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Mental Health Professional Perceptions of Barriers to Fidelity for Empirically- Supported Treatments

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Walden University
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Abstract

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MSW, Wayne State University, 2004

BSW, University of Toledo, 2003

Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

It is estimated that one in five adults in the United State of America experience mental illness in a given year. When mental health organizations implement empirically-supported treatments but fail to maintain them, it can result in individuals not being provided the services that they need. The purpose of this study was to identify perceived barriers to maintaining fidelity for empirically-supported mental health treatments. The study utilized a quantitative cross-sectional correlational research design (N = 154) and the Perception of Barriers Scale (PBS) was developed to measure perceived barriers to maintaining fidelity for empirically-supported treatments. Bandura's social cognitive theory as it related to the likelihood of engaging in new professional behaviors was used as the theoretical framework of the study. The PBS was found statistically reliable (Cronbach's alpha = 0.80) and factor analysis was used to determine instrument scales. Multiple linear regression analyses identified a statistically significant relationship between age and perception of barriers among professionals (p = 0.02) but no other independent variables (race, gender, geographic area, years in field, highest degree held, discipline, role in organization) were statistically related to the dependent variable at significant levels. The results of this study could be used to inform future inquiries by enhancing the field's understanding of fidelity maintenance. Positive social change may include improved treatment outcomes for people in need of behavioral health services and more available services due to better use of resources by mental health agencies.

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Dedication

In dedication to the memory of my father, William Streidl. The best man I have ever known. For all of his sacrifices to ensure that I had every opportunity to succeed.

Acknowledgments

I would like to acknowledge my committee members for putting up with how long it took me to finish. And specifically, to Dr. Jorissen, for the many (many) times she has read this to achieve this quality, I am forever in your debt.

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Chapter 1: Introduction to the Study

Introduction

Empirically-supported treatment programs are tailored to resonate with the needs and special conditions of the specific client as established through scientific analysis (Patterson Silver Wolf, Maguin, Ramsey, & Stringfellow, 2014). Therefore, an expectation of academia and practitioners in the mental health field is that clients who are placed under these programs eventually enjoy the best outcomes (Norcross, 2002). Funding for healthcare remains a major issue preventing the distribution and availability of these research-supported mental health services (Chorpita et al., 2002). The mental health needs of the general population continue growing amidst the shrinking supply of mental healthcare services (Hunt & Eisenberg, 2010). Purchasing empirically-supported treatments, training the workforce and making the necessary administrative accommodations is associated with costs that often deter stakeholders from using of empirically-supported treatments, because resources are limited (Proctor et al., 2009). There are instances where service providers have the intention to use empirically-supported treatments, but the capacity of these providers may not always meet the demands of the programs (Archer-Kuhn, Bouchard, & Greco, 2014). The expanding demand for mental health services and the diminishing capacity of the system to meet this demand may result in reduced mental health outcomes for both practitioners and their clients (Hunt & Eisenberg, 2010).

Lack of fidelity to treatment programs is a common problem in mental healthcare (McHugh et al., 2009). It is often referred to as a type III error in research but is also

evident in practice (Kirk & Kutchins, 1988). A type III error (lack of fidelity) correct diagnosis is made, but a wrong treatment procedure is applied because the procedures are not advanced enough to be effectively used, or the practitioner has incomplete knowledge of how to appropriately apply the treatment. Practitioners have a responsibility of ensuring that treatment programs are implemented according to established standards demonstrated in the research (McHugo et al., 2007).

Much of the recent literature has primarily focused on the implementation and sustainability of empirically-supported treatment programs. There is a need within the field for mental health practitioners to draw their attention toward empirically-supported treatment programs in order to ensure that clients receive the treatment they need in order to increase the possibility of positive outcomes and decrease the possibility of doing unintentional harm. Pressure to implement and sustain empirically-supported treatment programs has been on mental health practitioners through legislation, financing, and accreditation (Bernal & Scharró-del-Río, 2001). However, the stakeholders in legislative, financial, and accrediting bodies too often ignore the need for fidelity to the empirically-supported treatments they are demanding the use of (Herschell et al., 2004). This study examined the issue of maintaining fidelity for empirically-supported treatment programs, especially from the perspective of mental health practitioners. The project focused on barriers to sustained fidelity for empirically-supported treatment programs as reported by mental health practitioners who deal directly with clients.

This chapter will briefly describe the background of the study, as well as related research. The problem statement and purpose of the study will be described. The research

question and theoretical framework from which the research question was developed will be explained. Finally, the methodology, limitations, and significance of the study will be defined within this chapter.

Background

Empirically-supported treatments are those mental health programs with interventions that have been proven to be effective through rigorous research (Kazdin, 2008). Empirically-supported treatment of mental health issues is a relatively new concept. Health service providers, practitioners, financiers, families, and communities have yet to fully embrace these new methods of treatment. As a result, empirically-supported treatments and the importance of fidelity may be poorly understood, and important aspects of the treatment programs are disregarded (Murray, Culver, Farmer, Jackson, & Rixon, 2014). Practitioners may not follow treatment procedures as they were created, and this can result in treatments not being administered as intended by the developer. The frequency, quantity, and number of strategies that the practitioner decides to use, if not following recommended treatment guidelines, may often be motivated by factors such as saving resources such as time and costs or because the practitioner does not fully understand the ramifications of not following the recommended treatment protocol exactly (Teague et al., 1998). The degree of nonconformity to prescribed strategies is often compromised, resulting in the delivery of poor-quality services (O'Donoghue & Tsui, 2012).

Reduced fidelity in empirically-supported treatment programs may also reduce the level of commitment and effort of participants. Many empirically-supported treatment

programs are launched by mental health centers but later abandoned due to lack of support and follow-through from clients, their families, and communities (Novella, 2010; O'Donoghue, 2015). The withdrawal of participant support of empirically-supported treatments may be due to perceived impracticality or other factors such as lack of resources and time (Pelham, Jr. et al., 1998). Empirically-supported treatment programs may be viewed as nonviable investments and wastes of time. It would benefit the field to ensure that practitioners and agency leadership understand that the higher level of investment required in empirically-supported treatment programs, including increased demands for time, funding, and training, results in better mental health outcomes. The purpose of this study is to determine professional perceptions of barriers to fidelity in terms of empirically-supported treatments in mental health. Developing a better understanding of these barriers may provide an opportunity to sustain empirically-supported treatment programs and improve the management of resources in behavioral health.

Problem Statement

Insufficient access to services is a long-standing issue within the mental health field and has increased since the turn of the century (Roll, Kennedy, Tran, & Howell, 2012). As funding for mental health services continues to scarcely be able to meet the needs of the population of the United States, it is critical that resources not be wasted (Saxena, Thornicroft, Knapp, & Whiteford, 2007). Costs associated with purchasing empirically-supported treatments, training the workforce, and making necessary administrative accommodations are often high, and are frequently cited as a deterrent to

their use (Bond et al., 2014). Failure to sustain an implemented empirically-supported treatment diverts limited resources away from treatment, and failure to maintain fidelity of ongoing programs does not allow clinical outcomes to be maximized (Archer-Kuhn et al., 2014; Murray et al., 2014; Raffel, Lee, Dougherty, & Green, 2013). This can negatively impact clients who receive services in two ways. Resources that may have been able to be used to enhance care are no longer available, as they were used for implementation of an empirically-supported treatment that was unable to be sustained. Additionally, the behavioral health service no longer offers the empirically-supported treatment which was likely to provide the best outcome for the client. Therefore, the problem is poorer than expected clinical mental health outcomes due to a lack of understanding within the field of the barriers involving maintaining fidelity as identified by mental health professionals in the field.

While researchers have studied the implementation and sustainability of empirically-supported treatments, little is known about the current understanding of barriers to sustained treatment fidelity among practitioners in the field. Pressure to implement and use empirically-supported treatments has continued to increase on practitioners from funding, legislative, and accrediting bodies (Bond et al., 2014; McHugh & Barlow, 2010; Oancea, 2010; Stevens, Liabo, Witherspoon, & Roberts, 2009). Although the mental health field has moved toward implementation of programs with demonstrated empirical value, little research has been done on whether these are being maintained with fidelity to the model, and programs are vulnerable to failure.

Purpose of the Study

The purpose of this cross-sectional quantitative correlational study is to determine how licensed mental health practitioners perceive barriers to sustaining fidelity for empirically-supported treatments. Participants were mental health practitioners, at least 18 years of age, who provide direct services to clients, or families in the United States. Mental health practitioners are uniquely positioned to provide information about barriers experienced when providing empirically-supported treatments. The study attempted to describe the relationship between demographic variables of age, race, gender, geographic location, length of time in the field, degree held, held, length of time since attaining most recent degree, current role in the field and the perceived barriers to sustaining fidelity for empirically-supported treatments.

Research Question and Hypotheses

RQ: Are there statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically supported-treatments in mental health as measured by the Perception of Barriers Scale (PBS)?

H_0: There are no statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically- supported treatments in mental health as measured by the PBS.

H_a: There are statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically-supported treatments in mental health as measured by the PBS.

