create a family safety plan
Parental assessment skills	For example, supporting parents to discuss personal thoughts/emotions and sensitive issues beyond the child, including family of origin experiences

two major themes emerged: (a) prioritise building a strong and positive therapeutic relationship with the family, with trust, rapport, empathy, and transparency about the intervention, to gain accurate information about the family, engage them in the intervention, support them in trying new behaviours and approaches and develop a network of resources for them; (b) conduct a thorough initial and ongoing assessment of child, parents and other family members, into symptoms, interpersonal dynamics, barriers, strengths, supports and hopes/goals. Inadequate assessment may result in a failure to identify complex needs (e.g. comorbid neurodevelopmental

problems; interparental conflict) that warrant unique treatment plans. It may also contribute to blame and stigma by failing to validate parents' concerns. Assessment competencies therefore underlie both formulation-driven treatment planning and clinical engagement in SLT-PIs (Piotrowska et al., 2017). This reflects the dual emphasis on engagement and formulation-driven practice in previous recommendations (Hawes & Dadds, 2021a; Scott & Dadds, 2009).

In addition to recommendations regarding competencies that may be particularly vital to complex cases in general, novel recommendations regarding

Table 2 Descriptions of parenting intervention competencies

Competency category	Description
<i>Understanding relevant theory and research</i>	
Behavioural theories	Have knowledge of the behavioural theories underpinning PIs for conduct problems, particularly operant conditioning, classical conditioning, and social learning theory
Implementation based on theory	Be able to implement PIs in line with theoretical underpinnings and related behaviour modification strategies
Additional theoretical perspectives	Be able to integrate additional theoretical perspectives while maintaining PI fidelity
Risk, maintenance and protective factors	Have knowledge of PI research, including evidence of contextual/child/parent/family factors implicated in risk/maintenance and protective processes, and how these differ for specific subgroups
Adult mental health strategies	Be able to integrate evidence-based strategies for adult mental health and behaviour change while maintaining PI fidelity
<i>Family-based formulation and treatment planning</i>	
Formulation development	Collaboratively devise and revise case formulations, accounting for the presenting problem, comorbidity, developmental level, individual differences related to subtype of conduct problems, and family/parental/social/contextual factors, including family strengths
Treatment plan development	Collaboratively devise, implement, flexibly revise PI treatment plans by selecting, sequencing, applying the most appropriate PI techniques, at the appropriate dosage, based on the formulation and the family's values and priorities, while maintaining PI fidelity
Communication of formulation	Communicate psychoeducation about the nature of the problem nonjudgementally to parents and stakeholders, and support them to reflect on their own parenting where appropriate
Treatment goals	Collaboratively negotiate concrete and measurable treatment goals with parents and other stakeholders (e.g. teachers) informed by baseline measures
Roles in treatment	Collaboratively negotiate roles and presence of family members and other stakeholders in treatment
Engagement of wider network	Engage additional family members and stakeholders as appropriate, including other clinicians where needed
Progress monitoring	Use measures and self-monitoring to guide therapy and monitor outcomes
End of treatment planning	Plan for the end of therapy and long-term maintenance of progress
Limits of treatment	Distinguish between parent/family needs that can be addressed in the current PI versus needing longer term work
<i>Collaboratively conducting parent-focused sessions</i>	
Session goals	Collaboratively set and adhere to session goals/agenda
Communication of rationale	Communicate the rationale for therapeutic processes and techniques
Client feedback	Elicit and respond to feedback from parents and family members
Flexible technique implementation	Implement specific techniques flexibly for the client's presentation, needs/preferences, cultural background, family relationships and mental health
Experiential strategies	Utilise experiential strategies to implement and promote specific parenting skills in session
Technique monitoring and shaping	Monitor and shape implementation of strategies/techniques, sharing feedback on progress with family
Sensitivity to parent factors	Conduct sessions with sensitivity to parent factors
In-session family collaboration	Facilitate in session collaboration between members of the parenting team/other family members
Strategy implementation between sessions	Facilitate parents to implement strategies as a supportive parenting team between sessions
Between-session activities	Collaboratively set, plan and review personally meaningful between-session activities
Information sharing	Manage how information is shared across the family system
Family boundaries and routines	Empower parents to improve boundaries/routines with other caregivers
Barriers to treatment and resistance to change	Support parents to overcome this by assessing, formulating and managing barriers to engagement, including relational dynamics; and applying motivational interviewing/enhancement strategies

PI, parenting intervention.

competencies for specific presentations of case complexity were also generated. Preliminary recommendations were first proposed by panel members through open-ended responses in the first round of data collection. A total of 42 such recommendations were proposed, which addressed clinical scenarios related to comorbidity (e.g. developmental delay, autism), parent factors (e.g. parental depression, interparental conflict) and other factors. These recommendations were

subsequently presented back to the panel to determine consensus. Expert consensus was reached for 21 of these recommendations. As shown in Table 4, these recommendations relate to the adaptation of competencies across all three of the major domains. Specifically, six relate primarily to generic therapeutic competencies; six relate primarily to parenting intervention competencies; nine relate to specific parenting skills and techniques.

Table 3 Descriptions of specific parenting skills/techniques

Competency category	Description
<i>Psychoeducation</i>	
Child development	Explain child development, including information about typical & atypical development, including developmental effects of trauma, and correcting misinformation, such as harmful effects of time-out on development and views of praise/rewards as coercive control
Parent-child interactions	Explain parent-child interactions including information about how parents and children shape each other's interactions in daily life, including effects of temperament; family of origin and systemic/contextual/cultural influences on parenting; the importance of self-care to parenting; the functions/ABCs of behaviour from operant and attachment perspectives
<i>Reinforcement of positive behaviour</i>	
Social rewards	For example, verbal praise, non-verbal cues such as smiles, thumbs up; physical affection; quality time/activities with parents
Tangible rewards	For example, tokens, charts, incentive systems
<i>Nonviolent disciplining</i>	
Time-out	Using time-out for inappropriate behaviours, using least restrictive practice that is appropriate
Planned ignoring	Using planned ignoring or selective attention for inappropriate behaviours
Natural/logical consequences	Using natural/logical consequences, including removal of privileges and addition of chores, as age-appropriate
<i>Proactive parenting</i>	
Effective commands	Using effective commands that are direct, positively stated, specific, age-appropriate
Rule setting	Setting rules about appropriate and inappropriate behaviour; techniques for managing rules
Child monitoring and supervision	Knowing what the child does and with whom they play when out of view, including media use and direct supervision
Structuring the environment	Pre-emptively structuring environments and routines to avoid problem behaviour
<i>Relationship enhancement</i>	
Quality parent-child time	Having parent-child quality time and child-directed interaction/play, including spending time focused on the child; showing interest/engaging in what they are doing; having daily child-led play with child; warmth and mutual enjoyment
<i>Empathy</i>	
Active listening	Understand what the child feels in different situations Concentrate on what the child says; show that they are listened to; reflect back to them what they say; and show them that they are valued in the family
<i>Skills for parents to improve their own well-being</i>	
Emotion regulation and stress-management skills	Parents recognising their own emotions and how they affect parenting, validating and regulating
Problem-solving and conflict management skills	Parents generating and implementing solutions to difficult situations and crises directly and indirectly related to parenting
Partner/social support	For example, improving relationship/communication between parents; support from partner/family/friends
Self-care skills	For example, parents engaging in personal/pleasant activities and time for self; support parent to access own therapy where appropriate
<i>Skills parents teach children</i>	
Child emotion regulation skills	Giving child words for emotions; validating emotions; modelling how to regulate emotions and control impulses/attention
Child problem-solving skills	Teaching child how to solve everyday problems
Child social skills	Teaching child social skills including communication and conflict resolution skills; prosocial behaviours such as helping others
Child general learning and life skills	For example, teaching colours, promoting independence in child self-care
<i>Coordination of parenting skills/techniques</i>	
Technique coordination and consistent implementation	For example, selecting, sequencing, and combining techniques, as appropriate to the situation; being able to 'recover' after discipline, so as to optimise child outcomes

Discussion

Despite the considerable variation among widely disseminated SLT-PI programs, in terms of content, format and skills-training practices, there appears to be considerable consensus among practitioners regarding the core competencies that these interventions necessitate. In addition to highlighting this consensus, the current model also reflects some of the recent shifts in conceptualisations of these interventions in the field at large, which have

numerous implications for clinical practice and training. This includes a growing recognition regarding the importance of engaging not only mothers, but also fathers, in such interventions, and that this inclusion should extend to diverse caregivers (Burn et al., 2019; Gonzalez et al., 2023). It likewise reflects growing recognition that the successful delivery of parenting interventions often necessitates competencies that extend well beyond those focused on parenting, to encompass those concerned with

broader aspects of the family system (e.g. the parents' own relationship and mental health; Piotrowska et al., 2017) and the wider ecology of the child (e.g. parent-teacher communication; cultural/historical context; Dishion & Stormshak, 2007). Similarly, there has been growing interest in the integration of theory beyond social learning theory (e.g. attachment theory; family systems models) into these traditionally behavioural interventions (Cavell & Quetsch, 2023; Dadds & Hawes, 2006; McNeil et al., 2010). This was also reflected in the final model, with an emphasis on ensuring that such integration does not undermine the integrity of the social learning theory foundation that is core to intervention effectiveness (Scott & Dadds, 2009).

The current model contributes to growing literature on the implementation science of SLT-PIs, which has often focused on the related construct of therapist fidelity. Fidelity has been found to predict not only improvement in conduct problem outcomes across SLT-PIs, but improved parental engagement, parenting practices and parental psychopathology (Hukkelberg & Ogden, 2013; Smith, Dishion, Shaw, & Wilson, 2013; Thijssen, Albrecht, Muris, & de Ruiter, 2017). This work has been supported by progress in the conceptualisation and measurement of fidelity, and the findings of the current study have the potential to inform similar work on the measurement of core competencies. Likewise, research is now needed to develop measures and related tools for supervision and reflective practice based on the current model. The literature has further emphasised the importance of ongoing supervision and feedback to the maintenance of therapist fidelity and skills, while highlighting the need for further research into the implications of distinct supervision and training methodologies for this purpose (Garbacz et al., 2014).

Implications for training and practice

The current model points to a range of core competencies that are often neglected in manualised protocols for SLT-PIs and that are therefore important for practitioners to pursue through ongoing training, supervision and reflective practice. Competencies pertaining to culture, diversity and trauma were prominent among expert recommendations, beginning with the first domain of Generic Therapeutic Competencies. For example, competencies for building a therapeutic relationship encompass inclusive practices for engaging diverse parents/caregivers (e.g. inclusive of women and men; non-traditional family structures; cultural diversity; sexuality and gender identity); and culturally responsive and strength-based practices (e.g. acknowledging the unique experiences of families; recognising parents as experts on their own child). This focus is consistent with evidence that culturally bound adversities can serve as barriers to parenting interventions, and

recent calls for models of service delivery to address these barriers (Weisenmuller & Hilton, 2021).

The second domain, Parenting Intervention Competencies, emphasises the importance of incorporating a family's own values and priorities into treatment planning, while at the same time maintaining programme fidelity; the importance of non-judgemental communication of psychoeducation about parenting and child mental health; and the importance of parent-focused strategies to overcome barriers to treatment and manage resistance to change (Hawes & Dadds, 2021b).

The final domain, Specific Parenting Skills/Techniques, included the competencies with the highest level of consensus among any competency category: parent-child relationship enhancement skills. This is interesting given that these skills are based less explicitly on social learning theory than other positive parenting skills such as reinforcement. It is also noteworthy that, while there was consensus support for the nonviolent discipline skills listed, time-out was the focus of considerable feedback. In particular, experts emphasised the need to be informed by theory and evidence regarding topics such as attachment and trauma when supporting parents to implement time-out, consistent with the growing focus on these topics in the literature (Dadds & Tully, 2019; Morawska & Sanders, 2011).

Expert recommendations regarding complex cases appear to diverge considerably, which may reflect the limited availability of evidence regarding interventions with complex presentations. It is only recently, for example that the implications of adverse childhood experiences for SLT-PIs has been explicitly tested (e.g. Roach et al., 2022). Likewise, emerging evidence regarding interventions for children with CU traits was reflected in recommendations to focus on positive reinforcement and the promotion of children's emotion-processing skills in such cases (Dadds et al., 2012; Fleming et al., 2022). Comorbid psychopathology featured prominently among recommendations reaching consensus, which included integrating non-avoidant ('brave') behaviours among targets of positive reinforcement for children with comorbid anxiety. These recommendations further indicated a need to go beyond operant strategies, as seen in the emphasis on competencies for parent-child relationship enhancement in cases involving chronic parent-child attachment problems. Rather than suggesting that these relationship enhancement competencies are not sufficiently covered in existing manualised resources, our data highlight the role of assessment and case formulation in guiding how these competencies are applied. That is, practitioners should be competent at identifying attachment problems early in assessment and making predictions regarding the optimal approach to relationship enhancement based on the unique needs and strengths of the family. An additional emphasis is placed on competencies for supporting

Table 4 Consensus-based recommendations for specific complex presentations

Competency category	Description
<i>Understanding relevant child and family factors</i>	
Child psychopathology and individual differences	Knowledge of theory and research related to ASD and developmental delay is needed when a child with CPs presents with comorbid problems of this kind
<i>Building a therapeutic relationship</i>	
Engagement with parents/caregivers	When access-to-care barriers are evident (e.g. financial or transportation difficulties, difficult work hours), additional attention should be given to parent/caregiver engagement
<i>Conducting a thorough assessment</i>	
Assessment areas	For comorbid anxiety or OCD, it is important to identify and appropriately address parental accommodation to the child's anxiety/OCD-related demands (e.g. parent participation in checking rituals)
Assessment of violence and risk	A safety plan for self-injurious behaviour (including, but not limited to, the context of time-out) should be considered for children with comorbid ASD; In cases involving severe interparental conflict, safety planning is recommended; Where appropriate, safety plans should be developed to address parental use of corporal punishment or physical discipline
<i>Understanding relevant theory and research</i>	
Additional theoretical perspectives	Knowledge regarding the importance of exposure is needed when working with children who present with CPs and comorbid anxiety and/or OCD
<i>Family-based formulation and treatment planning</i>	
Treatment plan development	In group interventions, individual support should be given to families with high needs; For parents with significant depression, the pacing of content/skills-training should be reduced
<i>Collaboratively conducting parent-focused sessions</i>	
Experiential strategies	For parents with significant depression, additional practice via role play should be provided, as much as the parent allows
Between-session activities	For parents with significant depression, home practice assignments should be made smaller
Barriers to treatment and resistance to change	If a parent is disinhibited or difficult to contain, within-session boundaries should be set up and maintained
<i>Reinforcement of positive behaviour</i>	
Social rewards	For children with CPs and comorbid anxiety and/or OCD, parents should target non-avoidant ('brave') child behaviours using positive reinforcement (e.g. praise)
Both social and tangible rewards	Additional emphasis should be placed on positive parenting skills to enhance the parent-child relationship, when harsh or inconsistent parenting persists; For children with CPs and CU traits, additional emphasis should be placed on positive reinforcement strategies for appropriate behaviour; For children with CPs and language impairments, rewards for child communication skills are advised (in addition to standard behaviour management techniques)
<i>Nonviolent disciplining</i>	
Natural/logical consequences	In the case of heavy parental reliance on consequences, time-out and/or harsher practices, therapists should emphasise properly dosed, consistent, predictable evidence-based natural and logical consequences
<i>Proactive parenting</i>	
Effective commands	For children with CPs and language impairments, instructions should be simplified
<i>Relationship enhancement</i>	
Quality parent-child time	In the context of long-term disruption to caregiver-child attachment, relationship enhancement skills should be emphasised
Empathy	
Active listening	
<i>Skills for parents to improve their own well-being</i>	
Emotion regulation and stress-management skills	For parents of children with CPs and developmental delay, parental self-care and emotion regulation skills should be emphasised
Self-care skills	
<i>Skills parents teach children</i>	
Child emotion regulation skills	For children with CPs and CU traits, an emphasis should be placed on promoting the child's emotional skills (e.g. emotion understanding; emotion recognition)

ASD, autism spectrum disorder; CPs, conduct problems; CU, callous-unemotional; OCD, obsessive compulsive disorder.

parents facing access-to-care barriers, such as socioeconomic adversity and logistical obstacles, in order to optimise engagement.

Limitations and conclusions

The findings of this study should be considered in light of some limitations, including those that are

inherent to the Delphi method. As a consensus-based method, Delphi does not involve experimental tests and has the potential to restate received wisdom that may or may not be supported by other empirical data. Moreover, the strength of the evidence produced through this method is highly dependent on the sources of expertise that are available. As noted by Jorm (2015), however,

research on the ‘wisdom of crowds’ supports the validity of group consensus judgements when certain conditions are met, and the Delphi method provides a systematic approach to ensure that these conditions are met. Notwithstanding its limitations, the Delphi method has a strong track record in mental research and allows researchers to answer questions in situations where experimental or meta-analytic tests are not directly applicable to a problem, or where existing data are extensive but complex for the purpose of drawing conclusions (Jorm, 2015). Given that Delphi research with practitioners focuses on the views of key end-users of interventions, findings are well suited to informing and promoting implementation of evidence-based practice in real-world settings.

The focus here on SLT-PIs is based on extensive support for these interventions as the treatment of choice for CPs in early-to-middle childhood. The current model therefore reflects consensus regarding core competencies for the evidence-based treatment of CPs for this age group. Distinct models of intervention supported for CPs in older children and adolescents, such as multisystemic therapy (van der Stouwe, Asscher, Stams, Deković, & van der Laan, 2014), may necessitate competencies that are somewhat distinct, and future research into those competencies is needed to build on the work presented here.

