

Nelson, T. D., & Steele, R. G. (2007). Predictors of practitioner self-reported use of evidence-based practices: Practitioner training, clinical setting, and attitudes toward research. (2007). *Administration and Policy in Mental Health & Mental Health Research Services*, 34: 319-330.

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While focusing on one study in particular, this Data Trends incorporates several research projects which address the challenge of moving evidence-based practice (EBP) research to the clinical setting. The primary article reports on the results of a survey of 215 mental health practitioners and their attitudes toward EBPs. Results suggest that “the relationship between clinical setting and EBP use was partially mediated by attitudes toward treatment research” (Nelson & Steele, p. 319). Respondent’s level of education and number of years in clinical practice were not related to their use of EBPs.

Although the number of evidence-based practices (EBPs) is increasing (Proctor, Knudsen, Fedoravicius, Hovmand, Rosen et al., 2007), moving EBPs from research to practice is a challenging endeavor. A qualitative study conducted by Proctor and colleagues (2007) indicated that limited access to research, provider resistance, and training costs impede this movement. Further, there is confusion over the meaning of EBPs among agency directors—conceptions of the meaning of “evidence-based practice” run from “practices that work” to “interventions or treatments that pass a particular threshold of evidence” (Rosen et al., 2007). In an attempt to address both research and clinical setting concerns about EBPs, Aarons and Palinkas (2007) suggest that the Institute of Medicine’s definition of EBPs might be helpful; that definition “includes a balance of the best research evidence, clinical expertise, and consumer choice and preference” (p. 416).

Nelson and Steele (2007) conducted a national, on-line survey of 215 mental health practitioners from 15 states on their use of EBPs in their practice. Respondents were MA- or PhD-level practitioners who spent at least 25% of their time delivering treatment services. Over one-quarter were in private practice (27%); 23% worked in hospitals, 19% in community mental health centers; 11% in schools<sup>1</sup>; 8% at university clinics, and 12% in other locations. Most practitioners delivered cognitive or behavioral cognitive therapy (60%), and others practiced psychodynamic (10%), behavioral (10%), family systems (8%), humanistic (4%) and other (9%) forms of treatment. On average, respondents had 10.6 years of clinical experience (SD = 9.4). Through a multi-tiered recruitment process, 1,260 potential respondents were identified; of these, 215 met criteria for inclusion in the study or completed the online survey. To minimize the risk of self-selection, participants were not told that the study focused on EBPs “or any related term” (p. 322).

The survey contained 97 items (some of which were used for another study), and took approximately 15-20 minutes to complete. For the current study, three questions were uppermost. First, “How often do you use EBPs in your work?” This question was presented with a four point likert scale, with 1 = almost/never, and 4 = almost/always. Mean responses were 2.62 (SD = .86). The second question asked whether the respondents had ever taken a class in “evidence-based treatments,” “empirically supported treatments,” or “any comparable version of these?” (p. 323). Respondents were not provided a definition of EBPs. Almost half (49%) answered affirmatively. The third question asked respondents to rate their “primary clinical setting on its openness to using EBPs in treatment,” (p. 323), where a rating of 1 = not at all, and 5 = extremely open. Responses indicated a mean of 4.44 (SD = .84).

Respondents who practiced behavioral or cognitive behavioral therapy reported the highest use of EBPs; those who worked at hospitals and university clinics also reported high levels of EBPs use. A series of analyses indicated that practitioners were most likely to use EBPs if they had positive attitudes about research conducted on EBPs; most of the research they were exposed to had been published within the last 10 years. These respondents believed that clinical practice

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should be based upon research. They also believed that researchers generally understood the clinical needs of practitioners and that research addresses questions relevant to their practice. Overall, respondent's level of education and number of years in clinical practice were not related to their use of EBPs.

Nelson and Steele (2007) also found that some respondent's reluctance to base their practices on research-identified EBPs was not due to the absence of positive attitudes toward research but to "strong negative sentiments toward research itself" (p. 326). These practitioners believed that their clinical judgement was more important than research-based theories about what works. They also expressed the opinion that research is too simplistic and does not address questions that are important to them. Further, they reported that it took too much time to keep up with current research.

Clearly, more work needs to be done on EBPs and practitioner attitudes toward them in order to move the best research based practices into the field of children's mental health. Aarons, McDonald, Sheehan, and Walrath-Greene (2007) are currently testing the Evidence-Based Practice Attitude Scale (EBPAS) in order to further study provider attitudes toward the use of EBPs and the organizational change that such use may imply. Aarons (2004) found that the EBPAS "demonstrated good internal consistency reliability" (p. 70), and Aarons and colleagues (Aarons, McDonald, et al. 2007) report on a study of the factor structure of the EBPAS. In brief, the EBPAS assesses four types of attitudes toward the use of EBPs among practitioners: (a) the appeal of EBPs, (b) the possibility that a practitioner will adopt an EBP if required to do so, (c) willingness to try new practices, and (d) the gap between research-based/academically developed interventions and current practice (Aarons, McDonald, et al., 2007).

In conclusion, moving research to practice is a challenging task, partially because of the lack of a standard, working definition of EBPs, and partially because of practitioner hostility toward the adoption of EBPs over practices that are already in use. However, Nelson and Steele found that over 50% of their respondents used an EBP, and that having positive attitudes about research in general guided the acceptance of EBP use by practitioners. It is hoped that Aaron and colleagues will shed new light on the use of EBPs with the EBPAS.

#### Note:

<sup>1</sup> The authors do not indicate whether all respondents worked with children.

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