Theoretical Framework

This study involved the social learning theory. There are four requirements for learning to occur: observation, retention, reproduction, and motivation (Bandura, 1977). Bandura (1977) said that behavior is reinforced through trial and error with some aspects of modeling and imitation. Human beings have choices to either reinforce specific behaviors or avoid them (Bandura, 2014). An aversive stimulus may result in newly unwanted behavior. The behavior becomes unwanted as the individual carries out analysis and determines that there is a greater negative than positive impact (Cherry, 2011). Aversive stimuli can also be extended to behaviors that are disapproved by peers and mentors. Therefore, there are many times when people get involved in certain behaviors, not necessarily due to direct benefits on their lives, but because of the approval that the specific behaviors enjoy from the rest or specific section of society.

The social learning theory explains how factors within respective environments that practitioners function within can influence learning of perceived barriers involving empirically-supported treatments. Practitioners may alter, ignore, or incorrectly implement empirically-supported treatment programs because of opinions and observed actions of fellow practitioners, hospital managers, and clients. Bandura (2011) noted that

observation is a key aspect of learning. People are more likely to participate in certain activities because they observed other people taking part in them. This also means that incorrect modeling of empirically-supported treatments could result in other practitioners and clients not following prescribed processes and procedures, resulting in less positive outcomes than would be expected. Lack of repercussions for incorrect behaviors encourages individuals into repeating these incorrect behaviors, and this type of cycle can perpetuate incorrect implementation of treatments and eventual abandonment of potentially successful treatment practices due to less successful outcomes resulting from incorrectly implemented treatments (Akers, 2017; Vax, Schreuer & Sachs, 2012). A more detailed explanation of the theory appears in Chapter 2.

Nature of the Study

This was a cross-sectional online correlational study using primary data collected from respondents who are active practitioners in mental health across the United States. The study relied on quantitative data collected through questionnaires. I conducted a survey of mental health practitioners across the U. S. in order to determine relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically-supported treatments in mental health as measured by the PBS. Primary data were collected from mental health practitioners using online questionnaires through the Walden University participant pool as well as recruitment through social media groups on Facebook.

The independent variables in this study were age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field. The dependent variable in this study was perceptions of practitioners toward barriers to sustaining empirically-supported treatments. Additional information about the reasoning behind the inclusion of variables in the study can be found in Chapter 2, and additional information about variables and coding can be found in Chapter 3. Multiple linear regression was used to determine the relationship between the independent variables and the dependent variable. Linear regression is statistical modeling approach that compares variables to determine whether a relationship exists between them (Seber & Lee, 2012). The approach also determines the strength of the relationship.

Definitions

The following definitions were important to the study:

Empirically-supported treatment: Mental health interventions that, through controlled clinical research, have led to statistical clinical changes (Kazdin, 2008).

Evidence-based practice: A decision-making model to guide professional practice requiring the integration of research evidence with clinical expertise and client values (Straus et al., 2005).

Fidelity: Fidelity to a procedure or program is defined as the ability to ensure that it is completed or implemented according to protocols of proponents or designers (Lee et al., 2008).

Mental Health Practitioners: Licensed or certified professionals providing mental health services to individuals with a diagnosed mental illness (Vogel, Wade, Wester, Larson, & Hackler, 2007).

Stakeholders: Persons with an interest in mental health care such as community members, funders of services, legislators, administrative staff, and those with mental illnesses and their families (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009).

Assumptions

Two key assumptions were made by me in this study. The first was that practitioners completing the survey would know what empirically-supported treatments are and have some familiarity with the concept. This assumption is reasonable as empirically-supported treatments have increased in importance and have been more frequently required over the past 20 years. Another assumption in this study is that respondents answered honestly. As the survey did not require any identifying information, it is reasonable to assume that respondents provided honest responses to the best of their ability.

Scope and Delimitations

The study involved convenience and snowball sampling methods to recruit practitioners of mental health services. This study was limited to the perspectives of mental health practitioners. While there would have been benefits in gathering information regarding the perspectives of all stakeholders, including funders, administrators, community members, administrators, and people suffering with mental illnesses, it was not feasible in terms of time and funding available to me. Mental health

practitioners were chosen because they have a vital role in the provision of empirically-supported treatment and thus were the most logical choice for an initial inquiry. The study was also delimited to mental health practitioners in the United States. This allowed respondents to be guided by similar codes of ethics and accrediting bodies for their formal education.

The study was guided by the social cognitive theory. The social cognitive theory was selected because the concept of self-efficacy is well-suited to explain the adoption and maintenance of behaviors associated with empirically-supported treatments. Rational choice theory was also considered as it is also closely related to how people and therefore mental health practitioners choose to behave and thus would have been applicable to the adoption of new professional ideas and behaviors. However, it was limited by not addressing the pressures on mental health practitioners to use the authoritative passing of information behavioral health organizations operated under prior to the adoption of evidence-based practice (Gambrill, 1999).

As the study involved nonprobability purposive convenience and snowball sampling, it is unlikely the findings of this study are generalizable to the entire population of mental health practitioners in the United States. Additionally, the sampling frame included members of Facebook groups and the Walden University participant pool, and it is possible those potential respondents would not be generalizable to the general population even with a probability sample within that frame. However, the results may still have value to the field in terms of directing future inquiries.

Limitations

This study involved a close-ended questionnaire where each participant was expected to choose points on the Likert scale through various prompts to show their perspectives towards certain barriers to empirically-supported treatment programs. Close-ended questionnaires limit the discretion of participants (Frankfort-Nachmias & Nachmias, 2008). An alternative to this study method would have been to have open-ended questionnaires where the participant can introduce other challenges according to their experiences in care. The problems identified in the literature may not reflect the issues faced among the mental health practitioners sampled. Open-ended questionnaires pose a challenge when it comes to coding and analysis of the data in quantitative form.

Researcher bias is a potential limit in any study (Frankfort-Nachmias & Nachmias, 2008). I attempted to minimize the impact of bias on this study through the involvement of a committee in the review of the study. Response bias was another potential limit to the study, as it is a convenience sample and participation is entirely voluntary. There may be unmeasured differences in responses and perceptions between those who choose to respond to the survey and those who do not.

Significance

This study described potential relationships between perceived barriers and traits of mental health practitioners. Results provided by the study may include information that can be used to better direct future research inquiries and educational efforts to targeted populations that are identified as needing further educational efforts. Future research may be able to build upon these findings to develop solutions to better sustain

empirically-supported treatment programs in community mental health centers. Additionally, the findings of the study may provide information that can be used to inform governing boards regarding the perceptions of managers and administrators, as well as direct service providers. The information gained through this survey may be beneficial in allowing administrators to address potential barriers identified by mental health practitioners, as well as challenging misconceptions as part of implementation and ongoing sustainability efforts. While it is unlikely a single study will result in a dramatic change, it may provide important information that leads to the elimination of identified barriers. Eliminating perceived barriers may allow programs to maintain fidelity and therefore continue to achieve expected treatment outcomes resulting in better care for service recipients and continued availability of empirically-supported treatments.

Summary

This study may provide the mental health field with valuable information that can be used to improve treatment of those with mental health disorders, as well as limit waste of precious resources available to mental health agencies and practitioners. The quantitative correlational cross-sectional design provided a point-in-time view of how mental health practitioners view barriers to providing treatment, and how those perceptions are related to their education and professional experiences as well as other demographic factors. While there are limitations to this design, it was the most appropriate choice in terms of the resources that were available to the research, and the design is well-fitted to answer the research question.

This study was guided by the social cognitive theory, which involves explaining human behavior, specifically how behaviors are chosen to be repeated or discontinued by a person. The agentic process described by the theory is critical to the understanding of professional behaviors, and thus the adoption or discontinuation of empirically-supported treatment programs among mental health practitioners. This concept will be explored in greater detail in Chapter 2.

Chapter 2: Literature Review

Introduction

The mental health system has yet to fully embrace the concept of empirically-supported treatment programs (Beidas et al., 2012). As a result, the protocol established by the designers of these programs is hardly followed. Mental health practitioners are usually at the center of these programs, and fidelity to established procedures relies on them (Murray et al., 2014). The purpose of this study is to explore barriers to empirically-supported treatments from the perspective of mental health practitioners.

Empirically-supported treatment has grown in importance since the year 1998. Key stakeholders in the healthcare sector, including legislators, financiers, and accrediting bodies, seem to have realized the enhanced efficacy of this form of treatment. However, there have been few efforts to ensure that the right people use the right protocols and processes. Access to empirically-supported treatment has been reduced despite the insistence on the use of these methods. Many community mental health programs experience shortcomings that affect the sustainability of empirically-supported treatment programs. To understand barriers to empirically-supported treatment, this researcher reviewed research associated with the development of mental health treatments, evidence-based practice, empirically- supported treatment, and issues arising from implementation.

This chapter covers the literature search strategy employed for the study. A good literature search strategy helps the researcher filter available publications and identify what is most appropriate for their research. The chapter also involves analysis of the

theoretical framework which guides the study. The purpose of a theoretical framework is to help readers understand how the research challenges and extends existing knowledge. The chapter then covers concepts related to empirically- supported treatments that are relevant to the study, as well as the roles of various stakeholders, especially mental health practitioners, and common barriers to empirically-supported treatment programs.