Although the scope of the current model is consistent with that of models for evidence-based interventions in other child and adult populations (e.g. Roth & Pilling, 2008; Sburlati et al., 2011), this broad scope limits the attention that can be given to each of these competencies individually. Research is especially needed to understand how to effectively support therapists in developing a number of these competencies, such as knowledge and recognition of factors related to culture and race and their significance to therapy. It should also be noted that the findings reported here do not address the relative or unique contributions of the respective competencies to change processes or child outcomes. Furthermore, while participants came from a range of countries, these were largely anglophone, and the southern hemisphere was poorly represented, with the exception of Australia and New Zealand. This reflects the countries in which research on these interventions has most often been conducted, yet limits the generalisability of our findings.

The testing of these competencies as active elements represents a key direction for future research and could inform the further development and revision of core competency models. There is a particular need to build on the current study through process research based on the coding of therapist behaviour during sessions. This was previously undertaken to investigate the role of therapist behaviours in engagement and resistance to

change among parents of children with conduct problems (e.g. Patterson & Chamberlain, 1994) yet has remained limited since. Programmatic research of this kind is needed to test our model in clinical settings and has much potential to support translation into training and practice.

It is important to recognise that the competent delivery of SLT-PIs is not always successful and that clinically significant levels of CPs persist for as many as 50% of children in receipt of such treatment (e.g. Overbeek et al., 2021). Research with these non-responders remains limited, while recent advances in the development of novel interventions for high-risk subgroups, such as children with CPs and CU traits (e.g. Fleming et al., 2022), have highlighted the need to regularly update competency-based models, especially those intended to inform practice with complex cases. Additionally, many children fail to benefit from these interventions because their parents decline to participate or face access barriers. In the Connect-Attend-Participate-Enact model (CAPE; Piotrowska et al., 2017), this initial recruitment into SLT-PIs is conceptualised as the first stage of clinical engagement (Connect), and the model argued that therapist competencies, as well as service-level practices, in part determine the success or failure of such connection with individual families. This may include the use of effective processes for inviting partners who disagree with the need for intervention and flexible formats of delivery (e.g. eHealth) to overcome barriers to service access (Weisenmuller & Hilton, 2021).

It is noteworthy that some of the major themes emphasised by the expert panel here concerned topics that programmatic research has only recently begun to investigate, such as the transportation of SLT-PIs across cultures (e.g. Mejia, Leijten, Lachman, & Parra-Cardona, 2017), and the implications of child and parent trauma for specific SLT-PI components such as time-out (e.g. Roach et al., 2022). Ongoing research on these topics is therefore needed. In addition to informing clinical practice and training specific to child CPs, the current model has the potential to inform consensus-based research into core competency models for other disorders that are commonly a focus of parenting interventions, such as ADHD (Coates, Taylor, & Sayal, 2015), and ASD (Green et al., 2017).

Supporting information

Additional supporting information may be found online in the Supporting Information section at the end of the article:

Appendix S1. Expert panel participants.

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Key points

- Models of practitioner competencies for specific child mental health problems and interventions are needed to support evidence-based practice and training.
- There is strong expert consensus regarding core competencies for the delivery of evidence-based parenting interventions for child conduct problems, despite the many differences between individual programs.
- Practitioners require competencies for engaging not only mothers, but fathers and diverse/non-traditional caregivers and other stakeholders in evidence-based parenting interventions.
- The successful delivery of these interventions necessitates competencies that extend beyond parenting and encompass broader aspects of the family system and the wider ecology of the child.

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Appendix B – Identified Participants of Study 1

The following experts who participated in the study agreed to be named. Names are listed in alphabetical order. The remaining 28 experts who participated in the study would like to remain anonymous.

Dr. Shanna Alvarez

Dr. Brandi Hawk

Dr. Amie Bettencourt

Prof. Eva Kimonis

Dr. Susan Breitenstein

Dr. Karrie Lager

Prof. Wolfgang Briegel

Dr. Mike McCart

Prof. Tim Cavell

Dr. Cheryl McNeil

Dr. Heather Davis

Dr. Rachael Murrehy

Prof. Sharon Dawe

Ms. Laura Rains

Dr. Georgette Fleming

Dr. Carol Warren

Dr. Carolina Gonzalez

Dr. Amy Weir

Ms. Jeannie Gordon

Dr. Melanie Woodfield

Dr. Divna Haslam

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ORIGINAL ARTICLE



Complex presentations of child conduct problems: Validation of a competency-based model for clinical practice

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Abstract

Background: Children with conduct problems often present with a range of complex needs and many factors have the potential to complicate the delivery of evidence-based interventions for conduct problems. Little, however, is known about how to optimise the delivery of such interventions for complex cases, and there has been a lack of consensus regarding the features that reflect case complexity in treating child conduct problems. The aims of this study were to examine practitioner perceptions of the factors that contribute to case complexity in child conduct problems, and perceptions of the therapist competencies necessitated by distinct features of case complexity when delivering these interventions.

Methods: Practitioners ($n = 49$) with expertise in evidence-based parenting interventions for conduct problems were recruited from nine countries. Using the Delphi method, participant consensus was established across multiple rounds of consultation and feedback with the expert panel.

Results: Experts reached consensus on a model comprising seven distinct drivers of case complexity among children with conduct problems, spanning child-related factors, caregiver-related factors, and broader ecological factors. Consensus was also reached regarding 16 therapist competencies of key importance to distinct drivers of case complexity, thereby validating the conceptualisation of these drivers.

Conclusions: These findings represent a novel consensus-based practitioner perspective on the complex needs of children with conduct problems, and offer researchers and practitioners a common language for communicating information about case complexity. This perspective has the potential to inform clinical research, practice, and training, to better meet these complex client needs.

KEYWORDS

case complexity, clinical competence, disruptive, impulse control, and conduct disorders, evidence-based practice, psychosocial intervention, therapeutic alliance

INTRODUCTION

Evidence-based interventions for child conduct problems (e.g., oppositional and aggressive behaviour) are widely available, yet many factors may complicate the delivery of these interventions, and

treatment for complex presentations of conduct problems remains poorly understood (Andrade et al., 2022; Fonagy & Luyten, 2018). At the same time, approaches to classifying such presentations as complex have often been inconsistent, thereby hampering progress. In the broader biomedical literature, *case complexity* has generally

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been defined as the presence of factors that make the delivery of treatment difficult (e.g., Kazdin & Whitley, 2006; Ruscio & Holohan, 2006; Safford et al., 2007; Schaink et al., 2012). It has been theorised that this complexity arises from a cumulative interplay between factors across multiple domains, spanning not only diagnostic features, but also environmental, socioeconomic, and cultural factors (Delgadillo et al., 2017; Shippee et al., 2012). Such a conceptualisation suggests that although the factors that drive case complexity may increase risk for poor treatment outcomes, nonresponse is not inevitable when case complexity is present. Importantly, optimal outcomes may depend in part on practitioner adaptations based on such factors (Georgiadis et al., 2020).

Multiple approaches to characterising presentations of conduct problems can be found in the literature. Diagnostic models of oppositional defiant disorder (ODD) and conduct disorder (CD) have evolved in recent years to account for this heterogeneity and emphasise multiple factors associated with increased risk. This includes the introduction of specifiers (e.g., irritability-anger in ICD-11), subtypes (e.g., early-onset CD in DSM-V-TR), and severity classifications (e.g., for ODD based on number of problem contexts in DSM-V-TR). These models assume that clinical needs of children vary depending on such distinct presentations, based in part on evidence of treatment outcomes associated with risk pathways (Fairchild et al., 2019; Hawes et al., 2023). For example, the conduct problems of children with limited prosocial emotions are particularly severe and likely to persist following intervention, and novel treatment components for this group have therefore been subject to growing research (Perlstien et al., 2023).

Clinical presentations of conduct problems have also been described as complex due to factors beyond those specified within diagnostic models of ODD and CD. Most frequently, case complexity often refers to comorbid psychopathology (e.g., Dadds et al., 2012; Leijten et al., 2020; Weisz et al., 2012). Beyond comorbidity, clinical needs of children with conduct problems may also be complicated by contextual factors, which may impact adversely on treatment implementation and engagement, placing additional demands on practitioners. This includes caregiver-related factors, such as quality of parenting, parental psychopathology, and factors in the broader ecology of the child, such as cultural fit of the programme, socioeconomic disadvantage, and other environmental stressors (Andrade et al., 2022; Chacko et al., 2016; Piotrowska et al., 2017).

Despite the broad range of factors implicated in complex needs of families presenting with child conduct problems, research has often operationalised such complexity on the basis of a single factor alone and has typically focussed on individual factors in relative isolation. Based on treatment outcome research and clinical experience, Hawes and Dadds (2021) argued that the needs of children with complex presentations of CPs are best represented across multiple domains. They proposed that the factors that contribute to case complexity among children with CPs relate largely to six dimensions. These dimensions reflect complexity arising from (1) the topography of the child's conduct problems (e.g., range and severity; settings occurring); (2) developmental and dispositional factors (e.g., language impairments; temperamental factors including callous and unemotional traits); (3) co-morbid child psychopathology (e.g., internalising disorders; neurodevelopmental disorders); (4) quality of parenting

Key Points

What's known?

- Parenting interventions based on social learning theory are the treatment of choice for child conduct problems, yet many factors may complicate the delivery of these interventions.
- Children with conduct problems often present with a range of complex needs, yet there has been a lack of consensus regarding the features that reflect case complexity among such children.

What's new?

- Expert practitioners across nine countries were able to reach consensus regarding the factors that contribute to case complexity among children with conduct problems, and some therapist competencies necessitated by distinct drivers of case complexity.
- Support was found for seven drivers of case complexity among children with conduct problems, spanning child-level, caregiver-level, and ecological factors.

What's relevant?

- Evidence regarding the practitioner perspective on complex presentations of child conduct problems is particularly novel, and has the potential to inform clinical practice and training guidelines for the delivery of evidence-based interventions in real world settings.

(e.g., harsh or inconsistent discipline; parenting skill deficits); (5) parental characteristics (e.g., personality; mental health; parental attributions); and (6) the family system and social environment (e.g., interparental conflict; lack of social support; financial disadvantage). However, this model is yet to be tested empirically, and research continues to operationalise complex needs heterogeneously.

Variable definitions of *case complexity* in the literature hamper understanding of it and concerns have arisen amongst practitioners that complex client needs are not met by existing evidence-based parenting interventions for child conduct problems. A major criticism of treatment outcome research in child and adolescent mental health is that it has often been conducted under controlled conditions that may not reflect real-world clinical populations and settings, and this has resulted in a gap between research and practice related to factors of this kind (Ruscio & Holohan, 2006; Weisz et al., 2015). Indeed, lack of programme fit with client and service needs and practitioner beliefs has been found to be a core barrier to use of evidence-based parenting interventions (Turner et al., 2011). Many therapists consider that overly rigid adherence to a manualised intervention detracts from therapeutic alliance or ability to respond to complexity arising during session (Addis & Krasnow, 2000; Chorpita et al., 2014). Literature has discussed that practitioners subsequently often perceive that evidence-based interventions would not benefit their clients with complex needs, and that they may be more likely to rely on clinical judgement to determine how to meet these needs, which may be detrimental to clients (Ruscio & Holohan, 2006). Adaptation to client needs is recognised as necessary and common in

community settings (Pinto et al., 2024), yet in the absence of guidelines concerning if and how practitioners should adapt programmes, and what competencies therapists require to do so, many adaptations deviate from the evidence base (Moore et al., 2013), broadening the research-practice gap.

In the field of conduct problems, emerging research has targeted this gap by informing approaches to adapting evidence-based interventions based on the unique needs of a case (for a review see Andrade et al., 2022). Research aimed at decreasing the research-practice gap has included: examination of treatment effects associated with specific intervention elements or components (Garland et al., 2008; Leijten et al., 2019); development of transdiagnostic treatment components and modular models of delivery to address individual client needs related to complex comorbidities (Chorpita et al., 2005; Evans et al., 2021; Weisz et al., 2012); development of a framework for adaptations (Georgiadis et al., 2020); and addressing caregiver factors affecting clinical engagement and benefit (Gonzalez et al., 2023; Jones et al., 2021). Such approaches have shown much promise in translational research. For example, the Modular Approach to Therapy for Children (MATCH; Chorpita & Weisz, 2005) has been found to improve both client outcomes and efficiency of services compared to treatment as usual (Chorpita et al., 2017; Merry et al., 2020; Weisz et al., 2012). Research into MATCH has highlighted the importance of better understanding therapist competencies to support optimal intervention delivery (Cecilione et al., 2021).

One novel and potentially important approach identified to further reduce this research-practice gap is to investigate practitioner perceptions of case complexity. Little is currently known about practitioner perceptions of the factors that contribute to case complexity among children with CPs, in terms of the specific features of a case that are likely to complicate the delivery of evidence-based intervention and potentially cause practitioner deviation from evidence-based practice. These perceptions may be particularly important to understanding the demands that case complexity places on practitioners, and to understanding therapist competencies for the optimal delivery of evidence-based interventions with case complexity.

In implementation science, therapist competence has been conceptualised as a subcomponent of fidelity. Specifically, fidelity has been defined as comprising both adherence (i.e., implementation of programme components as intended according to protocol) and competence (i.e., the quality with which this is done, including therapist skill and style of delivery) (Breitenstein et al., 2010; Martin et al., 2023). Notably, a recent systematic review found that fidelity was most consistently associated with parenting intervention outcomes when operationalised in terms of adherence, competence and knowledge, compared to studies in which it was operationalised only in terms of adherence or another single component (Basha et al., 2025). Associated outcomes included improved parenting behaviours and stress, and improved child behaviour, self-esteem, and adjustment. In addition to highlighting the significance of fidelity, this supports the importance of ongoing research into competence regarding the delivery of such interventions.

Therapist competencies for evidence-based practice have been subject to growing research in their own right across various fields of mental health. Drawing on the expert consensus Delphi method used to inform the Improving Access to Psychological Therapies (IAPT)

initiative in the UK (now called NHS Talking Therapies; Clark, 2018), Barker and Hawes (2024) produced a comprehensive model of competencies for the evidence-based treatment of conduct problems. Such treatment was found to rely on a broad range of competencies, including 25 competencies related to general clinical practice in child mental health (e.g., knowledge of influence of cultural and racial factors on therapy); 27 specific to parenting interventions (e.g., use of experiential strategies to teach skills); and 23 specific to the content of evidence-based interventions for conduct problems (e.g., nonviolent disciplining; caregiver-child relationship enhancement; Barker & Hawes, 2024).

Therapist competencies may be particularly important to address complexity in treatment delivery. Practitioner perspectives on specific dimensions of case complexity, and what competencies may be particularly important to each, have not previously been examined. If practitioners perceive that case complexity has distinct dimensions, investigation of the specific competencies that are particularly important to each is also relevant, as these may differ between each and have implications for treatment adaptations. Whilst the term *case complexity* is used here for consistency with existing literature (Delgado et al., 2017; Hawes & Dadds, 2021; Kazdin & Whitley, 2006), we wish to clarify that our use of the term refers to difficulties clinicians face due to the limitations of current clinical practices, rather than difficulties that are inherent in a client. The major aims of the current study were therefore twofold. Firstly, we aimed to examine practitioner perceptions of the factors that contribute to case complexity among children with conduct problems. Specifically, we tested whether the model of key dimensions of case complexity proposed by Hawes and Dadds (2021) was supported by consensus among practitioners with high levels of experience in the delivery of evidence-based parenting interventions for CPs. Secondly, we examined practitioner perceptions of the therapist competencies necessitated by distinct features of case complexity when delivering these interventions. Of key interest was the relative importance that experienced practitioners place on specific competencies (Barker & Hawes, 2024).

METHODS

Participants

Participants consisted of an international expert practitioner panel, all currently practicing a social learning-based parenting intervention for conduct problems (hereby referred to as PIs), with at least 5 years of experience in PIs. 117 practitioners were invited by email, identified through relevant literature publications and recommendations from other practitioners who were recruited, including developers of established programmes. All interested eligible practitioners willing to complete the multiple rounds of data collection required (60 practitioners) were recruited with informed consent, with 49 participants completing the first round of data collection. The final sample, which was the same sample as that recruited for the Delphi study reported by Barker and Hawes (2024), was demographically highly comparable to those initially approached regarding sex, nationality, profession, and research experience. Forty one participants completed all three main testing rounds, resulting in a high

participant retention rate (84%) compared to similar Delphi studies (Morrison & Barratt, 2010; Spain & Happé, 2020). Twenty-eight participants completed the follow-up round (57% retention rate)—a comparable retention rate to similar Delphi studies that had fewer testing rounds (Bauer et al., 2019; Kim et al., 2021; Rubio et al., 2020), highlighting strong participant engagement.

Participants represented nine countries across three continents, including the United States of America (51% of participants), Australia (31%), Canada, New Zealand, England, Wales, Germany, Finland, and the Netherlands. Professions were predominantly psychology (73% of participants) and social work (10%), along with nursing, education, and psychiatry. Clinical experience spanned the major PIs for conduct problems (e.g., Parent-Child Interaction Therapy, 45% of participants practicing; Helping the Noncompliant Child, 24%; Triple-P, 24%; Incredible Years, 22%; Parent Management Training-Oregon Model, 22%; Barkley's Defiant Child, 16%; Parent-Child Care, 14%). Practitioners had a mean of 18 years of experience in PIs, and 98% of participants reported working with case complexity in their current and/or previous positions. Varied settings were represented, including private practice, university/research clinics, community health settings including hospital-based care, and government child welfare agencies. All participants provided informed consent to participate and chose whether to be identified (see acknowledgements for names of identified participants).

