Data Trends

Summaries of research on mental health services for children and adolescents and their families

November, 2007
No. 149

Sheehan, A. K., Walrath, C. M., & Holden, E. W. (2007). Evidence-based practice use, training and implementation in the community-based service setting: A survey of children's mental health service providers. *Journal of Child and Family Studies, 16*, 169-182.

keywords: Evidence-Based Treatment Survey, evidence-based practices, promising practices, training, workforce, implementation

This article adds to the research base for bridging the gap between service need and service capacity. The authors surveyed community-based providers of mental health services about their use of evidence-based practices (EBPs). Respondents (N = 446) practiced cognitive behavioral therapy most often (68%), followed by wraparound (18%); anger management (14.6%); family education and support (14.3%); social skills training (13.1%); and case management (11.8%). The rate of full implementation of the six programs was low, ranging from 35.4% for CBT, to 68% for wraparound.

The study was part of the national evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program. The authors distributed the 65-item Evidence-Based Treatment Survey (Walrath, Sheehan, Holden, Hernandez, & Blau, 2006) to direct service providers whose names were supplied by 26 systems of care sites and two comparison sites associated with the national evaluation. Only those respondents who indicated that they used at least one existing EBP or a promising practice (e.g. wraparound, case management, family education and support) were included in the study. An EBP was defined as "A treatment that has been developed through research protocol, is supported by results of controlled treatment studies, and has guidelines and procedures for its implementation" (p. 173). The survey prompted respondents to report on up to three EBPs (other than medication) that they used in their work. For each EBP reported, a series of questions regarding initial training, frequency of follow-up trainings, years since initial training, and implementation protocols followed.

Most respondents were female (68%), White (85%)[1], and were an average age of 42.2 (SD = 10.8) years. Many had a masters or a doctorate degree (89%), and over half were employed by a mental health agency (57%). Seventy-seven percent were licensed mental health providers and 51% held positions as clinicians or therapists. On average, respondents had worked 6.1 (SD = 5.9) years at their current system of care; 9.2 years (SD = 7.4) with children having SED; and 11.2 years (SD = 8.4) as mental health service providers. Demographics of the comparison sites were similar.

As shown in Table 1, the six most often reported practices were Cognitive Behavioral Therapy (CBT), Wraparound (Wrap), Anger Management (AM), Social Skills Training (SST), Family Education and Support (FES), and Case Management (CM). Thirty-six percent of those who practiced CBT were required to do so by their employer. Most respondents (68.8%) received their initial training in CBT as graduate students; annual follow up training for CBT was reported 47.2% of the time, but only 35.4% reported that they "always or most always" implemented the full CBT treatment protocol. Graduate training in wraparound was noticeably low in comparison to CBT; only 6.8% of respondents received wraparound training in graduate school. However, wraparound had the highest reported required use of an EBT (54.7%), and the highest rate of full implementation (68.0%). With the exception of CBT, over half of all program respondents reported full implementation of their program at least 50% of the time.

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Table 1 Required Use of Evidence-Based Practices, Training Activities, and Implementation Protocol*

	Type of Evidence Based Practice or Promising Practice					
	CBT n 256	Wrap n 75	AM n 64	SST n 56	FES n 60	CM n 54
Agency required use of EBT	36.2%	54.7%	34.9%	35.1%	41.0%	41.5%
Source of Initial Training						
Graduate School	68.8%	6.8%	25.0%	25.0%	24.1%	18.0%
Conf/Wkshp/Cont. Ed.	12.9%	23.0%	28.3%	32.1%	24.1%	10.1%
Agency sponsored or inservice	4.7%	54.1%	25.0%	25.0%	18.5%	40.0%
Other or no initial training	13.7%	16.2%	21.7%	17.9%	33.3%	32.0%
Follow up Frequency of Training and Implementation Protocol						
Annually	47.2%	43.8%	41.4%	36.5%	39.1%	38.1%
At least monthly	23.6%	37.5%	19.0%	32.7%	30.4%	45.2%
Never/less than monthly	29.2%	18.8%	39.7%	30.8%	30.4%	16.7%
Mean Years since initial training (*SD*)	10.7 (7.0)	6.2 (5.6)	9.5 (6.2)	9.6 (6.2)	12.7 (8.5)	9.4 (7.2)
Full Implementation of Protocol	35.4%	68.0%	54.1%	50.8%	50.0%	58.8%

* Excerpted from the author's table: "Demographic, workforce, and training and treatment implementation factors of providers of the six highest reported evidence based practices," p. 176.

According to the authors, the most notable finding concerned the low rates of implementation across practices, suggesting the absence of fidelity and a lack of training to increase fidelity among practitioners. As shown in Table 1, AM, SST, and FES training histories varied; in comparison to practitioners of CBT, wraparound and case management, these practitioners may come from a wide variety of backgrounds and may be in need of additional training. Training results cannot be generalized, however, since training may have been supported by federal funds available through the demonstration project. Further, the relatively low rates of programs requiring the use of EBPs is also a concern, and calls for agency policy or mandates to incorporate these practices into their service array. Interestingly, Multi-systemic Therapy and Brief Strategic Family Therapy, having the strongest evidence base of all practices according to the authors, were identified by less than 10% of respondents.

Practitioners who provide mental health services to these children come from various backgrounds and work in a variety of service fields. Due to this variety of practitioner background and an "extremely complex client base" (p. 170), the task of transferring EBPs to the clinical setting and then implementing them with fidelity is a monumental challenge. Barriers to overcoming this challenge include administrative bureaucracy, availability of funds for training and implementation, professional development, and workforce shortage.

[1] *Due to the small number of respondents who self-identified as either Hispanic/Latino, American Indian, Asian, Black or African American, Native Hawaiian or Other, race was dichotomized into White v. non-White.*

Reference

Walrath, C. M., Sheehan, A. K., Holden, E. W., Hernandez, M., & Blau, G. M. (2006). Evidence-based treatments in the field: A brief report on provider knowledge, implementation, and practice. *The Journal of Behavioral Health Services & Research, 33*(2), 244-253.

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