Literature Search Strategy

Searches for peer-reviewed literature included databases accessible through Walden University: SocINDEX, PsycINFO, PsycARTICLES, MEDLINE, and Academic Search Complete. Other general academic databases such as Google Scholar, CINAHL, MEDLINE, Nursing Reference Center Plus, and HAPI were also used. Search terms included *social learning theory*, *social cognitive theory*, *self-efficacy*, *career*, *decision-making*, *evidence-based*, *empirically supported*, *mental health*, *history*, *deinstitutionalization*, *transinstitutionalization*, *community*, *public*, *perceptions*, *attitude*, *implementation*, *practitioner*, *social work*, *therapist*, and *counsel*. The literature search was not bound by publication dates because the treatment of mental illness has developed over a long period. This development needs to be highlighted to understand empirically-supported treatments. However, the primary themes covered in this study are adopted from research conducted between 2010 and 2017. Literature between this period was used to identify key themes, especially barriers to empirically-supported treatment methods. Mental health is a dynamic sector. Thus, issues experienced within programs keep changing with time. The literature was used to determine whether barriers to

empirically-supported treatment programs at the moment are the same ones to those experienced in the early 2000s.

I conducted additional searches to find articles. Additional searches led to identifying key information regarding the development of the social cognitive theory and mental health practices. Subsequent searches were not confined to any time periods. Mental health has a rich history which needed to be studied to determine how treatment methods have evolved. The inception of empirically-supported treatments was followed by rigorous research and efforts to invest and support the programs. The literature review provided a wide perspective regarding the issue and supported the process of coming up with effective solutions to barriers to maintaining fidelity for empirically-supported treatments.

To establish the most appropriate literature for this study, I filtered available literature based on various criteria. According to Bond et al. (2012), the 1980s marked the advent of changes in the treatment of mental conditions. Therefore, I chose articles between the late 1985 and the current year (2020). However, quantitative research articles used in this study were limited to those published at least 10 years before this research. The main criterion for filtering was the use of keywords. However, keywords are not always perfect indicators of the relevance of the literature. Therefore, I analyzed abstracts to identify the most appropriate literature.

Theoretical Foundation

The theoretical framework used in this study is the social cognitive theory. The theory involves examining processes of acquisition of knowledge. It also involves

looking at how interactions between an individual and the environment influence their ability to acquire and use knowledge (Schwarzer & Luszczynska, 2005). The following section is an analysis of the social cognitive theory and its application to the topic of perceived barriers for empirically-supported treatment.

Social Cognitive Theory

Learning is impacted in two ways: through feedback resulting from the individual's behavior and observation of the behavior of those around them and the feedback the observed individuals receive (Bandura, 2011). The latter introduces an important distinction between simple trial and error and the impact of the social environment. Bandura (1986) identified that humans could circumvent the need for trial and error by observing modeled behavior, thereby avoiding potential consequences inherent to trial-and-error learning. People have choices and control over their current and future behavior, and they exercise that by using the information available to them to determine whether they will be successful using a proposed behavior (Bandura, 1995). Conner and Norman (2005) said that health is an extremely sensitive issue and people are unwilling to take risks, especially regarding the implementation of a new procedure. Individuals are more likely to stick to practices that they have observed among others. Procedures that are uncommon in the agency or local community are likely to be ignored or declined, irrespective of their efficacy proven through research (Wood & Bandura, 1989).

Bandura's work on social cognitive theory began in the 1960s as the social learning theory, which is an agentic framework for understanding human behavior.

People are active agents who deliberately influence their environment and social systems while simultaneously being a product of those systems (Bandura, 2011). Learning and developing is a constant process that involves the learner and those around him or her. People have an active role in determining who or what they might be, rather than being a product of their environment (Lent & Brown, 2013). It is this intentional action toward self-development that is critical in its application to professional behaviors and has resulted in the development of social cognitive career theory.

Social cognitive theory began as social learning theory in 1977, with Bandura explaining that people tend to learn through the consequences of their actions or modeling and imitation. Humans tend to make decisions regarding behavior based on the likelihood of reinforcement of that behavior (Bandura, 1977). Behaviors that are unlikely to be positively reinforced, or responded to with aversive stimuli, are avoided (Bandura, 1995, 2011). Observation of others is an important aspect of learning, as people may imitate the behaviors they have witnessed as this reinforces that this is an appropriate way to behave (Bandura, 1977).

By exhibiting the behavior, they have seen, people are more likely to receive acceptance from others and avoid criticism and aversive responses (Bandura, 2011). The combination of positive reinforcement and the absence of punishment encourage a pattern of behavior (Savolainen, 2002; Schunk, 1987). Experiencing an aversive outcome is likely to result in the behavior being abandoned (Bandura, 1977, 1986a, 1995; Brown & Inouye, 1978). Although this concept explains much of human behavior, it does not account for whether a person is capable of replicating observed behavior.

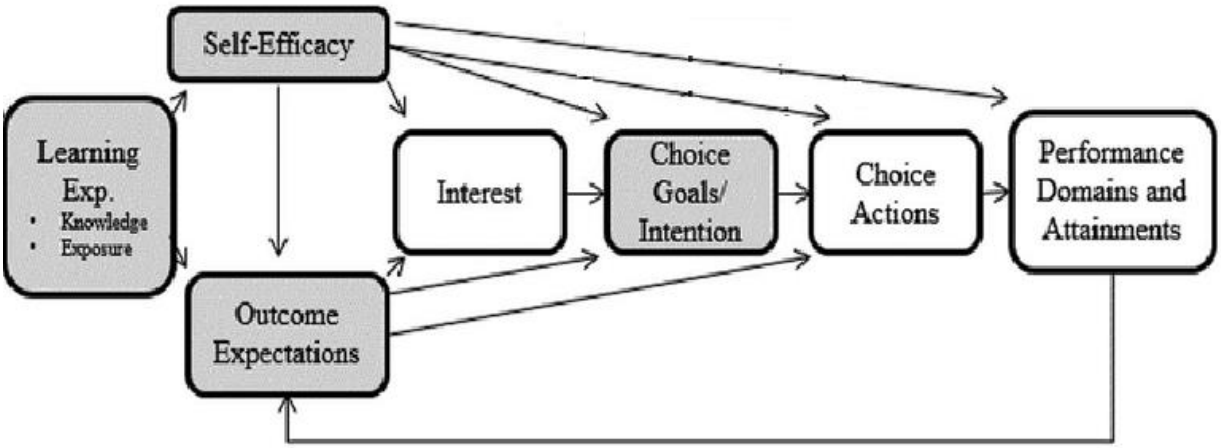

Figure 1. Model of how interests develop over time. Adapted from "Toward a Unifying Social Cognitive Theory of Career and Academic Interest, Choice, and Performance," by Lent, R., Brown, S., & Hackett, G, 1994, *Journal of Vocational Behavior, 45*, p. 88.

The recognition of required skills to successfully complete behavior, observation of behavior being successful, and understanding of potential outcomes of attempting the behavior all influence whether a person has interest in, whether they will set goals to, and whether they will attempt particular behaviors (Lent et al., 1994). An understanding of one's skills as well as what skills are necessary to complete a behavior both impact a person's belief in whether they will be successful (Bandura, 2011). If one does not believe they will be successful they are unlikely to attempt a behavior, it also impacts whether they will show an interest in and set goals related to that behavior (Lent et al., 1994). Thus, it is not only that a person will not engage in a behavior, they are unlikely to engage in behaviors that will later result in them having greater confidence in success.

When the social cognitive theory is directly applied to the subject of fidelity to treatment programs in mental health treatment, one will expect that a mental health

practitioner will only implement treatments that they fully understand and have experienced in practice. Michie et al. (2005) conducted a research to determine the effect of the level of theoretical understanding and implementation of mental health treatment programs; the findings indicated that practitioners would only use treatment methods that they understand and have seen in practice. Allen et al. (2004) researched the use of social cognitive theory to determine the relationship between self-efficacy and the behavior of health practitioners and their patients. The findings indicated that evidence on successful interventions enhanced self-efficacy in the use of the interventions under study. Evans (2006) noted that treatment plans were best implemented when they were introduced through alteration of cognitive patterns. Therefore individuals wishing to introduce new treatment methods should first seek social acceptance among practitioners by providing evidence that they are effective.

Self-efficacy. Bandura (1986a) further developed the theory and renamed it social cognitive theory, to better illustrate the cognitive aspects and role of the person in the environment. Further development of the theory resulted in a focus on self-efficacy. Self-efficacy represents the belief of the person regarding his or her ability, or lack thereof, to successfully complete the behavior (Bandura, 2011; Bandura & Locke, 2003). People may examine what behavior is most likely to receive a desired consequence and whether that behavior is possible with their current skill and knowledge.

The concept of self-efficacy is particularly important as it relates to workplace behaviors and the development of clinicians. As people have a desire to feel useful and receive praise, they may attempt to predict potential outcomes of their behavior and try to

determine if they possess the necessary skills to achieve the desirable outcome (Bandura, 1986b). This thought process can shape clinician behavior and their perception of whether they can affect positive change in their clients (MacAteer, Manktelow, & Fitzsimons, 2015). Clinicians may practice behaviors they believe they have the skills to employ and have the best chance at being successful with clients. How clinicians determine what will be effective, and how they perceive their own ability to deliver treatment are essential to the dissemination of empirically supported treatment (Prins, 2014).