Design

Practitioner perceptions regarding complex presentations of child conduct problems were examined through Delphi method consultation with the international expert panel. Data collection comprised three main testing rounds, undertaken in April-May, June-July, and September-October of 2022, with a follow-up round in July 2023 specifically to further examine competencies for complexity. Each round consisted of an approximately 30–50-min questionnaire, for which participants were given two weeks to respond. Following Delphi method guidelines, consensus on proposed drivers of complexity, and competencies most vital for each, was developed through iterative questionnaire rounds in which participants provided qualitative responses and quantitative ratings (Chalmers & Armour, 2019). Participants remained anonymous to each other, whilst receiving summary feedback on panel responses in previous rounds, to encourage convergence of opinions. Participants could participate via videoconference (Zoom) interviews or via online questionnaires using the Qualtrics platform, whereby most chose the latter. Ethics approval was obtained from the University of Sydney Human Ethics Research Committee.

Procedure

The first round of testing consisted of three parts: (1) participant revisions to a preliminary model of core therapist competencies for PIs for conduct problems (reported elsewhere; Barker & Hawes, 2024); (2) participant revisions, including edits, additions, and omissions, to a proposed model of drivers of case complexity for conduct problems (Hawes & Dadds, 2021); and (3) participant

perceptions of what therapeutic competencies (from the proposed core competencies model or otherwise) they would draw on most, or see as most vital, to address each case-complicating dimension. These priority competencies for case complexity were developed alongside the model of drivers of case complexity to minimise testing rounds and hence optimise participant retention. In doing so, participants were asked to consider the term *complex* throughout the survey to mean 'particularly challenging, demanding, or difficult to treat'.

Following Round 1, revisions were made to the model of case complexity for conduct problems by content analysis of participant responses. Round 2 focussed on obtaining participant perspectives on these revisions. Participants were asked to select whether they perceived further revisions necessary for each part of each model. Consensus support was received for the model of drivers of case complexity in Round 2 hence no further revisions were required. Round 3 therefore focussed on developing consensus on priority competencies specific to each driver of case complexity. For each driver, participants were presented with the priority competencies suggested in Round 1 and asked to identify those they perceived as most vital. A follow-up, Round 4, was implemented to refine consensus for priority competencies as consensus was not met in Round 3. In Round 4, participants were again asked to select which competencies they perceived as most important for each driver of case complexity and additionally, of those, rank their order of importance in addressing that driver. For each driver of case complexity, participants were informed of which competencies met consensus in the previous round, and which did not have agreement.

Content analysis of open-ended expert responses to Round 1 was conducted manually, to aptly revise the drivers of case complexity. Reliability of analysis was evidenced by the researchers' agreement on content themes, drivers of case complexity, and wording of final competencies. Participant acceptability of the revised model showed the analysis had good validity (Chalmers & Armour, 2019). Data was deidentified to minimise bias. The criterion for consensus, consistent with recent Delphi studies, was 70% agreement for each individual driver of case complexity (Khazaie & Khan, 2020; Kim et al., 2021). For each priority competency, consensus required at least 70% of participants to both (a) rate the competency as 'most' vital; and (b) rank the competency amongst the number most highly rated. This double consensus method was employed to optimise validity of consensus.

RESULTS

Drivers of case complexity

Practitioners reached consensus regarding the factors that contribute to complex presentations of child conduct problems, and the grouping of these factors into seven dimensions, or drivers, of case complexity (see Table 1). Ninety four percent of experts agreed that the six-driver model proposed by Hawes and Dadds (2021) was acceptable, that is, that it appropriately grouped factors associated with case complexity in child conduct problems. However, in Round 1, almost half of experts (42%) suggested revisions to this model. Consequently, each driver, except severity of child conduct problems, was revised by content analysis.

TABLE 1 Drivers of and priority therapist competencies for case complexity in conduct problems.

Driver of complexity	Priority therapist competencies
Severity of child conduct problems The frequency and range of problem behaviours/symptoms, and the range of settings in which symptoms create impairment (e.g., home, school, with peers)	No specific competencies were identified as particularly important above other competencies.
Child developmental history Developmental history as typically gathered in clinical assessment or reported in medical documentation. This includes language impairments, traumatic experiences etc	For treatment planning: Devise, implement, and revise treatment plans, collaboratively and flexibly, especially adjusting for child factors such as age, developmental needs, ability level and other factors (e.g., through additional modules/content)
Comorbid child psychopathology and dispositional factors Temperament, irritability, callous-unemotional traits, emotional dysregulation, internalising disorders like anxiety, depression and PTSD, neurodevelopmental disorders like ADHD	For assessment: Assess symptoms, developmental factors, and function of behaviour (functional analysis) including those related to comorbidities (e.g., self-injurious or repetitive behaviours in ASD), trauma history, and family history, to identify most appropriate intervention(s) based on the child's needs For treatment planning and delivery: Collaboratively and flexibly devise, implement, and revise treatment plans, helping the family prioritise the most significant concerns to address first in therapy, applying all parenting intervention skills in accordance with the needs of the individual child, to address what is possible for each presenting issue For assessment, case formulation and goal setting: Use skills for evidence-based multi-method, multi-informant assessment to be very clear on the case formulation, diagnoses (including primary/secondary and disorder subtypes) and what factors are maintaining the problems, to therefore be clear on primary diagnoses or needs and consequent treatment goals and priorities
Caregiver-child relationship and parenting practices Significant lack of: warmth, engagement, positive affect, and sensitivity in caregiver-child relationship; permissive, harsh, or inconsistent discipline; parenting skill deficits	For therapeutic relationship: Build a collaborative therapeutic relationship with primary caregivers and repair any ruptures (e.g., by focusing on building rapport, showing empathy, seeking to understand the primary caregivers and prevent potential negative countertransference, and potentially engage them with additional techniques such as motivational interviewing); so that primary caregivers see the therapist as an ally, are willing to collaborate and build investment in the intervention including shared goals, and also can be challenged in their parenting without becoming defensive For barriers to change: Support primary caregivers to overcome barriers to treatment and manage resistance to change (e.g., assess, formulate and manage barriers to engagement, including relational dynamics; apply motivational interviewing/motivational enhancement strategies) For assessment: Assess quality and patterns of parenting and caregiver-child interaction, and drivers thereof, using valid methods of observation, interview and ongoing sessions For strengths-based practice: Apply culturally responsive and strengths-based practices (e.g., acknowledging the unique experiences of families; recognising primary caregivers as experts on their child)—including to reduce negative countertransference For goal setting: Collaboratively create and set concrete and measurable shared treatment and session goals with caregivers to encourage caregiver investment in the intervention and alignment with the therapist, even when addressing parenting deficits
Parental characteristics Parental personality, mental health (e.g., depression, substance use), trauma history, or cognitive/affective processes (e.g., attributional biases, emotional flooding, poor self-regulation)	For therapeutic relationship: Develop and maintain a trusting therapeutic relationship with primary caregivers, with rapport and empathy, developing this before moving into active intervention, to engage primary caregivers as allies, gain access to information about family dynamics, reduce negative countertransference, and effectively intervene in parenting
Family context Family structure and dysfunction (e.g., interparental conflict, parenting conflict with extended family); parental social and economic adversity (e.g., lack of social support, financial disadvantage); cultural beliefs, context and	For therapeutic relationship: Foster and maintain engagement with primary caregivers in a collaborative therapeutic alliance (e.g., identifying and inviting in the child's parenting team; managing in-session conflict between caregivers; managing resistance and ruptures, including client challenges to the competence of the therapist)

(Continues)

TABLE 1 (Continued)

Driver of complexity	Priority therapist competencies
connectedness; intergenerational trauma; treatment history and experiences	<p>Culturally responsive and strengths-based practice: Apply culturally responsive and strengths-based practices, including recognising, understanding and clarifying the family's unique perspectives, experiences and knowledge; integrating the value, role and influence of culture for the family into formulation, psychoeducation and discussions; and adapting interventions and specific techniques with cultural sensitivity and humility so that they're in line with the family's cultural beliefs and values</p> <p>For assessment: Conduct a thorough and broad assessment (including of intergenerational or historical trauma; family storyline; social support; the family's ability to meet basic needs; culture; parental beliefs and cognitions; family dynamics such as responses to child behaviour; and other psychosocial factors), to understand the role of the broader context (including strengths and barriers) in the child's presenting problems and develop realistic treatment expectations for planning and outcomes</p>
Broader social environment Historical and/or systemic oppression, systems involvement for the family (e.g., child protective services, juvenile justice, parental justice involvement)	<p>For assessment: Conduct a thorough and broad assessment (including of intergenerational or historical trauma; family storyline; social support; the family's ability to meet basic needs; culture; parental beliefs and cognitions; family dynamics such as responses to child behaviour; and other psychosocial factors), to understand the role of the broader context (including strengths and barriers) in the child's presenting problems and develop realistic treatment expectations for planning and outcomes</p> <p>Culturally responsive and strengths-based practice: Apply culturally responsive and strengths-based practices, including recognising, understanding and clarifying the family's unique perspectives, experiences and knowledge; integrating the value, role and influence of culture for the family into formulation, psychoeducation and discussions; and adapting interventions and specific techniques with cultural sensitivity and humility so that they're in line with the family's cultural beliefs and values</p> <p>For therapeutic relationship: Foster and maintain engagement with primary caregivers in a collaborative therapeutic alliance (e.g., identifying and inviting in the child's parenting team; managing in-session conflict between caregivers; managing resistance and ruptures, including client challenges to the competence of the therapist)</p>

Note: Competencies are ordered by those most frequently ranked most highly by the panel listed first for each driver.
Abbreviations: ADHD, attention-deficit/hyperactivity disorder; PTSD, post-traumatic stress disorder.

The final model of drivers contributing to complicating the delivery of PIs for child conduct problems consisted of seven drivers. Three drivers of case complexity concerned child-level factors: (1) conduct problem severity; (2) developmental history; and (3) comorbid child psychopathology and dispositional factors. Additionally, two drivers related to caregiver-level factors: (4) the caregiver-child relationship and parenting practices, and (5) parental characteristics; and two drivers related to ecological factors: (6) family context (e.g. interparental conflict; cultural beliefs such as those that stigmatise mental health); and (7) broader social environment (e.g., legal system involvement; other systems involvement).

Experts reached consensus that factors related to parental characteristics, family context, and the broader social environment, always or almost always contributed to complexity among cases of conduct problems in early-to-middle childhood. Notably, practitioners also reached consensus regarding the cumulative nature of these drivers as they relate to overall level of complexity, with 94% of participants agreeing or strongly agreeing that 'when more of these factors/dimensions are present, a case is likely to be more complex'. The remaining 6% of participants responded 'neutral'; none disagreed.

Priority competencies for case complexity

Expert practitioners also reached consensus on up to five competencies for each driver of case complexity that they endorsed as particularly important to achieve optimal outcomes when that driver is present (see Table 1). 508 priority competencies were initially identified by participants across the respective drivers of case complexity in Round 1. Following Round 4, experts reached consensus on 16 priority competencies across the drivers. Notably, consensus was not reached on all competencies, with additional competencies identified as important by 30%–70% of participants. However, further rounds to reach more consensus were not possible due to attrition (Hasson et al., 2000; Sumsion, 1998).

The priority competencies identified by practitioner consensus for each driver of case complexity (Table 1) were adapted from those in the model of core therapist competencies by Barker and Hawes (2024). Of note, all priority competencies concerned generic therapeutic competencies and process skills/knowledge rather than specific parenting skills and techniques, and no priority competencies were identified for complexity driven by conduct problem severity. Competency regarding treatment planning was identified as important for the

remaining two child-level drivers: for developmental history, this competency included adjusting treatment plans for child factors including age, developmental needs, intellectual ability and other factors; whereas for comorbid child psychopathology and dispositional factors, this included helping the family prioritise the most significant concerns. Additional priority competencies were also identified for complexity driven by comorbidity and dispositional factors but not for developmental history. For each driver of case complexity beyond these child level-factors, a priority competency regarding the therapeutic relationship was identified. Specifically, a focus on building the therapeutic relationship with primary caregivers before moving into active intervention was the only priority competency highlighted by practitioners for complexity driven by parental characteristics. For other drivers, additional priority competencies were also identified alongside those specific to the therapeutic relationship. Priority competencies for ecological drivers of case complexity—family context and broader social environment—concerned assessment; culturally responsive and strengths-based practice; and the therapeutic relationship.

DISCUSSION

Parenting interventions (PIs) for conduct problems are amongst the most well researched interventions in child and youth mental health, yet they appear to often fall short of meeting the complex needs of children and families. Little is known about practitioner perceptions of the factors that contribute to case complexity among children with conduct problems (i.e., factors that make the treatment delivery process more difficult), or the therapist competencies necessitated by distinct features of case complexity. The current study is the first, to our knowledge, to examine practitioner consensus regarding these factors.

A model of drivers of case complexity originally proposed by Hawes and Dadds (2021), based on treatment outcome research, was acceptable to practitioners yet was found by the majority of participants to need revision, showing that it is not the model of best fit according to practitioners. The novel model produced here differs in both number and composition of these drivers and reflects consensus among expert practitioners from diverse practice settings and interventions, across nine countries. The current model therefore integrates treatment outcome evidence with the practitioner perspective, to provide a novel account of case complexity among children with conduct problems. These drivers of complex client needs include factors that complicate the treatment process but may not have a negative effect on outcomes of PIs, and, in the case of severity, may indeed have a positive effect on child conduct problem outcomes (e.g., Leijten et al., 2020), indicating that case complexity does not equate to nonresponse if intervention is delivered competently. Our findings also build on previous research regarding practitioner competencies for the delivery of evidence-based interventions for conduct problems (Barker & Hawes, 2024), by identifying specific therapist competencies of key importance for each distinct driver of case complexity.

The first three drivers in this novel model of case complexity in child conduct problems relate to child-level factors: (1) conduct problem severity; (2) developmental history; and (3) comorbid child

psychopathology and dispositional factors. These largely reflect child-level features specified in current approaches to classifying disruptive behaviour disorders in DSM-5 and ICD-11, including diagnostic specifiers for high-risk subtypes therein. Interestingly, practitioners endorsed a model in which child characteristics such as irritability and callous-unemotional traits were represented on a dimension incorporating comorbid child psychopathology and dispositional factors, separate to a developmental history dimension. This represents a modification to the original Hawes and Dadds (2021) model, and is consistent with qualitative responses from participants indicating a perception that the implications of such characteristics for treatment are often more considerable than those associated with common risk factors in a child's developmental history (e.g., language delays), and that they can be difficult to distinguish from comorbid symptoms in clinical practice. This is also consistent with transdiagnostic accounts of these characteristics (Chin et al., 2025; Hawes et al., 2023).

Two caregiver-level drivers in the model of case complexity comprised (4) caregiver-child relationship and parenting practices; and (5) parental characteristics. This is consistent with literature showing that caregivers play a critical role as agents of change in evidence-based interventions for conduct problems, and that both the caregiver-child relationship and specific parenting techniques contribute to change processes in these interventions (Leijten et al., 2018). The final two drivers in the current model, family context and broader social environment, further highlight a distinction between case complexity arising from these two factors, which were considered one dimension in the previously proposed model (Hawes & Dadds, 2021). These have both previously been found to impact adversely on engagement with clinical services and the translation of treatment delivery into enduring change in PIs (Piotrowska et al., 2017; Weisenmuller & Hilton, 2021).

In addition to characterising distinct types of factors that serve as drivers of case complexity, our results support a cumulative perspective on the contribution of these drivers to case complexity, consistent with models of complexity in physical health literature (e.g., Shippee et al., 2012). This does not preclude the possibility that a case may present as highly complex based on factors within a single domain (e.g., multiple comorbidities). Importantly, however, the emphasis here on high case complexity often spanning distinct risk-factor domains diverges considerably from research in which such complexity has been operationalised based on a single factor alone (e.g., comorbidity; Aitken et al., 2018; Dadds et al., 2012), or research that investigates multiple drivers of case complexity but neglects to explore the cumulative effect of these (e.g., Kazdin & Whitley, 2006; McMahon et al., 2021).

It is noteworthy that practitioners working in diverse settings demonstrate consensus regarding some of the competencies of distinct importance for responding to specific drivers of case complexity. Our findings can be seen to validate the distinction between the respective drivers in the current model, and to support the utility of this distinction in clinical practice. However, practitioner consensus on priority competencies for case complexity was not reached on all competencies in the current study, suggesting diversity among practitioners' responses to case complexity. This supports the need for further research, including implementation research (Pinto et al., 2024), and more specific frameworks for how and when to use adaptations (Georgiadis et al., 2020).

It is noteworthy that no priority competencies were identified for complexity arising from severity of child conduct problems. This suggests that practitioners may perceive all core competencies as equally important for highly severe presentations, consistent with literature showing that children with severe conduct problems benefit particularly well from existing PIs as delivered in standard practice (Leijten et al., 2018), and that adapting these interventions beyond their core components of caregiver-child relationship enhancement and effective non-violent discipline may lead to reduced benefit for severe conduct problems (Leijten et al., 2022). Regarding other child-level drivers of case complexity, treatment planning appeared in priority competencies for both complexity due to child developmental history and complexity due to comorbid child psychopathology and dispositional factors. This focus on tailored treatment planning is consistent with literature highlighting the importance of formulation-driven practice (Andrade et al., 2022; Day et al., 2011; Hawes & Dadds, 2021), and shows further support for modular models of intervention to which formulation and individual treatment planning is central (Chorpita et al., 2005; Weisz et al., 2012).

The current findings also emphasise the importance of process-related competencies, beyond competencies related to specific PI skills, when case complexity stems from caregiver-level and ecological-factors. No priority competencies were related directly to the content of specific parenting skills or techniques in PIs for conduct problems. Rather, priority competencies for caregiver-level and ecological drivers of case complexity most frequently concerned generic therapeutic competencies, that is, competencies common across all child and family therapy settings (Barker & Hawes, 2024). This focus on generic therapeutic competencies is consistent with longstanding evidence that common therapeutic factors, including therapeutic alliance, and agreed activities and goals, account for greater variance in outcomes than specific therapeutic techniques (Lambert & Barley, 2001). Literature on PIs specifically also supports this, emphasising the importance of therapeutic engagement competencies for programme effectiveness (Piotrowska et al., 2017). Indeed, a PI developed specifically for families with complex child conduct problems, the Helping Families Programme, focuses substantially on such competencies (Day et al., 2011). In light of previous research, the current findings suggest that the effective use of clinical process strategies is particularly critical for supporting children and families with complex needs.

The current model of drivers of case complexity and corresponding therapist competencies point to key priorities for future research to reduce the research-practice gap highlighted in recent literature (Andrade et al., 2022). Most importantly, treatment process and outcome research is needed to better understand the processes by which these drivers of case complexity can affect treatment outcomes. We predict this may include at least four broad processes, the most common being disruption to parental engagement at any stage of treatment (e.g., attendance, implementation; Piotrowska et al., 2017). Secondly, when ecological drivers of case complexity also perpetuate the disruptive child behaviours (e.g., interparental conflict) they may continue doing so if not adequately addressed in an intervention; the same may be true for child-level drivers associated with risk mechanisms not typically targeted in standard intervention (e.g., callous-unemotional traits). Finally,

therapists often respond to case complexity with treatment adaptations, which may improve outcomes for complex cases, but also have the potential to contribute to nonresponse when evidence-based components are modified or removed by practitioners unnecessarily (Hawes & Dadds, 2021; Roach et al., 2022).

We predict that a consistent approach in research to characterising complex presentations, based on such a model, would enhance the quality of clinically applicable evidence available. Secondly, given that distinct competencies appear to be of key importance to these drivers, it is vital that intervention research addresses the significant heterogeneity that is known to characterise clinical populations of children with conduct problems (Andrade et al., 2022). Guidelines for adaptations based on this heterogeneity are nonetheless necessary to ensure their effectiveness (Hasson et al., 2023).

In clinical settings, consistent use of the current model to characterise complex presentations of conduct problems may support evidence-based practice in various ways. Firstly, this model suggests a key focus be placed on the early identification and assessment, for each client, of the child and family factors represented by the respective drivers of case complexity. Likewise, these factors should be accounted for in formulation-driven treatment planning, such that the intervention delivery is adapted to meet the unique needs of the family and optimise clinical engagement where possible. Furthermore, this model offers multidisciplinary teams a shared language to facilitate communication at the service-level, where policy regarding referral, or the allocation of limited resources, may be based on criteria related to the complex needs of a family. Our findings likewise highlight that particular competencies may be beneficial to emphasise in practitioner training and supervision for complex client presentations, and that these may differ based on complexity profiles common to a particular service.

Our findings should be considered in light of some limitations. The current study focussed on the evidence-based treatment of conduct problems in early-to-middle childhood and may not be representative of case complexity and associated competencies necessitated by presentations of conduct problems in older ages. Additionally, despite a broad international sample, participants largely represented Western, educated, industrialised, rich, democratic (WEIRD) countries. The research team aimed for a more heterogeneous sample, with contact attempts to practitioners in other countries either unsuccessful or limited by availability of contacts. Therefore, findings may not be generalisable to other population groups. Intervention research in more diverse populations remains a high priority for the field of child conduct problems (Fairchild et al., 2019; Hawes et al., 2023). Finally, while widely used to establish consensus in health research, the Delphi method may restate received wisdom that may or may not be supported by other empirical data. Therefore, further research should test the relative contribution of identified priority competencies to treatment outcomes for families with various complex needs. This could support the development of clinical practice guidelines to assist practitioners to make evidence-based adaptations, which may differ according to different drivers of complexity.

There is much to be gained by adopting a consistent approach to characterising the complex needs of children with conduct problems in research and practice, and our findings have the potential to inform such an approach. An expert panel identified therapist

competencies of key importance to seven distinct drivers of case complexity among children with conduct problems, thereby supporting the differentiation of these drivers in clinical training and decision-making. The more that complexity arises from multiple drivers, especially those based in the family context and broader social environment of the child, the more likely it appears to be that optimal outcomes may rely on generic therapeutic competencies including process skills. There is a pressing need for coordinated, standardised, evidence-based approaches to complex presentations of child conduct problems. The current findings can inform further research, including into the development and implementation of formal practice and training guidelines to better meet the complex needs of children with conduct problems in real-world clinical settings.

AUTHOR CONTRIBUTIONS

Jessica M. Barker: Conceptualization; data curation; formal analysis; investigation; methodology; project administration; visualization; writing—original draft; writing—review and editing. David J. Hawes: Conceptualization; investigation; methodology; supervision; writing—review and editing.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Informed consent was appropriately obtained from all participants prior to their participation in this research study. Ethics approval was received on 16th March 2022 through the University of Sydney Human Research Ethics Committee (HREC; approval number 2022/HE000020).

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Appendix D – Countries From Which Participants in Study 3 Part 2 Were Invited

Below is a list of the countries in which invited participants resided at the time of recruitment, listed in alphabetical order.

In North America: Canada, Jamaica, Mexico, United States of America

In South America: Chile, Ecuador

In Africa: South Africa, Other (Africa-wide network)

In Asia: Hong Kong, Indonesia, Iran, Israel, Japan, Singapore, South Korea, Taiwan, Turkey, United Arab Emirates

In Europe: Austria, Cyprus, Czechia, Denmark, Finland, France, Germany, Iceland, Ireland, Netherlands, Portugal, Norway, Sweden, Switzerland, United Kingdom, Wales

In Oceania: Australia, New Zealand

Appendix E – CoPPI Tips & Frequently Asked Questions

Tips for Completing the CoPPI

- Use video or live observation of sessions if you can.
- Have both supervisor and supervisee complete it to compare scores.
- Make space to focus on strengths as well as areas for further improvement.
- You do not have to complete it all at once - you can save it and come back later to where you left off.

Frequently Asked Questions (FAQs)

What competencies does the CoPPI include?

The CoPPI includes three types of competencies:

- (1) generic therapeutic competencies (competencies employed in all forms of child and family therapies);
- (2) parenting intervention competencies (competencies employed in all parenting interventions for child mental health); and
- (3) specific parenting skills/techniques (competencies addressing the parenting processes/skills targeted in parenting interventions for conduct problems).

What do each of the ratings on the CoPPI mean?

The scale used to score the CoPPI, as shown below, is the same as that used for the Revised Cognitive Therapy Scale (CTS-R; Blackburn et al., 2001). The CTS-R is the official measure used to measure therapist competencies in the NHS Talking Therapies Initiative (formerly known as Improving Access to Psychological Therapies, IAPT; Clark, 2018; Liness et al., 2019a).

This scale assesses both adherence to the intervention model and therapist skill, where 0 represents non-adherence, and 6 represents adherence and extremely high skill. The scoring for this measure should follow a normative distribution, with most therapists scoring around the mid-point (3) and few therapists scoring at the extremes of the scale.

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competencies, but numerous problems and lack of consistency
Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Who can use the CoPPI?

The CoPPI is intended for ANY therapist practicing a social learning-based parenting intervention (any training background; any stage of practice, from beginning trainee to highly experienced therapist).

What is the scoring for?

The scoring can be used to highlight strengths and areas for improvement for individual therapists, to guide supervision. A checklist option of the scale, without scoring, is also available. This option is recommended for rating competencies of more experienced therapists, especially as a self-reflective tool, or for competencies that are expected prerequisites to training in parenting interventions.

What do trainee therapists typically score?

Competency scores of training supervisees are not generally expected to reach 'competent,' especially as they may not yet have had opportunity to develop this skill. This expectation should be discussed with supervisees to foster constructive discussion and accurate self-reflective practice. As a general guide, competency domains presented earlier in each competency type are expected to be developed earlier. E.g., higher ratings expected for 'A' compared to 'D' generic therapeutic competencies; 'E' compared to 'G' parenting intervention competencies; 'H' compared to 'N' specific parenting skill/technique competencies.

Why are scores lower now than they were last time I completed the CoPPI?

Supervisee scores may shift down over time as self-reflective practice capacity grows. This is expected for trainee therapists and may not reflect decrease in competency!

What should I do with the CoPPI scores?

Following completion of the CoPPI, discussion of scores is recommended between supervisor and supervisee. You may then develop SMART goals or another method to target supervisee competencies to further develop. Remember - use the CoPPI in a way that is sustainable to your practice.

Is it valid to compare scores between therapists?

No, this tool has not been designed to compare performance between therapists. It should only be used for reflection on performance of one therapist.

What do you mean by caregiver?

- Primary caregiver(s) = those primarily serving a parenting role to the child who is the client. This term is used where it is necessary to explicitly differentiate between caregivers in a parenting role versus in a secondary caregiving role to the child, such as a grandparent who looks after a child once a week.
- Caregiver = anyone who is in a caring role for the child who is the client, whether this be primary or otherwise, e.g., parents, foster carers, grandparents, aunts/uncles, adult siblings, daycare educators etc.
- Parental = related to a primary caregiver of the child who is the client.

What if I don't feel it's appropriate to rate a particular competency?

This may be for various reasons as areas of focus may differ between specific parenting interventions and the level of training of the supervisee. You do not have to rate every competency. If you feel that the competency is not applicable, you can select N/A; if you feel that you have insufficient evidence to assess the competency, you can select I/E. You can also just leave it blank and it won't be counted in the overall score.

What happens to competencies that I don't rate 0-6?

Competencies that you leave blank or for which you select N/A or I/E will be excluded from summary scores. The number of unrated competencies (selected N/A, I/E or left blank) will be displayed in the summary of your results so that you have an understanding of how holistic your summary scores are.

How long am I "locked in" to my FOCUS competencies?

At any point you can choose to re-rate all competencies, or your FOCUS list. If you choose to re-rate all competencies, you can choose to select different competencies to create a new FOCUS list of competencies to rate the next time.

What if I want to discuss competencies in a different order?

You are invited to discuss competencies in whatever order you find most suitable - the CoPPI is designed to aid rather than limit supervision. However, using current software you can not re-order the items on the written scale.

How often should I complete the CoPPI?

You can complete the CoPPI as often as it's useful! We suggest completing a smaller portion of it more often (focusing on the competencies that you choose to flag), and then recompleting the whole measure at set review intervals e.g., every 2-6 months).

Appendix F – CoPPI Discussion Scaffold for Supervision

Reflecting on your responses to the rating tool of therapist competencies (CoPPI), please complete the following questions at the start of the supervision session collaboratively with your supervisee/supervisor:

1. What are the supervisee's competency strengths? Is this consistent between supervisor and supervisee?
2. What are the supervisee's key competency areas for further development? Is this consistent between supervisor and supervisee?
3. What competency area(s) would be helpful to discuss in supervision today / over the period of the placement / over the next X weeks?

Appendix G – Study 3 Part 1 Semi-Structured Interview Questions

Usability

1. What was your experience of completing the tool like? Were there any difficulties/barriers with completing it? Time taken?
 - What did you like / not like?
 - How did you find the rating scale to use?
 - Any issues with wording?
2. How would you use the tool? (pre/post supervision, within supervision, as discussion etc)
3. Do you think you would use the tool as a supervisor with your supervisee weekly/fortnightly/monthly? Would this be feasible? If no, why not?
4. Do you think you would be able to see change in the supervisee's scores on the tool, in their self-reflective practice or in their confidence in practice, if using the measure weekly over a 12-week supervision period? If no, why not / what would help?

Relevance

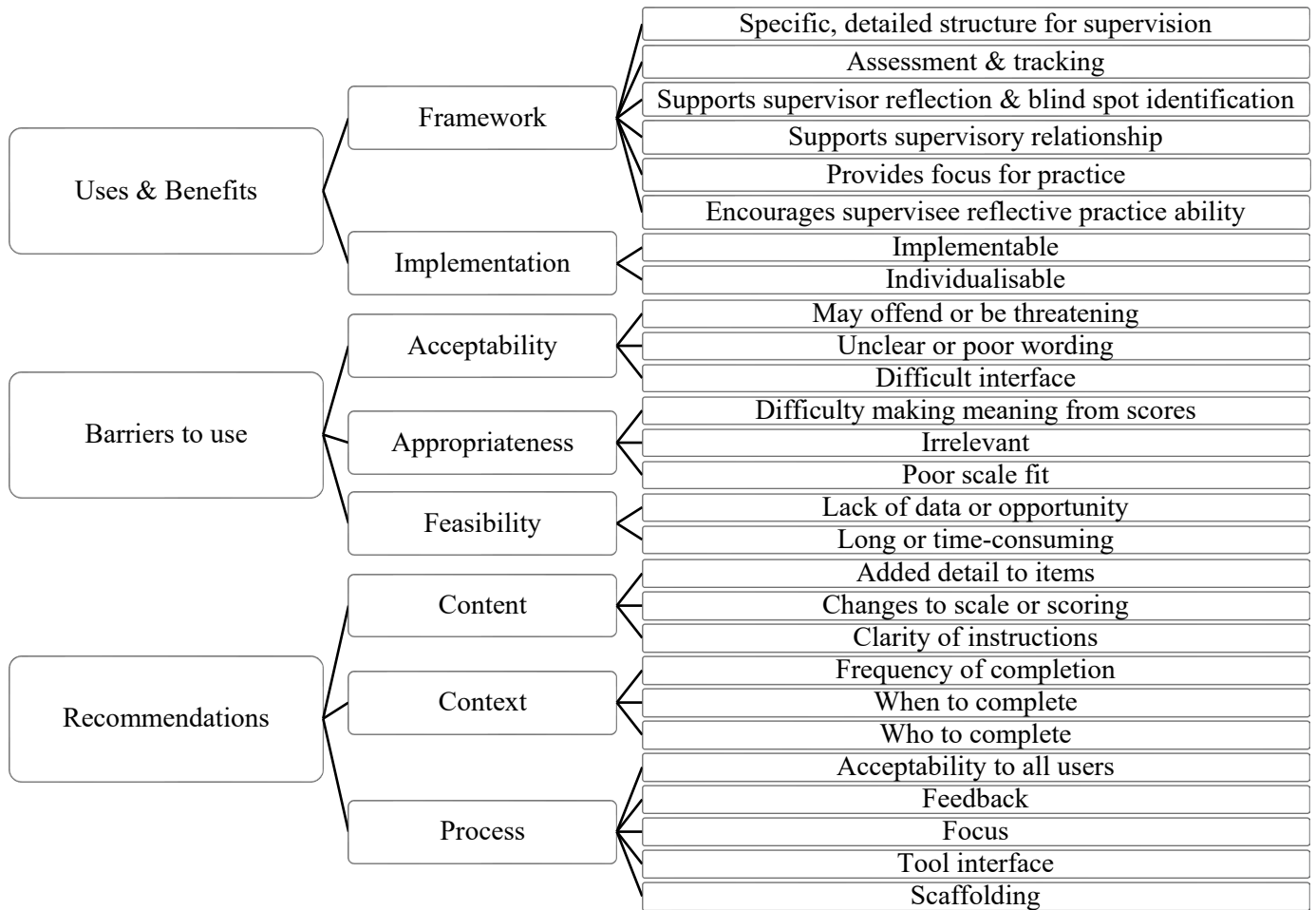
5. Would all components of the tool always be relevant to complete? Which ones would/would not be?
6. Do you think the tool could help improve the skills of your supervisee? Why/why not?
7. Do you think using the tool would improve your **competence as a supervisor**? How / how not?
8. Do you think the tool would be relevant to therapists beyond initial training? What would help support this e.g., different options / interfaces?

General

9. Most formal therapist training and supervision (i.e., provided in university courses) is generalist in nature. Do you think more specific supervision tools such as this would improve training and supervision?
 - If yes, what would you like to see in these tools?
 - If yes, what could optimise their usability?

Appendix H – Study 3 Part 1 Supplementary Results

Figure H.1. Framework Analysis Topics, Themes and Codes



Framework analysis

Uses & Benefits

Supervisors in individual interviews and focus groups identified uses and benefits of the CoPPI regarding its implementation, as well as its utility as a framework tool.

Framework. Firstly, regarding its utility as a framework, participants identified that the CoPPI provides a specific, detailed structure for supervision that decreases the cognitive load on the supervisor. One participant highlighted that “there’s a lot to keep track of, and there’s a lot for also the interns to keep track of, and so I really liked the level of detail,” and another participant also stated that “it would just be nice to know that there’s a framework in which to be a supervisor.” Supervisors also emphasised that this

structure could support assessment and tracking of change, with the CoPPI able to be used to scaffold check in and review processes, and to track specific goals.

Participants identified that use of the CoPPI as a framework could additionally improve their own skills as supervisors. Firstly, they identified that it could support them to reflect more specifically on the supervisee's practice, and to identify aspects of practice they may not have considered or reflected on, both in their supervisee's practice and their own. One comment summarises this well:

[The supervisee who] I was thinking about is recently graduated and has started working, and I would rate her as a, you know, excellent, proficient, practitioner or therapist working with parents and families. But looking at this, it prompted me to think about the areas where she's got short suits still. (Participant 10)

Secondly, participants described that the CoPPI could support the supervisory relationship, particularly if the CoPPI were completed by both supervisor and supervisee, with one expert stating that the CoPPI "provides a nice platform for discussion around any discrepancies." Also related to the supervisory relationship, supervisors felt the CoPPI could support supervisees to take onus of the supervision agenda because "they're more responsible for their self-monitoring and learning and taking things to the supervisor."

Ultimately, the ways in which the CoPPI would support both supervisor and supervisee as above were identified as relevant because they encourage development of a focus for practice. For example, one participant stated: "it'll make you go over areas...where you might need to do extra professional development...it's a really good reminder and a good way to kind of brush up on areas that you may need to."

Finally, participants identified that supervisees may develop their self-reflective practice throughout the process of discussing the CoPPI with their supervisor, which could have longer term benefits to their practice. One participant summarises this well: "I believe you probably will see an increase in reflectiveness, because some of the questions are kind of teasing that out, aren't they?" Hence, for several reasons, supervisors identified likely benefits of use of the tool as a framework.