Training and development within the mental health field relies on the concept of self-efficacy about the perception of their ability to carry out the new treatment (MacAteer et al., 2015). Positive past experiences and comfort within a job and field may lead to greater self-efficacy within a clinician. Increased self-efficacy may result in the clinician believing that they have the skills to be successful (Julien-Chinn & Lietz, 2015; Simons, An, & Bonifas, 2016). Given the long record of other therapy methodologies being successful, an experienced clinician could rely on those to bring continued success in the future thereby discounting newer treatments. Corona, Christodulu, and Rinaldi (2017) investigated whether prior experience might impact self-efficacy as it relates to new training, but no statistically significant results were found. However, they noted that self-efficacy is enhanced through training on a specific model that is continuously applied by the practitioner. Therefore, self-efficacy develops with training and continuous practice.

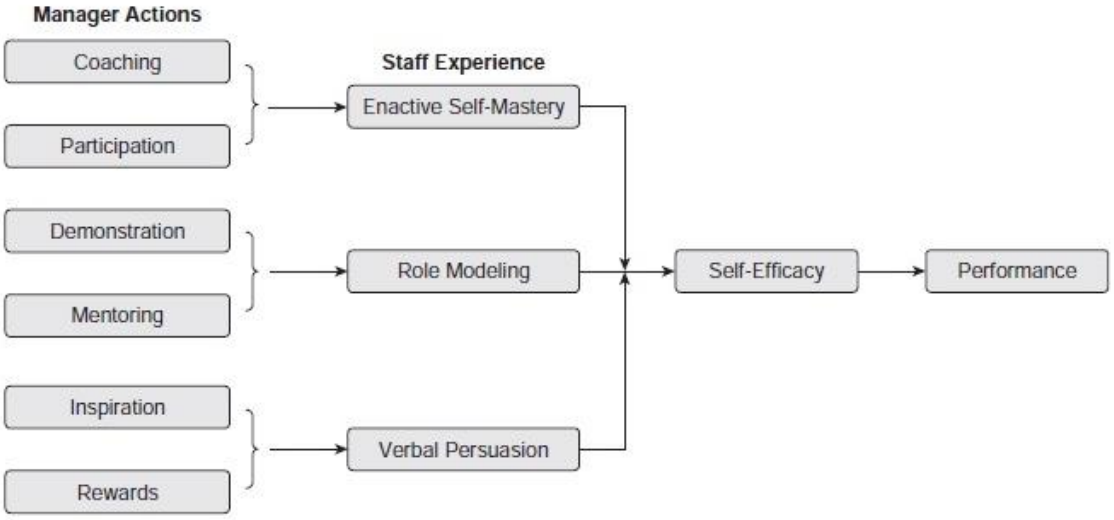

Figure 2. Explanation of what manager behaviors impact staff experience and inform self-efficacy and performance. Adapted from "Boosting Empowerment by Developing Self-efficacy," by Heslin, P, 1999, *Asia Pacific Journal of Human Resources*, *37*(1), p. 56. doi:10.1177/103841119903700105.

The concept of self-efficacy may also have an influence on the role of supervisors and managers, and whether their supervisees can successfully implement and maintain empirically supported treatments. As established above, the self-efficacy of the professional has a great deal of influence on whether they will engage in specific behaviors. However, Heslin (1999) demonstrated that supervisors have a vital role to play in improving self-efficacy of their supervisees. Supervisors may influence the behavior of their staff, in several ways, both directly and indirectly. They may coach and in some settings model behaviors for supervisees to observe and potentially imitate, but they also play a role in providing praise and rewards for observed behaviors of others. This

observed outcome impacts a supervisee's interest in pursuing specific behaviors, and thus makes those behaviors more or less likely to be attempted (Lent et al., 1994).

Self-efficacy may also play a role in gender differences in occupational decision making, at least in those new to the field. Females tend to show much greater self-efficacy than their male counterparts when selecting female-dominated occupations (Bandura, 1995). Self-efficacy in mental health practice motivates the practitioners into advancing their education and taking bigger roles in mental health practice (Branch & Lictenberg, 1987; Rooney & Osipow, 1992). Self-efficacy is an aspect of personality that is developed by an individual as they grow through various stages. A mental health practitioner's self-efficacy may be enhanced by their experiences while delivering services (Taylor & Betz, 1983). A practitioner who experienced a supportive environment and has experienced success during their years of practice may possess higher self-efficacy (Rosen, Ashwood, & Richardson, 2016). Mental health practitioners with positive beliefs in their ability to succeed have an easier time accomplishing tasks. Self-efficacy plays a key role in how one approaches the tasks, goals, and challenges that come up. (Taylor & Betz, 1983).

Use of social cognitive theory in research. Several researchers who have studied mental health practitioners have used social cognitive theory to better understand the attitudes and decision-making of professionals (Campbell et al., 2013; Couët et al., 2015; Wharton & Bolland, 2012). Some of these researchers have focused on change, changes in professional duties, service landscapes, or paradigmatic ideology (Carpenter et al., 2015; Lee et al., 2016; MacAteer et al., 2015). Responsiveness and success while

encountering a change are influenced by the belief one will be successful (Lee et al., 2016). Responsiveness makes a person more socially aware. Changes in the environment can easily influence an individual's behavior if they are more socially aware (Lee et al., 2016). Therefore, application of social change theory will help me understand how changes in the mental health sector have affected the experience of the practitioners regarding empirically supported treatment programs.

As the mental health discipline has moved toward the adoption of recovery-oriented care principals, the landscape of service provision for some professions within the field has changed (MacAteer et al., 2015; Vax et al., 2012). Vax, Schreuer, and Sachs (2012) examined self-efficacy as it related to these changes and the development of roles within community agencies, as opposed to hospital settings that were more traditional. The concept of self-efficacy was useful in determining confidence, but also shed light on the importance of role clarity for workers. Carpenter, Shardlow, Patsios, and Wood (2015) also examined this concept among new social workers, and they found that greater clarity in roles among social workers resulted in greater self-efficacy. While examining new social workers, the researchers were able to examine these professionals in a time of profound change and provide a greater understanding of the impact of self-efficacy through that change.

Though responsiveness to change is important, self-efficacy can also be related to clinical skill (Lee et al., 2016). Confidence in success is a chief aspect of practice for clinicians, and Lee et al. (2016) found higher ratings of self-efficacy were related to greater skill in assessment and response to client suicide risk. Though noteworthy in

relation to experienced clinicians, in contrast, Carpenter et al., (2015) found that newer social workers tend to overestimate their readiness and skill.

Gale and Marshall-Lucette (2012) used the concept of self-efficacy to examine utilization of recovery-oriented practice principals among mental health practitioners. The researchers found while confidence and self-efficacy were related to reported use, they did not relate to academic or professional training, and did not predict proficiency. If trained and prepared to provide care in the appropriate framework the mental health practitioners should have been able to provide service that was more consistently including the elements required by the model. Greater preparation would have improved fidelity and therefore improved clinical outcomes and improved self-efficacy moving forward.

The purpose of introducing empiricism in mental health treatment is to optimize patient outcomes by matching the treatment with the patient's needs and expectations (Bellamy et al., 2012). According to the social cognitive theory, an individual's knowledge acquisition is enhanced when they observe others within the specific context. Research forms a crucial aspect of the experiences of nurses both in practice and education. Nurses who are actively involved in the research process or can experience the application of the findings firsthand are more likely to implement them in their future practice. Wike et al. (2014) note that the translation of research into practice is often poor. However, the populations are diverse, and there is a need for further refining of the available evidence to ensure that it fits the context of the organizations and the needs and preferences of the clientele. Briggs and McBeath (2009) noted that many assumptions are

made during the research and implementation process on the needs and preferences of the clientele. Few of the empirically supported treatment programs are tested to verify whether the assumptions are correct. Briggs and McBeath (2009) note that cultural inappropriateness of empirically supported treatment results in resistance by the clients. Harvey and Gumport (2015) conducted research aimed at highlighting the modifiable barriers to empirically supported treatment at various levels. At the patient level, the researchers identified transportation, lack of childcare, time and place that are sensitive to family and work responsibilities, level of motivation and knowledge. According to Bellamy et al. (2012), ineffective treatment program is that which is sensitive to the abilities, needs, and weaknesses of the patient.

Research is a crucial aspect of any mode of healthcare practice. It informs the practitioners on the best way to achieve the set goals (Wiechelt & Ting, 2012). Research also motivates the practitioners by making the outcomes more realistic and achievable (Gallo & Barlow, 2012). Research helps practitioners in identifying the best ways to focus on clients' issues, preferences, characteristics and incorporating them into practice. Wike et al. (2014) noted that researchers had a role of carrying out conclusive studies and remaining in contact with practitioners throughout the implementation process. Researchers and practitioners have formed mutual relationships where the former does follow-up on whether their findings are relevant and useful while the latter seeks clarifications before implementing the recommendations. There are scenarios where such relationships do not exist resulting in the inability to maintain fidelity to empirically supported treatment due to lack of information and demotivation (Gallo & Barlow, 2012).

Wiechelt and Ting (2012) noted that though vast literature is available to practitioners, they are unable to utilize it because the findings are hidden in numerous and voluminous research articles. Wiechelt and Ting (2012) recommend that the best way of making research accessible to the practitioners is by compiling summaries of interventions then availing them to practitioners in accordance with the problems with which they deal.