Implementation. Participant responses also endorsed potential implementation of the CoPPI as a supervision tool. Comments included that supervisors liked the measure, found it relevant, helpful, and

usable. Various comments noted acceptability of the 5-point Likert scale, and of the breakdown of competencies into domains, for example, “I think it’s a fantastic collection of domains and questions. I went through it and went this is great, this is fantastic.” Supervisors were also asked if they felt it would be relevant in their own practice, with many affirming this. Finally, participants liked the individualisable nature of the supervision tool, which allowed respondents to select “not applicable,” so that competencies irrelevant to the specific program the individual is using would be excluded from resultant scores. Participants welcomed more flexibility in the tool such as this.

Barriers to Use

Despite positive comments regarding potential implementation of the supervision tool, barriers to use identified by participants centred around implementation factors, including its acceptability, appropriateness and feasibility.

Acceptability. Participants identified several concerns regarding unclear or poor wording, describing competencies as “fuzzy”, broad, or very condensed, whereby “you just get lost in [the specifics of each competency].” Experts raised concerns that, due to the breadth of some competencies, and/or the length of each, they would find it hard to both digest each competency, and decide on a single rating. Some comments concerned confusion about specific competencies. Additionally, some participants also made comments about not understanding the context of use of the scale.

Other participant concerns about acceptability of the CoPPI included that it was clunky to use on the REDCap platform, and that it may offend or threaten practitioners. Regarding threat to practitioners, some experts commented that they did not like written feedback that identified areas of lowest score, as they felt this could easily be perceived negatively, as “wrong” or a “weakness.” Other comments highlighted that practitioners may become defensive about being asked to reflect on their competencies if they are experienced, or if they feel their ratings could be used against them in a professional context.

Appropriateness. Participants’ concerns regarding appropriateness of the CoPPI included poor scale fit, irrelevance, and difficulty making meaning from scores. Poor scale fit was raised amongst participants with concerns that frequency of showing a competency may not make sense to rate for infrequently evident competencies, and that quality of the competency may be more useful information. Others also described

that the intervals between scale options seemed unequal. For example, one participant stated, “sometimes and half the time were kind of a bit too similar.” Some comments also centred around issues with the scale instructions being confusing regarding when to rate not applicable versus zero.

Regarding irrelevance, some comments centred around some competencies not being addressed in that specific supervisory relationship, such as when delivering group consultation, or delivering an intervention in a multi-disciplinary team. Others identified that program-specific tools, such as for Parent Management Training Oregon Model (PMTO), fulfill the same function as the CoPPI. Adjacent to this, some participants highlighted that the CoPPI would be hard to use in contexts where parenting interventions are being delivered briefly and/or in conjunction with other therapeutic interventions, such as in private practice. Finally, some participants raised that they felt the specificity to social-learning based parenting interventions could lead practitioners in neurodevelopmental disorders or other interventions for disruptive child behaviour, such as collaborative and proactive solutions, to avoid the CoPPI. Related to irrelevance, another participant concern was that they were unsure what to do with the information procured from the CoPPI, such as what to focus on in supervision based on scores, and what score and change therein to expect at different experience levels.

Feasibility. Participants had two clear concerns regarding likelihood of being able to realistically use the CoPPI in their clinical settings. Firstly, participants described that the length of the scale was a significant barrier. Many identified that they would likely procrastinate or de-prioritise the measure as a result, or that their ratings would be rushed and therefore less reliable or meaningful. “Admin burnout” and competing priorities were raised in several comments. Secondly, experts raised that it can be difficult, especially early in the supervision process, with infrequent supervision, or without direct clinician observation, to have sufficient understanding of the supervisee to accurately rate their competence.

Recommendations

Content. Expert participants made several recommendations to the specific content of the CoPPI, including the instructions, scale and scoring, and specific competencies and competency areas. Participants were informed that the meaning of specific competencies could not be altered as this was developed from previous data (Barker & Hawes, 2024). However, many recommendations concerned addition of detail and

examples to individual competencies, and to competency areas, to support their utility. Some participants also recommended adjustment to wording, such as replacing “parent” with “primary caregiver,” to recognise the versatility in family contexts.

Each participant was also specifically asked about their perspective on the rating scale, from which many recommendations were made. A clear pattern from responses was a recommendation for a scale based on quality rather than frequency of evidence of a competency, with the rationale encapsulated well by one respondent: “if I click ‘almost always,’ they could almost always be doing that completely incompetently.” Some recommendations on this theme included a rating scale differentiating between theoretical understanding and practical implementation as different competency levels, or scores that are comparative for their level of training e.g., “below average” to “above average,” and others included mention of competence e.g., “not at all competent” to “competent,” and skill development. On the contrary, many comments also reflected satisfaction with the frequency rating scale and instead requested adjustments to specific ratings within that so that the scale felt more balanced and evenly spaced between each rating (for example, “most of the time” and “almost always” were perceived as too similar). Finally, some participant recommendations included to add an additional option, separate to “not applicable” when there is “insufficient evidence” to rate a competency based on current information, as this may highlight a different response to “not applicable.”

The final code of content recommendations related to clarity of instructions for the CoPPI. Participants requested more information about what “evidence” meant for the scale, including recommendations that observation of sessions or recordings thereof should be used whenever possible, when completing the CoPPI. Recommendations also included clarity of instructions around the purpose of the CoPPI, important points to keep in mind when completing the tool (e.g., that decrease in scores may reflect increased awareness rather than decrease in competence), and clarity around how scores are produced (e.g., that ratings of “not applicable” are removed from scoring).

Context. Within the theme of recommendations for context of use of the MTCP, participants comments were coded as related to frequency of completion, when to complete it, and who completes it. For frequency of completion, some participants endorsed infrequent completion, such as once to twice annually,

often as part of a review process, whilst others endorsed more routine completion. Many participants also recommended that supervisees complete the tool more frequently than supervisors. Other comments highlighted that frequency of completion would depend on context. Some recommendations also recognised importance of completing the tool early in the supervisory relationship to support a baseline understanding of the supervisee's competence.

Recommendations regarding when to complete the CoPPI differed, with some participants recommending completion prior to supervision sessions by each party, and some recommending collaborative completion between supervisor and supervisee during supervision. Some recommendations also considered who completes the CoPPI, with one recommendation that only the supervisee completes it; others stating completion by both supervisor and supervisee is important as supervisee ratings may not be accurate without supervisor feedback. Some recommendations also included that an additional informant, such as a previous supervisor, a colleague, or even a client (adapted client-version), could be beneficial for highlighting competency areas on which to focus. One participant also highlighted that some competencies, such as related to practicing professionally, may be more relevant for a team leader to rate than a clinical supervisor, according to the clinical context.

Process. The process of using the CoPPI was the final theme related to recommendations for changes to the tool. Firstly, many supervisors emphasised that they'd want to know what supervisees thought of the measure, and for it to be acceptable to them. Some comments also highlighted that acceptability from supervisees may be variable and that therefore they would want it to be an optional exercise, for example, one participant stated "some are super keen for this sort of stuff...if it's just not their cup of tea, it would not be something I would want to insist upon. I think that could really undermine the supervisory relationship." Secondly, feedback was a code developed for process recommendations, with participant comments highlighting an interest in graphs to summarise results instead of a text summary. Participants cited that graphs would be easier to digest, preventing defensiveness based on scores, and would leave more room for individual interpretation and discussion.

Also related to process, a recurring discussion point amongst all participants was how to focus in on specific competencies, both as a method of making the tool shorter, and encouraging meaningful outcomes

from using the tool. Some participants suggested having a different focus at different time points. For example, some suggested looking at generic therapeutic competencies and understanding relevant theory and research at the start of training and/or the supervisory relationship, and focusing on other competencies later; others suggested using the full tool at review points, and otherwise only rating competencies for conducting caregiver-focused sessions and for specific skills and techniques. Some recommendations also included the focus being based on specific competencies being particularly important and therefore rated more often, although the competencies recommended differed between participants. Finally, many experts recommended that the competencies rated be determined individually, including based on the supervisee's stage of training and stage of treatment with clients. Some suggested that the supervisor may be responsible for determining this, whilst others recommended that this could be done collaboratively, identifying areas to focus on based on initial ratings and/or discussion.

The fourth code under process recommendations related to tool interface. Similarly to above for focus, some participants recommended that the tool be much shorter, for example, "if you can halve it, that would make it a lot more user friendly and I think more people will use it." However, many participants were particularly interested in flexibility within the tool, such as a choice between rating competencies or having a checklist (or other format without rating), and being able to vary between the two based on purpose and fit. Other comments called for ability to shift the order of competencies, or choose between different rating scales. One comment summarised this recommendation for flexibility well: "it's got to be customised as well enough to what they're being taught." Other aspects of interface on which experts made recommendations concerned minimising text on page (e.g., using hover text for examples and further explanations of competencies); including comment boxes; having features to track change across time points; and considering options to encourage accessibility of the tool (e.g., access through a website; printable and downloadable version).

Finally, participant recommendations also concerned scaffolding to support them to use the CoPPI, such as training and guidelines for use of the tool. Some participants requested guidelines on what scores to expect for different competencies, what competencies to particularly look out for low scores on, and how to address low scores. Regarding training, some recommendations included to have video or in-person training,

or to supply training videos of sessions to achieve high inter-rater reliability before using the CoPPI in practice. An in-supervision prompt sheet was proposed to support development of goals based on the CoPPI, with participants commenting on the utility of focusing both on strengths, and areas for further development of competencies, as well as consistency in ratings on each between supervisor and supervisee. Comments highlighted that supervisors perceived benefit of discussion of the tool results within supervision, in order to support supervision goals.

Changes to individual competencies based on recommendations

Changes were made to three individual competencies from the original core therapist competency model for PIs. Two competencies were added to the tool: the first competency under *building a therapeutic relationship* was split in two due to that competency being cited as difficult to rate as it was broad; and a new competency concerning technology use was added to *collaboratively conducting caregiver-focused sessions*. To the final competency about adult psychopathology in *understanding relevant child and family factors*, substance use was adjusted to an example of a behaviour related to adult psychopathology, rather than core to the competency. Otherwise, no changes were made to key words.

Appendix I – CoPPI Online Version

The following is an example of completion of the CoPPI to demonstrate mechanisms of the tool. Feedback is exemplified at the end of the CoPPI.

Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

- Aim: A tool to enhance supervision and reflective practice among practitioners delivering parenting interventions for child disruptive behaviour problems
- Context: Designed to be completed independently by both supervisor and supervisee on multiple occasions, for therapists from various training backgrounds and at all stages in clinical practice and training.
- Process: Enables a supervisor and supervisee to formulate shared goals by selecting specific competencies based on the formal model of core competencies for the treatment of conduct problems (Barker & Hawes, 2024). You will be asked to select competencies for focus after rating all competencies, to encourage this process.
- Note: Competencies are rated based on proficiency, according to all available evidence. (hover for more info).

For more information, open the [CoPPI Tips & FAQs](#).

Please continue to the next page to use the tool.

2%

Progress

Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

Please refer to the following to score:

= hover over this for 2-3 seconds to access extra information about each competency - try it here .

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competencies, but numerous problems and lack of consistency
Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

N.B. This scale assesses both adherence to the intervention model and therapist skill, where 0 represents non-adherence, and 6 represents adherence and extremely high skill. The scoring for this measure should follow a normative distribution, with most therapists scoring around the mid-point (3) and few therapists scoring at the extremes of the scale.

For each of the following competency areas (A to O), please:

1) Rate your / your supervisee's current level of proficiency , or tick **ADDITIONAL RATINGS** to rate specific competencies, and

2) Tick any competencies you would like to focus on in supervision

A Practicing professionally ⓘ

Score:

ADDITIONAL RATINGS (optional)

- | | | |
|--|--|--------------------------|
| 1 Codes of conduct | Knowledge of & ability to work within professional, ethical, legal codes of conduct relevant to children & families ⓘ | <input type="checkbox"/> |
| 2 Supervision & development | Active participation in supervision or professional development/consultation ⓘ | <input type="checkbox"/> |
| 3 Research evidence | Use of available relevant research evidence supporting interventions ⓘ | <input type="checkbox"/> |
| 4 Reflective practice | Reflective practice ⓘ | <input type="checkbox"/> |
| 5 Systems knowledge | Understanding of the role, purpose & responsibilities of key disciplines & institutional systems currently or prospectively involved in the care of the child/family ⓘ
<i>*Therapist's role in directly engaging additional stakeholders covered in F6.</i> | <input type="checkbox"/> |
| 6 Limits of expertise | Awareness of the limits of therapist's own expertise and/or the interventions being provided, and referral of client to another professional as appropriate for out-of-scope issues | <input type="checkbox"/> |

[Optional] Comments for discussion in supervision:



Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

[CoPPI Tips & FAQs](#)

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competencies, but numerous problems and lack of consistency
Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Rate your / your supervisee's current level of proficiency, and tick any areas to focus on in supervision.

B Understanding relevant child & family factors ⓘ

Score: 3 ▾

ADDITIONAL RATINGS (optional)

1 Child development	Knowledge of child development & developmental stages ⓘ	<input type="checkbox"/>
2 Culture and race	Knowledge & recognition of factors related to culture & race and their significance to therapy ⓘ	<input type="checkbox"/>
3 Family structure, experiences, dynamics	Knowledge of child & family structure, experiences, and relationship dynamics and how they can affect the process of therapy ⓘ	<input type="checkbox"/>
4 Child psychopathology and individual differences	Knowledge of risk pathways / predisposing factors to conduct problems, child psychopathology, comorbidity & other individual differences, and how these can affect therapy ⓘ	<input type="checkbox"/>
5 Adult psychopathology	Knowledge of adult psychopathology & related behaviours, and how these can affect therapy ⓘ	<input type="checkbox"/>

[Optional] Comments for discussion in supervision:



Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

[CoPPI Tips & FAQs](#)

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
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Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Rate your / your supervisee's current level of proficiency, and tick any areas to focus on in supervision.

C Building a therapeutic relationship ⓘ

Score: 5 ▾

ADDITIONAL RATINGS (optional)

- | | | | |
|----------|--|---|--------------------------|
| 1 | Engaging primary caregivers | Fostering engagement with the primary caregiver(s) in a collaborative therapeutic alliance ⓘ | <input type="checkbox"/> |
| 2 | Maintaining engagement with primary caregivers | Maintaining engagement with the primary caregiver(s) in a collaborative therapeutic alliance ⓘ
<i>*See G13 for managing resistance to change</i> | <input type="checkbox"/> |
| 3 | Inclusive practices | Using inclusive practices for engaging caregivers ⓘ | <input type="checkbox"/> |
| 4 | Hope and optimism | Instilling optimism, and hope for change | <input type="checkbox"/> |
| 5 | Therapeutic alliance with child | Fostering & maintaining therapeutic alliance with child when appropriate | <input type="checkbox"/> |
| 6 | Age-appropriate engagement | Using age-appropriate methods/pacing when engaging children | <input type="checkbox"/> |
| 7 | Partnerships and stakeholders | Forming partnerships with other family members/stakeholders where appropriate | <input type="checkbox"/> |
| 8 | Culturally responsive and strengths-based practices | Applying culturally responsive & strengths-based practices ⓘ | <input type="checkbox"/> |
| 9 | Therapist modelling | Modelling appropriate behaviours, reactions & emotion regulation consistently ⓘ | <input type="checkbox"/> |

[Optional] Comments for discussion in supervision:



Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

[CoPPI Tips & FAQs](#)

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competencies, but numerous problems and lack of consistency
Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Rate your / your supervisee's current level of proficiency, and tick any areas to focus on in supervision.

D Conducting a thorough assessment ⓘ

Score:

ADDITIONAL RATINGS (optional)

1 Assessment method	Using skills for evidence-based multi-method, multi-informant assessment ⓘ	6	<input type="checkbox"/>
2 Integration of reports	Integrating reports from diverse informants, along with clinical observations ⓘ	4	<input type="checkbox"/>
3 Diagnosis	Determining diagnoses with consideration of differential diagnosis, including physical health problems	4.5	<input type="checkbox"/>
4 Assessment areas	Assessing symptoms, function of behaviour (i.e., functional analysis), strengths, history, resilience, stage & suitability for the intervention ⓘ	3	<input type="checkbox"/>
5 Assessment of violence and risk	Assessing & managing violence/risk ⓘ	2	<input checked="" type="checkbox"/>
6 Parental assessment skills	Using parental assessment skills ⓘ	2	<input checked="" type="checkbox"/>

[Optional] Comments for discussion in supervision:

I rated additional ratings because they varied; need to work on

40%

Progress

Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

[CoPPI Tips & FAQs](#)

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
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Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Rate your / your supervisee's current level of proficiency, and tick any areas to focus on in supervision.

E Understanding relevant theory & research ⓘ

Score: 4 ▾

ADDITIONAL RATINGS (optional)

- | | | |
|---|---|--------------------------|
| 1 Behavioural theories | Knowledge of the behaviour change theories underpinning PIs for conduct problems ⓘ | <input type="checkbox"/> |
| 2 Implementation based on theory | Ability to implement PIs in line with theoretical underpinnings & related teaching strategies ⓘ | <input type="checkbox"/> |
| 3 Additional theoretical perspectives | Ability to integrate additional theoretical perspectives while maintaining PI fidelity ⓘ | <input type="checkbox"/> |
| 4 Risk, maintenance and protective factors | Knowledge of PI research, including evidence of contextual/child/parental/family factors implicated in risk/maintenance & protective processes, and how these differ for specific subgroups ⓘ | <input type="checkbox"/> |
| 5 Adult mental health strategies | Ability to integrate evidence-based strategies for adult mental health & behaviour change, as relevant to the parenting, while maintaining PI fidelity ⓘ | <input type="checkbox"/> |

[Optional] Comments for discussion in supervision:



50%

Progress

Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

[CoPPI Tips & FAQs](#)

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competencies, but numerous problems and lack of consistency
Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Rate your / your supervisee's current level of proficiency, and tick any areas to focus on in supervision.

F Family-based formulation & treatment planning ⓘ

Score:

ADDITIONAL RATINGS (optional)

1 Formulation	Collaboratively devising & revising case formulations ⓘ	1.5 ▼	<input checked="" type="checkbox"/>
2 Treatment planning	Collaboratively devising, implementing, flexibly revising PI treatment plans ⓘ	2.5 ▼	<input type="checkbox"/>
3 Communication of formulation	Communicating psychoeducation about the nature of the problem nonjudgementally to caregivers & stakeholders, and supporting caregivers to reflect on their own parenting where appropriate ⓘ	3.5 ▼	<input type="checkbox"/>
4 Treatment goals	Collaboratively negotiating concrete & measurable treatment goals with caregivers & other stakeholders as appropriate (e.g., teachers), informed by baseline measures ⓘ	3 ▼	<input type="checkbox"/>
5 Roles in treatment	Collaboratively negotiating roles of family members & other stakeholders in treatment ⓘ <i>*N.B., This differs from competency C7 as it is about role setting not initiating partnerships</i>	4 ▼	<input type="checkbox"/>
6 Engagement of wider network	Engaging others beyond the primary caregiver(s) as appropriate, including family members & stakeholders, and other clinicians where needed ⓘ	3.5 ▼	<input type="checkbox"/>
7 Progress monitoring	Using measures & self-monitoring to guide therapy & monitor outcomes ⓘ	N/A ▼	<input type="checkbox"/>
8 End of treatment planning	Planning for the end of therapy & long-term maintenance of progress ⓘ	N/A ▼	<input type="checkbox"/>
9 Limits of treatment	Recognising caregiver/family needs that can be addressed in the current PI versus needing longer term work	I/E ▼	<input type="checkbox"/>

[Optional] Comments for discussion in supervision:

Haven't answered 7 and 8 because they're not relevant yet

60%

Progress

Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

[CoPPI Tips & FAQs](#)

	Score	Descriptor
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Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competencies, but numerous problems and lack of consistency
Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Rate your / your supervisee's current level of proficiency, and tick any areas to focus on in supervision.

G Collaboratively conducting caregiver-focused sessions ⓘ

Score: 2.5 ▾

ADDITIONAL RATINGS (optional)

1 Session goals	Collaboratively setting & adhering to session goals/agenda ⓘ	<input type="checkbox"/>
2 Communication of rationale	Communicating the rationale for therapeutic processes & techniques ⓘ	<input type="checkbox"/>
3 Client feedback	Eliciting & responding to feedback from caregivers & family members ⓘ	<input type="checkbox"/>
4 Flexible technique implementation	Implementing specific techniques flexibly ⓘ	<input type="checkbox"/>
5 Experiential strategies	Utilising experiential strategies / active skills training to implement & promote specific parenting skills in session ⓘ	<input type="checkbox"/>
6 Technique monitoring and shaping	Monitoring & shaping implementation of strategies/techniques, sharing feedback on progress with the family ⓘ	<input type="checkbox"/>
7 Sensitivity to parent factors	Conducting sessions with sensitivity to parental factors ⓘ	<input type="checkbox"/>
8 In-session family collaboration	Facilitating in-session collaboration between members of the parenting team / other family members	<input type="checkbox"/>
9 Strategy implementation between sessions	Facilitating caregivers to implement strategies as a supportive parenting team between sessions ⓘ	<input type="checkbox"/>

10 Between-session activities	Collaboratively setting, planning & reviewing personally meaningful between-session activities <i>*N.B., Skills in both setting/planning and reviewing are needed to satisfy this competency</i>	<input type="checkbox"/>
11 Information sharing	Managing how information is shared across the family system ⓘ	<input type="checkbox"/>
12 Family boundaries and routines	Empowering the primary caregiver(s) to improve boundaries/routines with other caregivers ⓘ	<input type="checkbox"/>
13 Barriers to treatment and resistance to change	Supporting caregivers to overcome barriers to treatment & manage resistance to change ⓘ	<input type="checkbox"/>
14 Technology use	Using technology effectively to conduct sessions ⓘ	<input type="checkbox"/>
[Optional] Comments for discussion in supervision:		<input type="checkbox"/>
<input type="text"/>		

Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool (CoPPI)

[CoPPI Tips & FAQs](#)

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competencies, but numerous problems and lack of consistency
Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Rate your / your supervisee's current level of proficiency, and tick any areas to focus on in supervision.

H Psychoeducation ⓘ

Score: 4 ▾

ADDITIONAL RATINGS (optional)

- 1 **Child development** Explaining child development ⓘ
- 2 **Caregiver-child interactions** Explaining caregiver-child interactions ⓘ
*N.B. See G2 for psychoeducation specific to parenting techniques

[Optional] Comments for discussion in supervision:

I Reinforcement of positive behaviour ⓘ

Score: 2 ▾

ADDITIONAL RATINGS (optional)

- 1 **Social rewards** Teaching social rewards for good behaviour ⓘ
- 2 **Tangible rewards** Teaching tangible rewards for good behaviour ⓘ

[Optional] Comments for discussion in supervision:

J Nonviolent disciplining ⓘ

Score: 1 ▾

 ADDITIONAL RATINGS (optional)

1 Time-out	Teaching time-out ⓘ	<input checked="" type="checkbox"/>
2 Planned ignoring	Teaching planned ignoring / selective attention ⓘ	<input type="checkbox"/>
3 Natural-logical consequences	Teaching use of natural/logical consequences ⓘ	<input type="checkbox"/>

[Optional] Comments for discussion in supervision:**K Proactive parenting** ⓘ

Score: N/A ▾

 ADDITIONAL RATINGS (optional)

1 Effective commands	Teaching effective commands ⓘ	<input type="checkbox"/>
2 Rule setting	Teaching rule setting ⓘ	<input type="checkbox"/>
3 Child monitoring & supervision	Teaching monitoring & supervision ⓘ	<input type="checkbox"/>
4 Structuring the environment	Teaching pre-emptively structuring environments & routines to avoid problem behaviour ⓘ	<input type="checkbox"/>

[Optional] Comments for discussion in supervision:**L Relationship enhancement** ⓘ

Score:

 ADDITIONAL RATINGS (optional)

1 Quality caregiver-child time	Teaching caregiver-child quality time & child-directed interaction/play ⓘ	3 ▾	<input type="checkbox"/>
2 Empathic responding	Teaching empathic responding ⓘ *See N1 for teaching children emotional regulation	2 ▾	<input type="checkbox"/>
3 Active listening	Teaching active listening ⓘ	2 ▾	<input type="checkbox"/>

[Optional] Comments for discussion in supervision:

M Skills for caregivers to improve their own wellbeing ⓘ

Score: N/A ▾

ADDITIONAL RATINGS (optional)

1 Emotion regulation & stress-management skills	Teaching emotion regulation & stress-management skills ⓘ	<input type="checkbox"/>
2 Problem-solving & conflict management skills	Teaching problem-solving & conflict management skills ⓘ	<input type="checkbox"/>
3 Partner/social support	Covering partner and/or social support ⓘ	<input type="checkbox"/>
4 Self-care skills	Teaching caregiver self-care skills ⓘ	<input type="checkbox"/>

[Optional] Comments for discussion in supervision:

N Skills caregivers teach children ⓘ

Score: N/A ▾

ADDITIONAL RATINGS (optional)

1 Child emotion regulation skills	Teaching caregivers to teach children emotion regulation skills ⓘ	<input type="checkbox"/>
2 Child problem-solving skills	Teaching caregivers to teach children problem-solving skills ⓘ	<input type="checkbox"/>
3 Child social skills	Teaching caregivers to teach children social skills ⓘ	<input type="checkbox"/>
4 Child general learning and life skills	Teaching caregivers to teach children general learning & life skills ⓘ	<input type="checkbox"/>

[Optional] Comments for discussion in supervision:

O Coordination of parenting skills/techniques ⓘ

Score: I/E ▾

1 Technique coordination & consistent implementation	Teaching coordinated & consistent implementation of a range of parenting techniques to optimise child outcomes ⓘ	<input type="checkbox"/>
---	--	--------------------------

[Optional] Comments for discussion in supervision:

Date completed:

* must provide value

100%

Progress

-- Feedback --

To view a graphic summary of your results, please click [here](#).

Please review your ratings and add any desired notes or goals for supervision.

Generic Therapeutic Competencies		Average: 3.65	Competent
A - Practicing professionally		3	Competent
B - Understanding relevant child & family factors		3	Competent
C - Building a therapeutic relationship		5	Expert
D - Conducting a thorough assessment		3.58	Competent
Parenting Intervention (PI) Competencies		Average: 3.17	Competent
E - Understanding relevant theory & research		4	Proficient
F - Family-based formulation & treatment planning		3	Competent
G - Collaboratively conducting caregiver-focused sessions		2.5	Advanced beginner
Specific Parenting Skills/Techniques		Average: 2.33	Advanced beginner
H - Psychoeducation		4	Proficient
I - Reinforcement of positive behaviours		2	Advanced beginner
J - Nonviolent disciplining		1	Novice
K - Proactive parenting		___	N/A
L - Relationship enhancement		2.33	Advanced beginner
M - Skills for caregivers to improve their own wellbeing		___	N/A
N - Skills caregivers teach children		___	N/A
O - Coordination of parenting skills/techniques		___	N/A
Total Average Competency Score:		3.04	Competent



Click to view competency descriptors.

-- Focus Areas for Ongoing Supervision / Development --

Generic Therapeutic Competencies

D - Conducting a thorough assessment

5 - Violence/risk

6 - Parental assessment skills

Comment: I rated additional ratings because they varied; need to work on confidence with assessing and responding to risk, including managing relationship in this

[Optional] Tick here to specify more notes/goals

This is the main area to work on at the moment - my supervisee is just starting PIs

Expand

Parenting Intervention (PI) Competencies

F - Family-based formulation & treatment planning

1 - Case formulations

Comment: Haven't answered 7 and 8 because they're not relevant yet

[Optional] Tick here to specify more notes/goals

Specific Parenting Skills/Techniques

J - Nonviolent disciplining

1 - Time-out

O - Coordination of parenting skills/techniques

Comment: Haven't introduced enough techniques yet to see coordination

[Optional] Tick here to specify more notes/goals

-- For your reference, please find specifics of each competency below --

N.B. The PDF below is searchable and downloadable

image_vi... 1 / 12 86%

(CoPPI)

Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour Rating Tool

A Practicing professionally

These competencies include how a therapist navigates the professional sphere and understands their professional responsibilities and requirements.

1 Codes of conduct	Knowledge of & ability to work within professional, ethical, legal codes of conduct relevant to children & families (E.g., conduct regarding confidentiality, informed consent, matura minor, working with separated families, subpoenas, mental health legislation, record keeping, progress notes)
2 Supervision & development	Active participation in supervision or professional development/consultation (E.g., individual and group supervision, working proactively on areas of further development)
3 Research evidence	Use of available relevant research evidence supporting interventions (Ability to identify, understand, critically evaluate, and use evidence to inform practice)
4 Reflective practice	Reflective practice (E.g., accurate self-assessment of current competencies, processing

-- SAVE YOUR RESULTS --

Please ensure you print and/or save your graphs & summary as PDFs OR select 'Save & Return Later' and take note of your return code.

I have saved/printed my graphs and summary (Ctrl + P) OR made note of my return code

Summary of CoPPI Scores

Figure 1: Average Scores by Competency Type

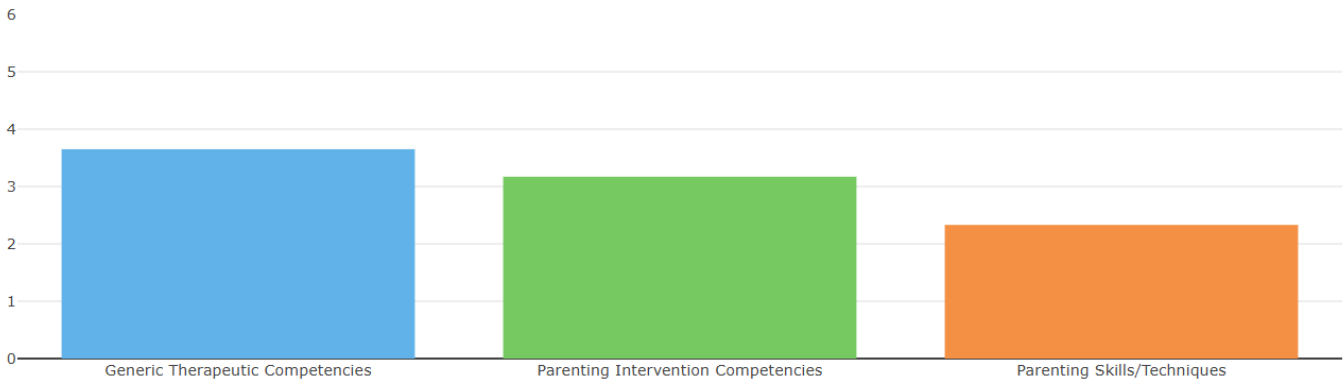
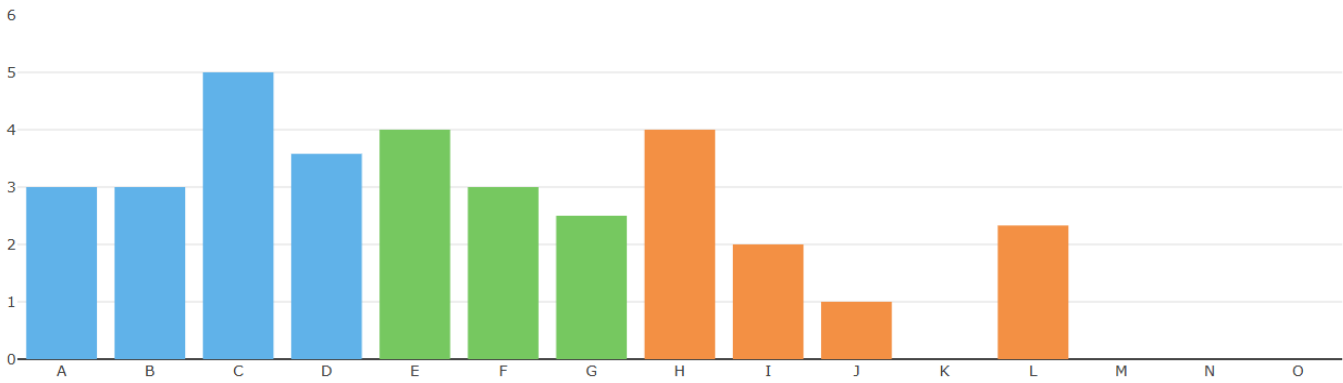


Figure 2: Average Scores by Competency Area



- A: Practicing professionally
- B: Understanding relevant child & family factors
- C: Building a therapeutic relationship
- D: Conducting a thorough assessment
- E: Understanding relevant theory & research
- F: Family-based formulation & treatment planning
- G: Collaboratively conducting parent-focused sessions
- H: Psychoeducation
- I: Reinforcement of positive behaviours
- J: Nonviolent disciplining
- K: Proactive parenting
- L: Relationship enhancement
- M: Skills for parents to improve their own wellbeing
- N: Skills parents teach children
- O: Coordination of parenting skills/techniques

Appendix J – CoPPI Paper Version

CoPPI – Competencies for Practitioners of Parenting Interventions for Disruptive Child Behaviour

Instructions

For each of the following competency areas (A to O), please:

- 1) Rate your / your supervisee's current level of proficiency using the scale below
 - a. You may use the *overall rating* for each competency area or use the *optional ratings* to rate each individual competency
 - b. If you choose to use *optional ratings*, please take the average of those competencies you rated to give the *overall rating*
- 2) Tick any competencies you would like to focus on in supervision

	Score	Descriptor
Not yet competent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competencies, but numerous problems and lack of consistency
Competent	3	Competent, but some problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, or very good even in the face of patient difficulties
	N/A	Not applicable to current practice
	I/E	Insufficient evidence to assess

Please note:

- Rate competencies based on proficiency, according to all available evidence (e.g., live observation video footage; discussion in supervision; supervisee's attitude to therapy; and feedback from clients or other professionals)
- This scale assesses both adherence to the intervention model and therapist skill, where 0 represents non-adherence, and 6 represents adherence and extremely high skill. The scoring for this measure should follow a normative distribution, with most therapists scoring around the mid-point (3) and few therapists scoring at the extremes of the scale.
- For more information, please read the CoPPI Tips & FAQs.

A Practicing professionally

Overall Rating:

These competencies include how a therapist navigates the professional sphere and understands their professional responsibilities and requirements.

		Optional Rating	Focus
Codes of conduct	Knowledge of & ability to work within professional, ethical, legal codes of conduct relevant to children & families (E.g., conduct regarding confidentiality, informed consent, matura minor, working with separated families, subpoenas, mental health legislation, record keeping, progress notes)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Supervision & development	Active participation in supervision or professional development/consultation (E.g., individual and group supervision, working proactively on areas of further development)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Research evidence	Use of available relevant research evidence supporting interventions (Ability to identify, understand, critically evaluate, and use evidence to inform practice)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Reflective practice	Reflective practice (E.g., accurate self-assessment of current competencies, processing personal reactions, managing transference/countertransference, review of own sessions by video, reflections with supervisor, case reviews/presentations, seeking peer feedback, identifying areas of difficulty, understanding the Dunning-Kruger effect)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Systems knowledge	Understanding of the role, purpose & responsibilities of key disciplines & institutional systems currently or prospectively involved in the care of the child/family (Supporting families to continue to engage in relevant systems e.g., health, education, legal, welfare services) *Therapist's role in directly engaging additional stakeholders covered in competency F "engagement of wider network."	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Limits of expertise	Awareness of the limits of therapist's own expertise and/or the interventions being provided, and referral of client to another professional as appropriate for out-of-scope issues	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>

B Understanding relevant child & family factors

Overall Rating:

These competencies include knowledge specific to child development and psychopathology and an understanding of how these may present in clients and affect therapy.