Literature Review Related to Key Variables and Concepts

The movement toward evidence-based practice was intended to streamline the field of social work with existing mental health needs, allow professionals an avenue to better incorporate research into their practice, and allow clients access to the most effective treatment (Gambrill, 1999; Sheldon, 2001; Webb, 2001). However, this was a substantial shift in practice and met with some resistance. This section briefly covers the history of mental health treatment, the role of stakeholders in empirically supported mental treatment, common barriers in empirically supported treatment programs and the changes experienced within the field upon the introduction of evidence-based practice. Theoretical frameworks link a phenomenon under study with existing knowledge. A review of the history of empirically supported treatment assists one in understanding how barriers to fidelity have evolved with time. The literature on the role of stakeholders and barriers highlighted in this section allows me to establish what factors should be given attention in the data collection and analysis processes.

History of Mental Health Treatment

Mental health policy and deinstitutionalization. Throughout history, many people with mental illness did not receive care and instead found themselves housed

within local jails and poorhouses. Through the efforts of Dorthea Dix, the first institutions for the mentally ill were formed (Katz, 1986, Trattner, 1999). The United States Congress passed the Land-Grant Bill for Indigent Insane Persons in 1854 which would have provided land on which asylums would have been built to house and treat those experiencing mental illness (Katz, 1986). Unfortunately, this land grant was vetoed, and provision of services for those with severe mental illness was auctioned off to whoever stated they could care for them for the least amount of public funds (Trattner, 1999).

Without federal assistance, the care of individuals with severe mental illness was left to the states; every state had built at least one publicly supported psychiatric hospital by 1890 (National Institute of Health, 2006). However, funding was scarce, treatments were limited, and the housed population rarely returned to the community (Crenson, 1998). The United States federal government would pass its first major mental health public policy related to providing program and housing funding to this population in 1946. This provided funding for pilot programs providing care in the community rather than the asylum and the population these asylums peaked in 1955 at 559,000 (Mechanic & Rochefort, 1990).

Between 1955 and 2010 the population housed in institutions decreased by 96% (Hudson, 2016). The reasons for this included: institutions becoming too costly, poor treatment of residents, unlivable conditions, and the development of community-based service ideologies such as normalization (Chaimowitz, 2012; Hudson, 2016; Sullivan, 1992). An increase in the number of medications available to treat mental illness was

thought to have impacted the numbers of individuals in institutions (Eisenberg & Guttmacher, 2010; Prins, 2011). However, Mechanic and Rochefort (1990) found no statistically significant correlation between the introduction of new medications and institution population decrease. Pow, Baumeister, Hawkins, Cohen, and Garand (2015) confirmed these findings by examining admissions and discharges before and after deinstitutionalization began in earnest in 1954. What was found to have a relationship with fewer individuals living in institutions was the increase in payment to community placements, which suggests that many of those that left public psychiatric hospitalization merely relocated to private nursing homes, funded through public insurance options (Mechanic & Rochefort, 1990; Pow et al., 2015; Prins, 2011).

Many believe that community-based placement of those with mental illness did not adequately replace hospitals and state-run institutions but instead relocated individuals to the criminal justice system because these individuals were not able to function appropriately in the community (Prins, 2011). Over 350,000 of the people incarcerated in the United States have a mental illness (Prins, 2014). The frequency in which those with mental illness are incarcerated has led to many complaints and eventual lawsuits (Simon, 2013). Many individuals with mental illnesses ended up homeless once deinstitutionalized. The increased homelessness and incarceration experienced by those with mental illness likely should be viewed as an indicator that rapid deinstitutionalizing these individuals was not a viable solution to the crisis of mental illness (Greenberg & Rosenheck, 2008).

Deinstitutionalization of people with mental illness has necessitated integration of families and communities in the process of providing care. As a result of the deinstitutionalization process, mental health practitioners must work closely with the families of the patients and communities in the process of providing care. Two issues examined in this research are strongly associated with the patient's support system. These issues are lack of time and empirically supported treatment not fitting the clientele. Some of the mental health patients may not possess the capacity to arrive at sound decisions and manage their time, and thus rely on the support system to follow up their treatment plans. On time, the support system works to bring together the practitioner and the clientele, thus facilitating the treatment program. Hunt et al. (2012) noted that evidence-based practice is a multifaceted approach to mental health problems that can only be implemented in situations where strong networks exist to link mental health workers, service providers, government agencies, family groups, academic institutions, and professional associations. Leggatt (2002) notes that trends have emerged in many Western countries where large psychiatric hospitals are becoming less popular. The contemporary mental health system is made up of practitioners who work closely with family members. This has resulted in a situation where the family has a burden of care (Henggeler & Sheidow, 2012). There are instances when family members have suffered from caregiving fatigue, resulting in the suffering of patients with mental illness. In Baker-Ericzén et al. (2013)'s qualitative study, including seven focus groups, and 10 semi-structured interviews, they found one effect of a family suffering from caregiving fatigue is a lack of fidelity to the mental health treatment plans. Gorman et al.'s (2011)

research involving a survey of 544 military members and their family members agreed with Baker-Ericzén et al.'s statement. Drifting from fidelity may result in situations where the population disapproves of the modern empirically based plans and reverts to the traditional generalized treatment plans.

Community-based services. The community acts as a source of support, advice, and education. Volunteers and organized teams within the community comprise a pertinent section of the support system. Support of community members towards mental health patients extends outside the mental health system (Ingoldsby, 2010). For instance, community organizations and individuals can take over the parental responsibilities of adults suffering from mental health conditions.

Members of the community possess vast knowledge on the progress of mental health patients. Their proximity to the patient and the family helps them understand the preferences and capabilities of the patient's family. The community is involved in enhancing the capabilities of families with mental health patients (Ingoldsby, 2010; (Grob, 2014)). The support enables the families to care for the patients. Some of the community members and organizations have been working towards eliminating vices such as stigma of mental health patients and their families.

Mental health workers, service providers, government agencies and professional associations have been making steps towards formalization of community involvement in mental health. Some of the steps taken toward the course are active involvement of professional mental health practitioners in community initiatives (Ingoldsby, 2010).

Community organizations and volunteers can access information and data that helps them make informed decisions.

The commercialized and professional mental health sector has a mutual relationship with the community from the perspective of mental health provision. Healthcare professions rely on the family and community members for evidence on specific cases as in the example with the patients' social skills, medical history and preferences (Lyon and Budd, 2010). The community relies on mental health practitioners for education, advice, and support to facilitate proper utilization of available data and information.

Some empirically supported treatment programs extend outside the mental health facilities. Mental health practitioners require the input of community members to enhance fidelity to empirically supported mental health treatment programs. Since some of the treatment plans are implemented when the patients are outside mental health facilities, it is imperative that the community be prepared to perform some of the roles traditionally considered as being vested on mental health practitioners (Grob, 2014).

The community is in an advantageous position to monitor the mental state of patients within it. During the treatment program, the patient may stabilize and express the wish to resume their lives. In such instances, community members are tasked with the role of reintegrating the individual and helping them to adapt within places of work, education and social institutions. Community members should have knowledge that can help them monitor the mental state of the patients and make comprehensive reports that can be utilized as the basis for decision-making by practitioners (Ingoldsby, 2010). For an

effective monitoring process, the community must understand the goals of the empirically supported treatment program. The relevant practitioners should also provide information on how the community members can compare the patient's progress with the expected outcomes. To impart community members with this knowledge, the practitioner should take a personal initiative to involve the support system. However, the level of involvement of the community must be limited within the set of ethical standards. For instance, an individual in treatment for depression may wish to resume their careers at some point in the course of their treatment programs (Branch & Lichtenberg, 1987). This person may be uncomfortable with the sharing of their mental health history with their employer and colleagues (Grob, 2014; Plath, 2013). In such instances, people in the workplace will not be cognizant of their condition and may treat her in a manner that does not support the treatment program.

The patient under empirically supported treatment programs and their families must appreciate the role that the community plays towards their recovery. The patient must be willing to share information that can help individuals and community organizations to follow up on their progress and offer assistance where possible. In a workplace, for instance, the practitioner can liaise with the patient to identify one trusted and caring colleague who can monitor the progress of the patient (Wallerstein and Duran, 2010; Tol et al., 2011). They can also work closely with community organizations to pay regular visits to the patient in their homes, workplaces or schools to monitor on their progress and determine whether the required level of fidelity to the empirically supported treatment programs is being maintained.

Community mental health programs offer citizens affordable mental health treatment and resources (Briggs & McBeath, 2009; Prins, 2011). Community programs are associated with little or no costs to the individuals involved. Stakeholders in the mainstream the mental health system should view the community programs as supplementary rather than competition (Ingoldsby, 2010; Grob, 2014). In many instances, there are criteria before one can become a beneficiary of community programs. Some of the most common criteria include state of employment, residence within specific geographic areas, insurance criteria and gross income limits. Mental health programs initiated within the community are increasingly becoming empirical. Mental health practitioners working on these programs must ensure that they involve all key stakeholders (especially mental health workers, service providers, government agencies, family groups, academic institutions, and professional associations) to provide quality care.

In the US, community mental health programs and services receive funding from both the government and well-wishers. Some of the services provided through the programs are a result of orders from courts and government agencies. Thus the ability to maintain fidelity to the program stretches beyond the will and actions of mental health practitioners (Tol et al., 2011). The clinicians are mandated with the responsibility of organizing the other community and health workers and have them support the entire process. In the case of a court, for instance, the law may not have been updated to accommodate the new empirically supported treatment programs. Bureaucracies and established legal processes may curtail the ability of clinicians to maintain fidelity to the

programs (Ingoldsby, 2010). It is upon professional nursing groups, scholars and mental health service providers to lobby lawmakers and courts towards formulation and implementation of laws that consider the trends in mental health service provision.

Mental health agencies are within the community play a role of bringing together mental health workers, service providers, government agencies, family groups, academic institutions and professional associations (Briggs & McBeath, 2010). They provide services to clients and advocacy on their behalf. A practitioner who works closely with these organization is likely to achieve full fidelity to the respective empirically supported treatment programs.

Mental health workers have the best understanding of the nature of the caregiving role. Therefore, the family is expected to work under these individuals to deliver the best outcomes for their people. A treatment plan that actively involves the family easily meets expectations due to the elevated level of empathy between the caregivers and the patient (Gorman et al., 2011; Kates et al., 2011). There are instances mental illnesses are blamed on the actions of family members, for instance, there were cases where spouses have been blamed for causing stress on their partners before diagnosis and during the treatment process (Baker-Ericzén et al., 2013). Though most of such beliefs have been rebutted through neurobiological explanations, they are a proof that family members have a significant impact towards the psychological and mental stability of the patients (Henggeler & Sheidow, 2012).

There are situations where mental health practitioners exclude families from the treatment plans. Leggatt (2002) notes practitioners defend such scenarios with claims

such as the need for confidential relationships between patients and their mental health care service providers and practitioners. In these cases, family members are only offered information after an agreement between the patient and the doctor. Mental health practitioners are trained to maintain confidentiality. Confidentiality often assumes precedence over other issues in the treatment plan. A doctor can become legally liable by releasing details of the patient to their family members (Shim et al., 2011).

Anger, guilt, and anxiety of family members can affect the ability of clinicians to maintain fidelity to empirically supported treatment and care programs (Gorman et al., 2011). Anger can be remodeled to become a sense of concern for the ailing relative. Mental health practitioners should welcome and support expressions of warmth towards the patient (Khaylis et al., 2011). There is a need to promote recreational activities that optimize the times that the family spends together. Conflicts may arise from the antagonistic relationships in some families. Though clinicians have no primary roles towards such conflicts, they pose a danger to the ability of practitioners to maintain fidelity to the programs.

Empirically-Supported Treatment

Where empirically supported practice directs clinicians to examine all the available evidence and make clinical choices based on the best information available, empirically supported treatments provide some of those treatment options. Empirically supported treatments are those specific treatments that have demonstrated efficacy in controlled, rigorous, research experiments with specific populations (Godley, Garner,

Smith, Meyers, & Godley, 2011). In this section, a discussion is provided on the recent focus on, and attitudes toward, empirically supported treatments.

Evidence-based practice emergence. Evidence-based medicine developed in the late 20th century as a transformative practice to use the vast array of empirical data available regarding the treatment of medical patients (Sackett et al., 1996). The application of this ideology would follow to social work in the late 1990s (Gambrill, 1999, Gibbs & Gambrill, 2002, Sheldon 2001, Webb 2001). While still a relatively new movement, it is poised to have a dramatic impact on clinical practice (McHugh & Barlow, 2010; Stanhope, Tuchman & Sinclair, 2011).

Evidence-based practice is a paradigm shift that has the potential to have a positive impact on education, services, and processes for improving clinical practice in the field of social work (Gambrill, 2006; Shdaimah, 2009). Gambrill (1999) described evidence-based practice as a departure from assumed knowledge passed down from a supervisor, experienced clinician, or educator to a process where information and knowledge are critically analyzed for efficacy and value. Evidence-based practice requires a link between clinicians and the body of research evidence available to them (Ruth & Matusitz, 2013). It involves a rigorous set of standards and methods. Sackett et al. (2000) provided a layout of steps to be followed to properly employ evidence-based practice:

1. Converting information needs related to practice decisions into well-structured answerable questions.

2. Tracking down, with maximum efficiency, the best evidence with which to answer them.

3. Critically appraising that evidence for its validity, impact (size of effect), and applicability (usefulness in practice).

4. Applying the results of this appraisal to practice and policy decisions. This involves deciding whether evidence found (if any) applies to the decision at hand (e.g., Is a client similar to those studied? Is there access to services described?) and considering client values and preferences in making decisions and other application concerns.

5. Evaluating our effectiveness and efficiency in carrying out Steps 1 to 4 and seeking ways to improve them in the future. (p. 3-4)

Through the steps laid out by Sackett et al. (2000), practitioners now have a method to decrease the distance between the knowledge generated by the research community and the practitioners in the field (Gambrill, 2006). In addition to the clinical expertise and client values that has led practice before the introduction of evidence-based practice, empirical evidence adds another source of information that provides practitioners access to the best available information with which to make decisions (Gambrill, 1999; Gibbs, & Gambrill, 2002). Supporters of evidence-based practice contend that the adoption of the method is the best way forward for the field (Gambrill, 1999; Gambrill, 2008; Sheldon, 2001).

Paradigm shifts in the health sector experience resistance by practitioners whose fears range from lack of sufficient knowledge to implement the changes and threat to

their jobs. Therefore, the emergence of empirically supported treatment has been characterized by staff resistance. Research is a key aspect of any mode of healthcare practice. It informs the practitioners on the best way to achieve the set goals (Wiechelt & Ting, 2012). Research also motivates the practitioners by making the outcomes more realistic and achievable (Gallo & Barlow, 2012). Research helps practitioners in identifying the best ways to focus on clients' issues, preferences, characteristics and incorporating them into practice. Wike et al. (2014) note that researchers have a role of carrying out conclusive studies and remain in contact with the practitioners throughout the implementation process. Researchers and practitioners have formed mutual relationships where the former does follow-up on whether their findings are relevant and useful while the latter seeks clarifications before implementing the recommendations. There are scenarios where such relationships do not exist resulting in the inability to maintain fidelity to empirically supported treatment due to lack of information and demotivation (Gallo & Barlow, 2012). Wiechelt and Ting (2012) said that although plentiful literature is availed to practitioners, they are unable to follow it because the findings are hidden in numerous and voluminous research articles. Wiechelt and Ting (2012) said that the best way of making research accessible to the practitioners is by compiling summaries of interventions then availing them to practitioners in accordance with the problems with which they deal.

Fidelity in treatment. Fidelity is a widespread problem in many fields where tasks must be performed sequentially and to specified standards. In the research process, the fidelity problem is referred to as a Type III error. The prevalence of Type III errors is

evidence that fidelity is an issue for many fields. The goal of maintaining fidelity of a procedure is to ensure that it remains effective and helps stakeholders achieve their ultimate targets (Teague et al., 1998).

Fidelity to a procedure or program is defined as the ability to ensure that it is completed or implemented according to the protocols laid down by its proponents or designers (Lee et al., 2008). Various fields have various professions, with each assigned a specific role. Fidelity to a procedure is maintained where qualified professions implement the respective interventions or provide specified services. Teague et al. (2012) noted that the fidelity question has been long-ignored in mental health treatment. Mental health is a wide area of practice. Many factors and stakeholders determine the success of a procedure. Maintaining the fidelity of these procedures require that mental health workers, service providers, government agencies, family groups, academic institutions, and professional associations be brought together to harmonize their efforts (Monroe-DeVita et al., 2011).

Lee et al. (2008) categorized fidelity into three components: quality of delivery, exposure, and adherence. Quality of delivery is determined by the collective efforts of mental health workers, service providers, government agencies, family groups, academic institutions, and professional associations. In the case of mental health treatment, the provider must dedicate their time and effort towards ensuring that the intended outcome of the procedure is achieved. Another factor determining the quality of delivery is preparedness of the participants (Teague et al., 1998). This preparedness entails the

degree to which the behaviors and attitudes of participants are aligned to the expectations and goals of the program.

Authorities, institutions, and facilities set aside vast amounts of resources for research and implementation of treatment programs. The amount of resources set aside is determined after a thorough study is undertaken (Salyers et al., 2010). The current study entails the identification and documentation of essential stages that must be involved in the entire procedure. Effective utilization of the resources entails following the laid-down procedures for the benefit of the patient (Roy-Byrne et al., 2010). Adherence refers to the degree of conformity of the strategies and actions of mental health practitioners to the standard guidelines (Leggatt, 2002; Lilienfeld, 2007). There is a need to deliver all the activities as designed prior to the entire process. There may be assessments at various milestones aimed at determining the likelihood of the procedure yielding the desired outcome (Karlin et al., 2010). Adjustments are encouraged at various points to respond to the level of progress of the patient.

Practitioners require access to data, discussions, and recommendations to make decisions about directions to take in treatment (Manchak et al., 2014). The decision-making process can be expedited when the data used is reliable and closely-related to the specific case. For instance, action research is considered more reliable than other generalized forms that cover larger areas (Manchak et al., 2014).

Mental health is a dynamic field that requires frequent updating of knowledge and data (Salyers et al., 2010). To ensure that the practitioners are exposed to the process of empirically supported treatment, mental health workers, government agencies, academic

institutions, and professional associations should work towards maintaining fidelity to empirically supported treatment programs (Adelman & Taylor, 2010). High-frequency interventions are founded on the most recent research findings and recommendations (Henggeler & Sheidow, 2012). The number of available strategies should also be increased to provide alternatives to both consumers and practitioners (Kellam et al., 2011). Exposure can only be achieved if mental health workers understand their responsibilities. The contemporary mental health system has benefited from the enhanced availability of data as a benefit of improved communication technology (Manchak et al., 2014).