		Optional Rating	Focus
Child development	Knowledge of child development & developmental stages (Including age-appropriate behaviour; physical, cognitive, emotional and social maturation; effects of physical wellbeing on child behaviour such as illness, hunger, fatigue, sensory sensitivities etc)	<input type="checkbox"/>	<input type="checkbox"/>
Culture and race	Knowledge & recognition of factors related to culture & race, and their significance to therapy (E.g., values; lifestyle; family roles; intergenerational prejudice and discrimination)	<input type="checkbox"/>	<input type="checkbox"/>
Family structure, experiences, dynamics	Knowledge of child & family structure, experiences, and relationship dynamics, and how they can affect the process of therapy (E.g., attachment processes; intergenerational trauma; parental separation; parentification/infantilization of a child; sibling bullying; caregivers' experiences of being parented)	<input type="checkbox"/>	<input type="checkbox"/>
Child psychopathology and individual differences	Knowledge of risk pathways / predisposing factors to conduct problems, child psychopathology, comorbidity & other individual differences, and how these can affect therapy (E.g., child temperament; comorbid learning disorders; comorbid ADHD)	<input type="checkbox"/>	<input type="checkbox"/>
Adult psychopathology	Knowledge of adult psychopathology & related behaviours, and how these can affect therapy (E.g., substance use; social isolation; style of engagement in therapy, or lack thereof)	<input type="checkbox"/>	<input type="checkbox"/>

C Building a therapeutic relationship

Overall Rating:

These competencies include development and maintenance of therapeutic relationships and other related basic process skills. More complex process skills are highlighted in G.

		Optional Rating	Focus
Engaging primary caregivers	Fostering engagement with the primary caregiver(s) in a collaborative therapeutic alliance (E.g., identifying & inviting in the child’s parenting team; establishing initial and ongoing rapport)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Maintaining engagement with primary caregivers	Maintaining engagement with the primary caregiver(s) in a collaborative therapeutic alliance (E.g., managing in-session conflict between caregivers; managing therapeutic ruptures, including caregiver challenges to the competence of the therapist) *See G for managing resistance to change	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Inclusive practices	Using inclusive practices for engaging caregivers (E.g., inclusive of all genders; non-traditional family structures; cultural diversity; sexuality and gender identity)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Hope and optimism	Instilling optimism, and hope for change	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Therapeutic alliance with child	Fostering & maintaining therapeutic alliance with child when appropriate	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Age-appropriate engagement	Using age-appropriate methods/pacing when engaging children	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Partnerships and stakeholders	Forming partnerships with other family members/stakeholders where appropriate	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Culturally responsive and strengths-based practices	Applying culturally responsive & strengths-based practices (E.g., acknowledging the unique experiences of families; recognising caregivers as experts on their child)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Therapist modelling	Modelling appropriate behaviours, reactions & emotion regulation consistently (Including modelling parenting skills when interacting with the child and/or in role play e.g., modelling reward for desired behaviours and attachment neutral responses to unwanted behaviours)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>

D Conducting a thorough assessment

Overall Rating:

These competencies concern gathering an accurate picture of the client's functioning and needs for therapeutic purposes.

		Optional Rating	Focus
Assessment method	Using skills for evidence-based multi-method, multi-informant assessment (Including observation, interview, and standardised measurement tools)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Integration of reports	Integrating reports from diverse informants along with clinical observations (E.g., reports from all primary caregivers, other caregivers, teachers, child, professionals)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Diagnosis	Determining diagnoses with consideration of differential diagnosis, including physical health problems	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Assessment areas	Assessing symptoms, function of behaviour (i.e., functional analysis), strengths, history, resilience, stage & suitability for the intervention (Functional analysis including antecedent, behaviour and consequence)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Assessment of violence and risk	Assessing & managing violence/risk (E.g., creating a family safety plan as appropriate)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>
Parental assessment skills	Using parental assessment skills (E.g., supporting caregivers to discuss personal thoughts/emotions & sensitive issues beyond the child, including family of origin experiences)	<input style="width: 50px; height: 50px;" type="text"/>	<input style="width: 50px; height: 50px;" type="text"/>

E Understanding relevant theory & research

Overall Rating:

These competencies relate to integrating knowledge about parenting interventions, and other related theory, into practice.

		Optional Rating	Focus
Behavioural theories	Knowledge of the behaviour change theories underpinning PIs for conduct problems (Including operant learning; classical learning; social learning theory)	<input type="text"/>	<input type="text"/>
Implementation based on theory	Ability to implement PIs in line with theoretical underpinnings & related teaching strategies (As relevant to the specific family, including using functional analysis to inform use of e.g., backwards/forwards chaining; shaping; prompting; differential reinforcement of incompatible/alternative behaviours; minimising or eliminating setting events)	<input type="text"/>	<input type="text"/>
Additional theoretical perspectives	Ability to integrate additional theoretical perspectives while maintaining PI fidelity (E.g., attachment theory to inform implementation of behavioural techniques; structural family therapy theory to inform engagement of family members; Bordin's theory on therapeutic alliance; cognitive therapy to help manage therapeutic barriers; social-cognitive theory to inform caregiver self-regulation)	<input type="text"/>	<input type="text"/>
Risk, maintenance and protective factors	Knowledge of PI research, including evidence of contextual/child/parental/family factors implicated in risk/maintenance & protective processes, and how these differ for specific subgroups (E.g., children with callous and unemotional traits; with trauma history)	<input type="text"/>	<input type="text"/>
Adult mental health strategies	Ability to integrate evidence-based strategies for adult mental health & behaviour change, as relevant to the parenting, while maintaining PI fidelity (E.g., cognitive challenging/disputation; motivational interviewing; attribution retraining; mood monitoring; other cognitive therapy techniques)	<input type="text"/>	<input type="text"/>

F Family-based formulation & treatment planning

Overall Rating:

These competencies relate to setting up the therapeutic space with each specific client to optimise intervention effectiveness (e.g., communicating formulation, treatment plans, roles, goals).

		Optional Rating	Focus
Formulation	Collaboratively devising & revising case formulations (Accounting for: the presenting problem; comorbidity; neurodiversity; developmental level; individual differences related to subtype of conduct problems; family/parental/social/contextual factors, including family strengths; and how these explain current manifestation of behaviour problems)	<input type="text"/>	<input type="text"/>
Treatment planning	Collaboratively devising, implementing, flexibly revising PI treatment plans (Selecting, sequencing, applying the most appropriate PI techniques, at the appropriate dosage, based on the formulation and the family's values and priorities; making appropriate adjustments for comorbidities, such as accommodations for ADHD; maintaining PI fidelity; integrating management of potential crises into treatment plan so as not to detract from intervention; sharing with family as appropriate, including expected timeline of intervention)	<input type="text"/>	<input type="text"/>
Communication of formulation	Communicating psychoeducation about the nature of the problem nonjudgmentally to caregivers & stakeholders, and supporting caregivers to reflect on their own parenting where appropriate (Including responding appropriately to caregiver questions; avoiding blame or criticism of caregivers, including implicitly; communicating psychoeducation about diagnoses relevant to the child including comorbidities or neurodiversity)	<input type="text"/>	<input type="text"/>
Treatment goals	Collaboratively negotiating concrete & measurable treatment goals with caregivers & other stakeholders as appropriate (e.g., teachers), informed by baseline measures (Solution-focussed; specific; measurable; achievable; relevant; time-bound i.e., SMART goals)	<input type="text"/>	<input type="text"/>
Roles in treatment	Collaboratively negotiating roles of family members & other stakeholders in treatment (E.g., ensuring primary caregivers prepared to parent consistently with each other; deciding when children are present; involvement of school in intervention) *N.B., This competency is about role setting, not initiating partnerships. The latter is covered in competency C "partnerships & stakeholders."	<input type="text"/>	<input type="text"/>
Engagement of wider network	Engaging others beyond the primary caregiver(s) as appropriate, including family members, stakeholders, and other clinicians where needed (E.g., daycare educator; teacher; grandparents; coach/tutor; occupational therapist; speech pathologist; paediatrician, including for potential medication)	<input type="text"/>	<input type="text"/>
Progress monitoring	Using measures & self-monitoring to guide therapy & monitor outcomes (E.g., methods for single case designs)	<input type="text"/>	<input type="text"/>
End of treatment planning	Planning for the end of therapy & long-term maintenance of progress (E.g., termination sessions, written summaries of progress and replace prevention recommendations)	<input type="text"/>	<input type="text"/>
Limits of treatment	Recognising caregiver/family needs that can be addressed in the current PI versus needing longer term work	<input type="text"/>	<input type="text"/>

G Collaboratively conducting caregiver-focused sessions

Overall Rating:

These competencies relate to process skills for conducting sessions effectively (e.g., how active skills training is conducted and tailored to individual clients; getting caregivers on board, including those with strained relationships; managing barrier to engagement and/or progress).

		Optional Rating	Focus
Session goals	Collaboratively setting & adhering to session goals/agenda (E.g., ensuring goals are consistent with overall goals – see F4; including time in the agenda for shaping caregiver implementation of skills; managing clients who continually change goal focus each session; keeping to time)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Communication of rationale	Communicating the rationale for therapeutic processes & techniques (E.g., explaining involvement of specific family members; rationale for each technique introduced; responding appropriately to caregiver questions; avoiding judgement, blame, or criticism of caregivers)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Client feedback	Eliciting & responding to feedback from caregivers & family members (Including having mechanisms for regular collection of feedback; discussing measure outcomes with families; asking appropriate questions to elicit meaningful feedback)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Flexible technique implementation	Implementing specific techniques flexibly (Accounting for the client's presentation; needs/preferences; cultural background; family relationships & mental health)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Experiential strategies	Utilising experiential strategies / active skills training to implement & promote specific parenting skills in session (Role play; modelling; in vivo coaching; corrective feedback; reinforcement)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Technique monitoring and shaping	Monitoring & shaping implementation of strategies/techniques, sharing feedback on progress with the family (E.g., praising caregiver strengths and successes; incorporating caregiver views into feedback; responding appropriately to caregiver questions; conveying understanding that parenting skills require more than psychoeducation, taking time, repetition, and problem-solving to develop)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Sensitivity to parent factors	Conducting sessions with sensitivity to parental factors (E.g., accounting for parental mental health, accounting for marital discord / separated families; managing clients presenting in crisis, including perpetual crisis; for experienced clinicians, working with more complex family dynamics such as separated families, incarcerated families, foster families, families from diverse backgrounds)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
In-session family collaboration	Facilitating in-session collaboration between members of the parenting team / other family members	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Strategy implementation between sessions	Facilitating caregivers to implement strategies as a supportive parenting team between sessions (E.g., wrapping up sessions with a clear set of takeaways/goals; monitoring/promoting between-session change through telephone "check ins" or questionnaires as appropriate to the service and client)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Between-session activities	Collaboratively setting, planning & reviewing personally meaningful between-session activities *N.B., Skills in both setting/planning and reviewing are needed to satisfy this competency	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Information sharing	Managing how information is shared across the family system (E.g., guiding caregivers when topics should be discussed without children present)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>
Family boundaries and routines	Empowering the primary caregiver(s) to improve boundaries/routines with other caregivers (Boundaries/routines e.g., trust of parenting team's capability; parenting team's house rules being respected; bed-time routines being consistent with other major caregivers)	<input style="width: 40px; height: 30px;" type="text"/>	<input style="width: 40px; height: 30px;" type="text"/>

Barriers to treatment and resistance to change

Supporting caregivers to overcome barriers to treatment & manage resistance to change
(Assessing, formulating and managing barriers to engagement, including relational dynamics and process issues e.g., late arrivals, missed sessions, low engagement in sessions, negative attitudes about potential for change in child's behaviour; applying motivational interviewing / motivational enhancement strategies as appropriate; showing consistency, predictability and belief in the therapy through language and actions)

Technology use

Using technology effectively to conduct sessions
(E.g., effectively using digital tools to deliver outcomes measures or collect other information; using communication channels effectively for online sessions; minimizing technical interruptions to sessions; having good quality sound and vision during sessions; setting up camera position to minimise visual or attentional interference when using video; remaining updated with technological advancements; using technology to set up the family's home environment to facilitate desired child behaviour)

H Psychoeducation

Overall Rating:

These competencies relate to clinician skills in communicating psychoeducation to clients.

Child development

Explaining child development
(Info about typical & atypical; effects of trauma; effects of screen time; correcting misinformation e.g., harmful effects of time-out & praise/rewards viewed as coercive control)

Optional Rating

Focus

Caregiver-child interactions

Explaining caregiver-child interactions
(Info about bi-directional daily shaping of behaviour, including effects of child and parental temperament; parental family of origin; systemic/contextual/cultural influences on parenting; parental self-care; the functions/ABCs of behaviour from operant and attachment perspectives and variations thereof between children e.g., defiance vs difficulty concentrating)
*N.B. See competency G “communication of rationale” for psychoeducation specific to parenting techniques

I Reinforcement of positive behaviour

Overall Rating:

These competencies relate to clinician skills to help caregivers encourage positive child behaviours.

Social rewards

Teaching social rewards for good behaviour
(Using active skills training to teach these; social rewards e.g., verbal praise; non-verbal cues such as smiles, thumbs up; physical affection; quality time/activities with caregivers)

Optional Rating

Focus

Tangible rewards

Teaching tangible rewards for good behaviour
(Using active skills training to teach these; tangible rewards e.g., tokens, charts, incentive systems)

J Nonviolent disciplining

Overall Rating:

These competencies relate to improving clinician skills to help caregivers to directly discourage unwanted child behaviours.

Time-out

Teaching time-out
(Using active skills training to teach time-out: exclusionary vs non-exclusionary time-out i.e., time-out chair/room versus removal of reinforcing objects/activities/conversation; using least restrictive practice that is appropriate e.g., asking child to go to time out before physically moving them)

Optional Rating

Focus

Planned ignoring

Teaching planned ignoring / selective attention
(Using active skills training to teach planned ignoring)

Natural-logical consequences

Teaching use of natural/logical consequences
(Including removal of privileges and addition of chores, as age-appropriate. Use of active skills training to teach use of natural/logical consequences)

K Proactive parenting

Overall Rating:

These competencies relate to clinician skills to help caregivers set up the child's environment for positive behaviour.

Effective commands

Teaching effective commands
(Direct, positively stated, specific, age-appropriate commands. Therapist use of active skills training to teach commands)

Optional Rating

Focus

Rule setting

Teaching rule setting
(Rules about appropriate & inappropriate behaviour; techniques for managing rules, including discussion of ground rules e.g., “guided discussion for rule breaking.” Therapist use of active skills training to teach rule setting)

Child monitoring and supervision

Teaching monitoring & supervision
(Caregivers knowing what child does & with whom they play when out of view, including media use; observing in the moment)

Structuring the environment

Teaching pre-emptively structuring environments & routines to avoid problem behaviour
(E.g., avoid struggles with child by giving choices; prepare child for challenging situations; warn child before a change of activity; use timers; make necessary tasks fun; break down tasks; manage technology / have clear boundaries on screen time; plan activities for situations that often lead to problem behaviour, such as when child may become bored; use other positive behaviour support strategies. Therapist use of active skills training to teach structuring of environments and routines)

L Relationship enhancement

Overall Rating:

These competencies relate to clinician skills to help caregivers improve their relationship with their child.

		Optional Rating	Focus
Quality caregiver-child time	Teaching caregiver-child quality time & child-directed interaction/play (E.g., spending time focused on child showing interest/engaging in what they are doing; having daily child-led play with child; involving warmth and mutual enjoyment. Therapist use of active skills training to teach these)	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>
Empathic responding	Teaching empathic responding (Understand what child feels in different situations; emotional language. Therapist use of active skills training to teach empathic responding) *See competency N for teaching children emotional regulation	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>
Active listening	Teaching active listening (Concentrate on what child says; show that they are listened to; reflect back to them what they say; and show them that they are valued in the family. Therapist use of active skills training to teach active listening)	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>

M Skills for caregivers to improve their own wellbeing

Overall Rating:

The following competencies relate to clinician skills to help caregivers with skills for their own ongoing wellbeing.

		Optional Rating	Focus
Emotion regulation and stress-management skills	Teaching emotion regulation & stress-management skills (Recognise own emotions and how they affect parenting; validating & regulating e.g., with mindfulness, relaxation techniques. Therapist use of active skills training to teach these)	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>
Problem-solving and conflict management skills	Teaching problem-solving & conflict management skills (Generate & implement solutions to difficult situations and crises directly and indirectly related to parenting; communicate effectively where there's friction with others taking care of their children e.g., teachers, extended family, to advocate effectively for their children. Therapist use of active skills training to teach these)	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>
Partner/social support	Covering partner and/or social support (As appropriate/applicable, e.g., skills for improving relationship/communication between core parenting team members; support from partner and/or other family/friends)	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>
Self-care skills	Teaching caregiver self-care skills (E.g., personal/pleasant activities and time for self; support caregiver(s) to access own therapy where appropriate)	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>

N Skills caregivers teach children

Overall Rating:

These competencies relate to clinicians' skills in communicating techniques to caregivers about how to teach skills to their children.

		Optional Rating	Focus
Child emotion regulation skills	Teaching caregivers to teach children emotion regulation skills (Labelling emotions, validating emotions, modelling how to regulate emotions and control impulses/attention)	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>	<input style="width: 50px; height: 50px; border: 1px solid black;" type="text"/>

Child problem-solving skills	Teaching caregivers to teach children problem-solving skills (Teaching how to solve everyday problems)	<input type="checkbox"/>	<input type="checkbox"/>
Child social skills	Teaching caregivers to teach children social skills (Including communication and conflict resolution skills; prosocial behaviours such as helping others)	<input type="checkbox"/>	<input type="checkbox"/>
Child general learning and life skills	Teaching caregivers to teach children general learning & life skills (E.g., teaching colours, promoting independence in child self-care. Including therapists teaching caregivers to use teaching strategies e.g., ask-say-do; incidental teaching)	<input type="checkbox"/>	<input type="checkbox"/>

O Coordination of parenting skills/techniques

Overall Rating:

Clinicians' skills to help caregivers discriminate when and which parenting skills to use in different situations.