The three aspects explained above are regarded as highly predictive of the responsiveness of patients to treatments (Henggeler & Sheidow, 2012; Kellam et al., 2011; Adelman & Taylor, 2010). They raise the likelihood that the intervention will reach the maximum possible effect. Fidelity is also a result of heightened awareness of the client's needs (Yanos et al., 2012). Mental health clients have a variety of needs that must be identified then met by the medical practitioners. There are instances when the practitioner must involve others in the support system such as family and community members to raise the potential of the treatment being successful (Monroe-DeVita et al., 2011). Family and community members may understand the history, behavior, and needs of the individual and may be able to provide critical information that can guide intervention by the practitioners (Manchak et al., 2014). Some empirically supported treatment programs stretch beyond the mental health facility into homes and workplaces of the patients (Teague et al., 1998). In these cases, members of the family of the client

and the community may need to be integrated into the system. Therefore, these individuals should be well-informed about therapeutic needs and how they are part of the process (Monroe-DeVita et al., 2011).

Corrigan (2004) found that fidelity to mental health treatments is determined by social cognition. Individuals who are directly involved in the treatment process adhere to laid-down procedures if they are accepted within their social domains. Godin et al. (2008) noted that healthcare practitioners and patients violated the laid down protocols due to fear of stigmatization by their peers. They take part in processes that they have seen their colleagues or close acquaintances take part. Therefore, the social environment has an impact on the ability of mental health practitioners to maintain fidelity to empirically supported treatment programs.

Fidelity to empirically supported treatment is usually enhanced through uniqueness and personalization of the care strategies (Ingoldsby, 2010; Manchak et al., 2014). The amount of data available should facilitate the ability of the practitioners to handle each client unique in line with their needs. Program differentiation works towards making each client feel unique and responding to differences in their needs and preferences. These differences are often caused by factors such as gender, cultural background, age and medical history (Webb, 2001; Teachman, 2014). An increased level of program differentiation gives each client a unique experience and makes them more willing to support the mental health system in the future (Bernal & Scharró-del-Río, 2001).

The process of assessing fidelity is complex and may often require integration into a long-term program. The analysis process looked at the three factors outlined above: exposure, adherence, and quantity of delivery (Yanos et al., 2012). Fidelity helps the provider in setting up a delivery system that supports and sustains the implementation effort (Pelham et al., 1998). Infrastructure remains an aspect in the provision of mental health services. A high level of fidelity means that the service provider, through the practitioner, can identify the gaps in infrastructure (Teague et al., 1998). Once these gaps are identified, the service provider can carry out replacements or upgrades to meet the needs of the clientele.

Fidelity assessment is only relevant in situations where the needs of the patients and the expected outcomes of the intervention are well identified (McHugh & Barlow, 2010). A higher degree of fidelity means that the practices undertaken by the practitioner are in line with the goals and expectations of the program (Pullman et al., 2013; Salvers et al., 2010). There are instances when these goals must be revised to become unique and relevant to the situation of the client being handled.

Common barriers to empirically-supported treatment programs. Mental health treatment programs are rigorous processes that require vast resources and time to implement. Most of the procedures must be conducted in specific locations within a specified time (Nahum-Shani et al., 2017). Some of the issues that affect patients regarding time include family responsibilities, work commitments and movement between these locations and therapy sessions and physician appointments (Gambrill, 1999). Some patients require the support of family members, who may not always be

available due to commitments (Chatters et al., 2015). Implementation of administrative support also requires time to synchronize the activities of the administrators and the staff to those of the patients and the support system (Raffel et al., 2013).

According to Wike et al. (2014), empirically-supported treatment is anchored on procedures that require extensive time input. Mental health practitioners require time to search for and evaluate relevant research and data that that can inform dissemination and implementation of empirically supported treatment. Insufficient funding has been linked to time constraints (Wharton & Bolland, 2012). With limited resources, service providers and government agencies are not able to increase the number of person-hours available for the provision of service. From Wike et al.'s (2014) observations, time limitations start at the research level. Research is characterized by time-consuming procedures to help mental health practitioners keep up with the changes in the relevant area of practice.

Wike et al. (2014) observed that there is usually a time lag between generation of research findings and their publication. Research is published a few months or years after the data collection process. Therefore, the publication process may come at a time when the findings are no longer relevant to the current practice (Wharton & Bolland, 2012).

The American mental health sector is characterized by a shortage of personnel. Many practitioners spend time attending to patients to the extent that they lack the time necessary for learning emerging techniques that can enable them to merge empirically supported techniques into their future practice (Wharton & Bolland, 2012). Supervision can also become difficult or impossible due to time constraints. Most supervisors do not have an opportunity to assess interventions at the relevant steps to determine whether

they meet the set threshold. As a result, many procedures go on unchecked. With time, the practitioners come to relate non-compliance with no consequences. Thus the perception of lack of consequence undermines fidelity to empirically supported treatment programs (Edmond et al., 2006; Wharton & Bolland, 2012).

According to Weichelt and Ting (2012), researchers have come up with ways of mitigating on the challenges rising from time constraints in the implementation of empirically supported treatment programs. For instance, mental health practitioners should only focus on compilations of summaries rather than spend time looking for, appraising and reading research articles (Edmond et al., 2006). Thyer and Myers (2011) note that the emergence of the Internet has presented an opportunity for mental health practitioners to overcome the obstacle of time. Research summaries are available both on the public Internet and databases for easy access that is less time-consuming. Access-restricted databases are available, and facilities can purchase subscriptions to enhance their staff's ability to access more relevant research (Mullen et al., 2008).

In Wiechelt and Ting (2012)'s exploratory qualitative study with 17 field instructors, they found out that time available to mental health practitioners diminishes with an increase in the number of years of experience. The findings indicate that students had the most amount of time, which diminished as they got into practice, whether as a result of increased responsibilities at the workplace or other commitments such as family (Wharton & Bolland, 2012). Time constraints intensify the effect of other obstacles in the provision of empirically supported practice. For instance, lack of support and collaboration is an obstacle that can only be overcome if those involved in mental health

service provision spend more time together. Limited time means that these individuals have limited access to consultation, training, and supervision. Wiechelt and Ting (2012) noted that time constraints push practitioners into a situation where they no longer consider empirically supported treatment as a process, thus converting interventions into a series of arbitrary actions (Wharton & Bolland, 2012).

Wharton and Bolland's (2012) model of practice brings out resources as an aspect of service provision. Availability of resources facilitates the process of acquiring and interpreting evidence collected and its use. There are instances where resource utilization is under the influence of government agencies, whose operations are influenced by politics. Individuals at the helm of mental health systems often give in to political pressures and allocate resources in a manner that circumvents the views and expectations of active mental health practitioners (Wiechelt, & Ting, 2012). Individuals who design empirically based treatment may lack the data on the number of resources available (Bond et al., 2014). In other instances, there may be enough resources at the time of designing the treatment process. However, political pressures come in and negatively influence resource availability before implementation of the treatment (Wiechelt & Ting, 2012).

Bellamy, Bledsoe, and Traube (2006) note that mental health practitioners are not given an opportunity to become integral participants in shaping interventions for clients and delivering them to clients and communities because of their inability to influence resource allocation and utilization. Mental health practitioners are at the center of the system; they interact with the top managers, policymakers and the end consumers of

services (Wiechelt & Ting, 2012). Therefore, the practitioners are best suited to identify the needs of the population and sources of the appropriate amount of resources to meet these needs (Bond et al., 2014). However, there are many instances where the recommendations of mental health practitioners are ignored (Bond et al., 2014; Wike et al., 2014).

Mental health practitioners and providers who understand and appreciate the application of empirically supported treatment find themselves incapable of applying the treatment due to limited or lack of resources. Money is required to train staff, provide the necessary materials and remunerate them toward aspects of empirically supported treatment (Bellamy, Bledsoe and Traube, 2006; Bond et al., 2014). However, many policymakers often misread limitations that result from the resource as emanating from limited knowledge.

According to Ballamy, Bledsoe, and Traube (2006), the healthcare sector is yet to explore the full potential of technology, especially in the management of information and data. Most essential information in the contemporary world can be accessed in various forms from the Internet. Agencies and business organizations involved in the provision of mental health services should facilitate access to Internet resources (Wiechelt & Ting, 2012). Though some of these resources are free, the practitioners require training and guidance on how they can take advantage of the information available on the Internet. Many social work agencies have issues with consistency of funding training (Bond et al., 2014). Even in cases where the funding is regular and reliable, the decision makers may deviate the money from operations such as training aimed at enhancing the use of

technology, identification, institution, and maintenance of research (Garcia, Irwin & Smith, 2015).