Technique coordination and consistent implementation

Teaching coordinated & consistent implementation of a range of parenting techniques to optimise child outcomes
(E.g., selecting, sequencing, and combining techniques, as appropriate to the situation; being able to "recover" after discipline; how to respond to undesirable child reactions to positive reinforcement; refraining from using relationship enhancement skills like empathic responding or active listening when problem behaviour is occurring; generalising skills from home to other contexts; when to teach/challenge a child versus not; having some proactive parenting in place prior to teaching rewards and consequences to caregivers)

Focus

Summary

Ratings:

A	
B	
C	
D	
E	
F	
G	
H	
I	
J	
K	
L	
M	
N	
O	
Sum of A to O	
Average score (Sum ÷ 15)	

Focus Competencies / Goals for supervision:

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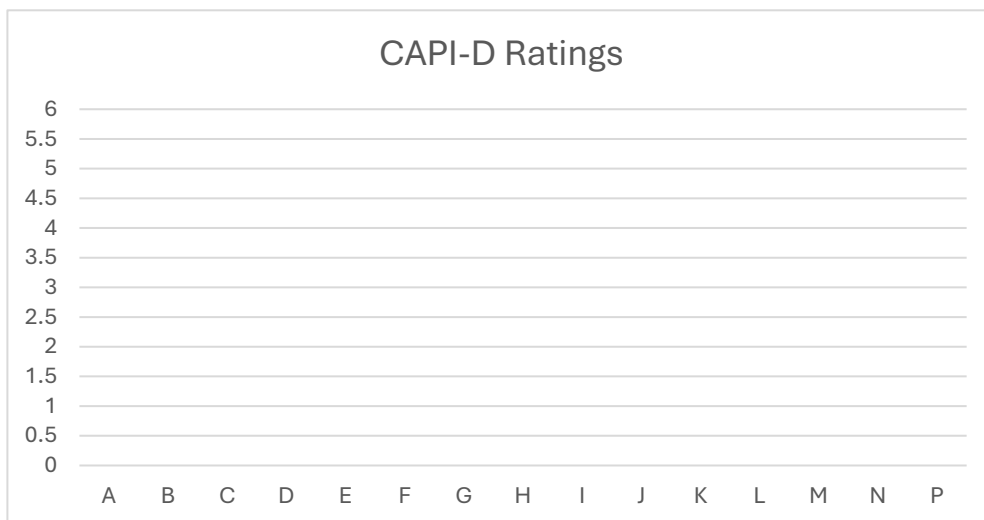
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Graph your ratings below:



Appendix K – Ethics Approval (Studies 1 and 2)



Research Integrity & Ethics Administration HUMAN RESEARCH ETHICS COMMITTEE

Wednesday, 16 March 2022

Prof David Hawes
Psychology; Faculty of Science
Email: david.hawes@sydney.edu.au

Dear David,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

I am pleased to inform you that after consideration of your response, your project has been approved.

Details of the approval are as follows:

Project No.: 2022/020
Project Title: Parenting Interventions for Child Externalising Problems: Core Therapist Competencies and Case Complexity
Authorised Personnel: Hawes David; Barker Jessica;
Approval Period: 16/03/2022 to 16/03/2026
First Annual Report Due: 16/03/2023

Documents Approved:

Date Uploaded	Version Number	Document Name
09/03/2022	Version 3	Participant Consent Form - Clean
09/03/2022	Version 3	Participant Survey - Clean
09/03/2022	Version 3	Participant Information Statement - Clean
11/02/2022	Version 2	Participant Recruitment Email - Clean

Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
 - Serious or unexpected adverse events (which should be reported within 72 hours).
 - Unforeseen events that might affect continued ethical acceptability of the project.
- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.

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- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.
- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,

Dr Jemma Todd
Deputy Chair
Psychology Review Committee (Low Risk)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) [National Statement on Ethical Conduct in Human Research \(2018\)](#) and the NHMRC's [Australian Code for the Responsible Conduct of Research \(2018\)](#)

Appendix L – Ethics Approval (Studies 3, 4 and 5)



Research Integrity & Ethics Administration
Human Research Ethics Committee

Wednesday, 15 November 2023

Prof David Hawes
Psychology; Faculty of Science
Email: david.hawes@sydney.edu.au

Dear David,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

After consideration of your response to the comments raised your project has been approved.

Approval is granted for a period of four years from **15/11/2023** to **15/11/2027**.

Project No.: 2023/687

Project Title: The Measure of Therapist Competencies in Parenting Interventions for Conduct Problems (MTCP-CP): Acceptability and Implementation of a Reflective Supervision Tool

Authorised Personnel: Hawes David; Barker Jessica;

First Annual Report due: 15/11/2024

Documents Approved:

Date Uploaded	Version Number	Document Name
08/11/2023	Version 3	PIS Phase 1 - clean version
08/11/2023	Version 3	PIS Phase 2 - clean version
08/11/2023	Version 3	Participant Consent Form Phase 1 - clean version
27/10/2023	Version 2	Participant Consent Form Phase 2 - clean version
27/10/2023	Version 2	Questionnaire Phase 2 Baseline Supervisee - clean version
27/10/2023	Version 2	Questionnaire Phase 2 Baseline Supervisor - clean version
27/10/2023	Version 2	Questionnaire Phase 2 End Supervisee - clean version
27/10/2023	Version 2	Questionnaire Phase 2 End Supervisor - clean version
27/10/2023	Version 2	Questionnaire Phase 1 - clean version
27/10/2023	Version 2	Participant Emails - clean version
30/08/2023		MTCP-CP
30/08/2023		Advertisement flyer
30/08/2023		MTCP example response
30/08/2023		Phase 2 - Supervision Program Group Instructions
30/08/2023		Phase 2 - Control Group Instructions
30/08/2023		Questionnaire - Phase 2 in-supervision

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Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
 - Serious or unexpected adverse events (which should be reported within 72 hours).
 - Unforeseen events that might affect continued ethical acceptability of the project.
- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.
- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.
- The Clinical Trials Support Office has been notified as outlined in the University's Clinical Trials Policy where a clinical trial is being undertaken.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,

Associate Professor Carolyn Maccann
Chair
Psychology Review Committee (Low Risk)

The University of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) current National Statement on Ethical Conduct in Human Research (2018) and the NHMRC's current Australian Code for the Responsible Conduct of Research (2018).



Research Integrity & Ethics Administration
HUMAN RESEARCH ETHICS COMMITTEE

Friday, 1 March 2024

Prof David Hawes
 Psychology; Faculty of Science
 Email: david.hawes@sydney.edu.au

Dear David,

Your request to modify this project, which was submitted on 25/01/2024, has been considered.

After consideration of your response to the comments raised, this project has been approved to proceed with the proposed amendments.

Protocol Number: 2023/687
Protocol Title: The Measure of Therapist Competencies in Parenting Interventions for Conduct Problems (MTCP-CP): Development, Acceptability and Implementation of a Reflective Supervision Tool

Addition of Authorised Persons: Jaimie Northam
Annual Report Due: 15/11/2024

Documents Approved:

Date Uploaded	Version Number	Document Name
23/02/2024	v2	PCF Phase A - clean version v2
23/02/2024	v2	PIS Phase A - clean version v2
25/01/2024	v1	Advertisement Flyer Phase A v1
25/01/2024	v3	Participant Emails v3 - clean version
25/01/2024	v4	PCF Phase 1 v4 - clean version
25/01/2024	v4	PCF Phase 2 v4 - clean version
25/01/2024	v4	PIS Phase 1 v4
25/01/2024	v4	PIS Phase 2 v4 - clean version
25/01/2024	v1	Questionnaire Phase A

Please contact the ethics office should you require further information.

Sincerely,

Dr Daniel Pearson
Chair
Psychology Review Committee (Low Risk)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) [National Statement on Ethical Conduct in Human Research \(2018\)](#) and the NHMRC's [Australian Code for the Responsible Conduct of Research \(2018\)](#)

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THE UNIVERSITY OF
SYDNEY

RESEARCH INTEGRITY
& ETHICS ADMINISTRATION

HUMAN RESEARCH ETHICS APPROVAL

The University of Sydney confirms that this project meets the requirements of the National Statement on Ethical Conduct in Human Research.

Project identifier:	2023/HE000687
Project title:	The Measure of Therapist Competencies in Parenting Interventions for Conduct Problems (MTCP-CP): Acceptability and Implementation of a Reflective Supervision Tool
Version:	1.01
Chief Investigator:	Professor David Hawes
Authorised project team:	Ms Jessica Barker Dr Jaimie Northam
Date of approval:	Friday, 26 July, 2024
Project end date:	14 Nov 2027

Project summary

The aim of the current project is to investigate the utility of a measure of core therapist competencies for social learning-based parenting interventions for child conduct problems in early-to-middle childhood. From our previous research using the gold-standard Delphi method, we have developed a measure of core therapist competencies for child conduct problems. The current study now seeks to investigate the acceptability amongst practitioners and influence of this core therapist competency measure, as a supervision tool on therapist self-efficacy and self-reflective capacity. The aim of this research is to enhance education and training in evidence-based interventions for conduct problems, and therefore long-term delivery of such interventions.

Summary of changes

1. Clarification of Phase 1 PIS that trainee practitioners will be asked to complete the measure about themselves (not about another supervisee). This is a clarification in wording only, not a change to the design.
2. Replacement of the open-ended questions in Phase 1 with more specific questions about usability and implementation of the MTCP-CP, including additions to the MTCP-CP experience survey. Clarifying revisions to the wording of the MTCP-CP questions are also proposed.
3. Revisions to the Phase 2 supervision questionnaire to decrease the number of questions.
4. Adjustment from weekly to fortnightly participation tasks in Phase 2 (supervision program) and additional of a time point. Phase 2 is hence expected to take 14 weeks.
5. Adjustments to the wording of the Phase 2 baseline and end questionnaires as outlined below.

Documents approved

Document type	File name	Document version	Application version
Recruitment or advertising material	Competency Measure study_advertisement flyer v2_clean.docx	1	1.01



Participant Information Statement (PIS)	Competency Measure Study_PIS Phase 1 v5 supervisee_clean.docx	1	1.01
Participant Information Statement (PIS)	Competency Measure Study_PIS Phase 1 v5 supervisor_clean.docx	1	1.01
Participant Information Statement (PIS)	Competency Measure Study_PIS v5 Phase 2_clean.docx	1	1.01
Survey or questionnaire	Competency measure study_Phase 2 supervision session questionnaire v2_clean.docx	1	1.01
Survey or questionnaire	Competency measure study_Phase 1 questionnaire v3_clean.docx	1	1.01
Survey or questionnaire	Competency measure study_Phase 2 baseline questionnaire SUPERVISEE v3_clean.docx	1	1.01
Survey or questionnaire	Competency measure study_Phase 2 baseline questionnaire SUPERVISOR v3_clean.docx	1	1.01
Survey or questionnaire	Competency measure study_Phase 2 end questionnaire SUPERVISEE v3_clean.docx	1	1.01
Survey or questionnaire	Competency measure study_Phase 2 end questionnaire SUPERVISOR v3_clean.docx	1	1.01

Conditions of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted on or before the anniversary of approval and a final report on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
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Ethics Committee Representative

Chair

On behalf of the University of Sydney

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THE UNIVERSITY OF
SYDNEY

RESEARCH INTEGRITY
& ETHICS ADMINISTRATION

HUMAN RESEARCH ETHICS APPROVAL

The University of Sydney confirms that this project meets the requirements of the National Statement on Ethical Conduct in Human Research.

Project identifier:	2023/HE000687
Project title:	The Measure of Therapist Competencies in Parenting Interventions for Conduct Problems (MTCP-CP): Acceptability and Implementation of a Reflective Supervision Tool
Application version:	2.02
Chief Investigator:	Professor David Hawes
Project team:	Ms Jessica Barker Dr Jaimie Northam
Project start date:	14 Nov 2023
Project end date:	14 Nov 2027
Date of issue:	Friday, 8 November, 2024

Project summary

The aim of the current project is to investigate the utility of a measure of core therapist competencies for social learning-based parenting interventions for child conduct problems in early-to-middle childhood. From our previous research using the gold-standard Delphi method, we have developed a measure of core therapist competencies for child conduct problems. The current study now seeks to investigate the acceptability amongst practitioners and influence of this core therapist competency measure, as a supervision tool on therapist self-efficacy and self-reflective capacity. The aim of this research is to enhance education and training in evidence-based interventions for conduct problems, and therefore long-term delivery of such interventions.

Summary of amendments

We are applying to make the following changes to the study:

1. Introduction of validation process to Phase 1 – the Therapist Self-efficacy Scale, which is already in Phase 2 of the study, is being added to Phase 1 of the study so that the validity of the measure can be tested.
2. Revision of experience questions - the Phase 1 questionnaire is also being revised to include further questions about participants' experience completing the MTCP-CP.
3. Increase in the number of participants for Phase 1, such that participant numbers are no longer capped.
4. Revision of the study flyer for Phase 1.

Documents approved

Document type	File name	Document version	Application version
Recruitment or advertising material	Competency Measure study_advertisement flyer v3_clean.docx		2.01
Participant Consent Form (PCF)	Competency Measure study_PCF Phase 1 v5_clean.docx	4	2.01



Document type	File name	Document version	Application version
Survey or questionnaire	Competency measure study_Phase 1 questionnaire v4_clean.docx	4	2.01
Survey or questionnaire	Competency measure study_Phase 2 baseline questionnaire SUPERVISEE v3_clean.docx	3	1.01
Survey or questionnaire	Competency measure study_Phase 2 baseline questionnaire SUPERVISOR v3_clean.docx	3	1.01
Survey or questionnaire	Competency measure study_Phase 2 end questionnaire SUPERVISEE v3_clean.docx	3	1.01
Survey or questionnaire	Competency measure study_Phase 2 end questionnaire SUPERVISOR v3_clean.docx	3	1.01
Survey or questionnaire	Competency measure study_Phase 2 supervision session questionnaire v2_clean.docx	2	1.01
Participant Information Statement (PIS)	Competency Measure Study_PIS Phase 1 v5 supervisee_clean.docx	5	1.01
Participant Information Statement (PIS)	Competency Measure Study_PIS Phase 1 v5 supervisor_clean.docx	5	1.01
Participant Information Statement (PIS)	Competency Measure Study_PIS v5 Phase 2_clean.docx	5	1.01

Conditions of Approval

- Research must be conducted according to the approved proposal.
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Human Ethics Approval certificate

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HUMAN RESEARCH ETHICS APPROVAL

The University of Sydney confirms that this project meets the requirements of the National Statement on Ethical Conduct in Human Research.

Project identifier:	2023/HE000687
Project title:	The Measure of Therapist Competencies in Parenting Interventions for Conduct Problems (MTCP-CP): Acceptability and Implementation of a Reflective Supervision Tool
Application version:	3.02
Chief Investigator:	Professor David Hawes
Project team:	Ms Jessica Barker Dr Jaimie Northam
Project start date:	14 Nov 2023
Project end date:	14 Nov 2027
Date of issue:	Friday, 28 February, 2025

Project summary

The aim of the current project is to investigate the utility of a measure of core therapist competencies for social learning-based parenting interventions for child conduct problems in early-to-middle childhood. From our previous research using the gold-standard Delphi method, we have developed a measure of core therapist competencies for child conduct problems. The current study now seeks to investigate the acceptability amongst practitioners and influence of this core therapist competency measure, as a supervision tool on therapist self-efficacy and self-reflective capacity. The aim of this research is to enhance education and training in evidence-based interventions for conduct problems, and therefore long-term delivery of such interventions.

Summary of amendments

The below proposed changes affect Phase 2 of the study, which involves a pilot of the Measure of Therapist Competencies in Parenting Interventions for Conduct Problems (MTCP-CP).

1. Phase 2 smaller sample size, hence use of a case series approach with matched controls
2. Addition of a 2-5-minute questionnaire each fortnight for all supervisee participants
3. Update of experience questions as per Phase 1
4. Finalisation of Phase 2 questionnaires

Documents approved

Document type	File name	Document version	Application version
Recruitment or advertising material	Competency Measure study_advertisement flyer v3_clean.docx	3	2.01
Participant Consent Form (PCF)	Competency Measure study_PCF Phase 1 v5_clean.docx	5	2.01



Participant Information Statement (PIS)	Competency Measure Study_PIS Phase 1 v5 supervisee_clean.docx	5	1.01
Participant Information Statement (PIS)	Competency Measure Study_PIS Phase 1 v5 supervisor_clean.docx	5	1.01
Participant Information Statement (PIS)	Competency Measure Study_PIS v6 Phase 2_clean.docx	6	3.02
Survey or questionnaire	Competency measure study_Phase 2 supervision session questionnaire v2_clean.docx	2	1.01
Survey or questionnaire	Competency measure study_Phase 1 questionnaire v4_clean.docx	4	3.02
Survey or questionnaire	Competency measure study_Phase 2 baseline questionnaire SUPERVISEE v4_clean.docx	4	3.01
Survey or questionnaire	Competency measure study_Phase 2 baseline questionnaire SUPERVISOR v4_clean.docx	4	3.01
Survey or questionnaire	Competency measure study_Phase 2 end questionnaire SUPERVISEE v4_clean.docx	4	3.01
Survey or questionnaire	Competency measure study_Phase 2 end questionnaire SUPERVISOR v4_clean.docx	4	3.01
Survey or questionnaire	Competency measure study_Phase 2 reflective capacity Q SUPERVISEE v1.docx	1	3.01

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