The issue of resource management in mental health can also be understood by looking at the concept of market failure. Market failure occurs where markets cannot develop and allocate resources efficiently (Garcia et al., 2015). Williams and Doessel (2017) noted that healthcare is one of the sectors that is immensely affected by market failure. Mental health service providers are unable to put together enough resources to run a smooth system. Some of the factors behind this impairment are the lack of information and poverty levels among communities and families affected (Wiechelt & Ting, 2012). Some families do not acknowledge the effectiveness associated with empirically supported treatments. They will, therefore, opt for cheaper forms of treatment or fail to raise enough money to complete empirically supported treatment. Mwachofi and Al-Assaf (2011) note that countries have adopted public healthcare systems to circumvent the challenges of market failure. In the US, market failure is overcome through the provision of community mental health services. Private health facilities cannot make returns on elements of empirically supported treatment such as research. Therefore, the goals should be developed at the community level. Some stakeholders have created a network of local organizations and practitioners who bring together their resources and collaborate in training and research (Wiechelt & Ting, 2012). Strong links between mental health workers are therefore an indicator of better utilization of resources (Williams and Doessel, 2017).

Wike et al. (2014) noted that funding has an impact on timeframes in mental health. Lack of resources results in a situation where time is consumed in the research process. Lack of resources increases the lag time between the process of generating research findings and that of publishing the evidence. By the time the evidence gets to the practitioners to be utilized, it is outdated. Empirically based treatments rely heavily on evidence, which must be up to date to take advantage of emerging opportunities and mitigate the challenges (Bond et al., 2014).

According to Wike et al. (2014), social service funding has been growing over the years. A significant percentage of these funds are aimed at improving mental health services. However, they are too often misappropriated at the initial stages. Empirically based treatment is based on data and information. Once sufficient funds are not allocated to obtaining data and information, the entire empirically based treatment process is impaired. In Wike et al. (2014)'s review of current research, they noted that insufficient expenditure on research and evidence collection takes place when individuals who are actively involved in the provision of mental health services are sidelined during the decision-making process.

Funders of the healthcare system have a continuous mandate of ensuring that research knowledge and its relationship with evidence-based practice is explored to satisfactorily levels (Wike et al., 2014). Any interruption in funding renders the research findings less helpful. Therefore, the funding is key in facilitating the smooth translation of research knowledge into practice and eventually into patient outcomes. Mental health practitioners react differently to funding constraints; some may use outdated information

and data while others ignore the empiricism factor in treatments. In both instances, fidelity to empirically supported treatment is violated, and the system is unable to keep up with crucial changes (Bond et al., 2014; Wiechelt & Ting, 2012). Policy and funding are often subject to external factors, especially in community-based settings. Allocations by government authorities, funding of community organizations and the general status of the welfare of the clients and their families are some of the external influences of funding. According to Wike et al. (2014), many of the individuals involved in making key decisions on funding do not understand the differences between empirically supported treatment and other related concepts such as empirically based practice and empirically supported practice. As a result, there is no differentiation of funds aimed at processes under these concepts. The influence of funders who do not understand these differences results in uptake of interventions that do not meet the needs and expectations of the agency involved, the mental health practitioners, the clients and the cultural background of the community involved (Wiechelt & Ting, 2012; Wike et al., 2014).

According to Williams and Doessel (2017), America lacks an efficient public health care system that can mitigate market failures associated with mental health. Therefore, organizations and administrators mostly work together under their initiative. There is no defined criterion at the macro level where mental health service provision is well coordinated. According to Wike et al. (2014), funders and policymakers are often uninformed about the requirements and features of empirically supported treatment. When the mandate of decision making is left to these two stakeholders, they are unlikely to emphasize the factors that matter in service provision. Therefore, the mental health

practitioners do not get the required support to enable them to offer effective and efficient treatment. The practitioners lack the support that can help them meet the needs and expectations of the patients, the community and even their own. Lack of support towards aspects of empirically based practice acts as a demotivating factor, thus affecting the fidelity of the empirically supported treatment (Bellamy et al. 2006).

Briggs and McBeath (2009) note that empirically supported treatment can only succeed where there is empirically supported management of psychiatric services. The ability of a mental health practitioner to maintain fidelity to empirically supported treatment program is affected by actions of National Institutes of Health, accrediting bodies, state and local government authorities (Wiechelt & Ting, 2012; Briggs and McBeath, 2009). Lack of accountability of public funds and failure by the administrators to avail the relevant technology result in a situation where the practitioners cannot deliver services in accordance with the established protocol. Briggs and McBeath (2009) note that it is the mandate of the health administrators to create a performance-focused environment. The environment serves to help the practitioners to use evidence as justification for the new strategies.

According to Briggs and McBeath (2009), managers have a role in integrating empirically supported treatment programs with client-centered approaches. Therefore, fidelity to empirically supported treatment programs can be breached if these managers fail to create an environment that activates the link between the practitioners and their patients. Wharton and Bolland (2012) note that barriers to empirically supported treatment programs are created when administrators are unaware of how key factors such

as skills, time and access affect the efficiency of service delivery. According to Bellamy et al. (2006), most mental health practitioners believe that key factors within the workplace are influenced by the management and that their role stops with getting the attention of the management towards these issues.

Wiechelt and Ting (2012) notes that empirically supported treatment programs must be supported by regular updating of the skills and evidence available to mental health practitioners. The practitioners in the field may experience constraints such as limited time and resources, which prevent them from pursuing further knowledge on empirically supported treatment programs (Bledsoe-Mansori et al., 2013). Therefore, these individuals should be trained through programs supported by their employers and other key organizations such as professional associations. Professional associations have a role of informing financiers on the importance of the training (Wike et al., 2014). Wiechelt and Ting (2012) note that many employers have a rigid work schedule that does not allow their employees to pursue educational and professional goals. According to Bledsoe-Mansori et al. (2013), all disciplines require continuing professional education to grow. Training helps practitioners in healthcare to seek answers to arising issues and find ways of taking advantage of new opportunities (Harvey & Gumport, 2015). The practitioners often lack the knowledge and resources that can be utilized for positive patient outcomes (Wiechelt & Ting, 2012).

Various expectations are placed on mental health practitioners by service providers, professional associations and government agencies in the sector, including themselves. These competing priorities result in a situation where the practitioners must

deliver on several fronts, empirically supported treatment being key among them. Wike et al. (2014) note that many concepts have been introduced in mental health in the recent past. Apart from empirically supported treatment, other concepts such as evidence-based practice and empirically supported practice have been introduced. Other cases comprise a lack of continuous training results in a situation where mental health practitioners lack a clear understanding of the factors that distinguish these forms of practice (Bledsoe-Mansori et al., 2013). Research knowledge utilization and decision making are slowed and inconvenienced by confusions when the practitioners are trying to implement aspects under these forms of practice. Bellamy et al. (2006) recommended training for each form of care to motivate the mental health practitioners and give them necessary knowledge towards the efficient provision of services.

According to Bledsoe-Mansori et al. (2013), most mental health facilities have supervisors who are not trained on the new interventions and the rationale for their inclusion in mental health treatment. Wiechelt and Ting (2012) note that many policymakers leave supervisors out of the training process. However, it is important that the supervisor be acquainted with the process and outcome of empirically supported treatment programs. A supervisor who is not well-informed about empirically supported treatment will not handle staff resistance and other obstacles associated with empirically supported treatment programs. Wiechelt and Ting (2012) proposed peer supervision as one of the ways of cutting costs and ensuring that empirically supported treatment is followed without conflict. The staff members take charge of each other in a friendly and understanding way. According to Bledsoe-Mansori et al. (2013), many facilities lack

supervisory discussions due to differing perceptions of the treatment process by the practitioners and their supervisors. In such situations, communication is cut, and the mental health practitioners do not feel the need and urgency to implement the empirically supported practice.

According to Wiechelt and Ting (2012), the top cause of resistance to empirically supported treatment is lack of understanding on the entire process. The resistance starts with administrators and policymakers and trickles down to mental health practitioners (Bellamy, Bledsoe, & Traube, 2006). Staff often resents the pressure to deliver empirically supported treatment programs. The resentment results from many factors, including perceived fickleness of administrators and policymakers, lack of relevant equipment and funding (Wike et al., 2014; Gallo & Barlow, 2012). Some practitioners are uncomfortable with changes and feel that implementation of empirically supported treatment increases work demands. The resistance starts with avoiding meetings and training. The staff remains oblivious on empirically supported treatment, and they continue implementing treatments that incorporate minimum or no evidence (Bellamy et al., 2006). Resistance often emerges where there are no channels to engage staff and address their needs. It may be used as a way of getting the administrators to consider these needs and open clear communication channels with junior mental health practitioners. Availability and efficiency of supervision rely on other factors such as time and money (Briggs and McBeath, 2009). A facility or organization can only employ supervisors once there are enough direct care providers. Some facilities also reduce the

level of supervision to save time (Wike et al., 2014). Therefore, elimination of supervision can be viewed as a strategy of saving on costs and time.

Ethical considerations. Many researchers and practitioners view a move toward empirically supported practice as a move away from client preferences and values (Gibbs & Gambrill, 2002, Nevo & Slonim-Nevo, 2011; Webb, 2001). Adoption of empirically supported practice for social workers has become an issue with an ethical implication (McNeece & Thyer, 2004). Respect for individuals and diversity should be a goal of all ethical, social workers but providing these services can be a challenge.

Definitions of illness, symptoms, and treatments can vary among cultural groups. Zayas, Drake, and Jonson-Reid (2011) advised practitioners to consider the beliefs and views of clients carefully before providing treatment, as failing to do so was failing to serve clients. Clinicians must strive to understand their clients and their culture and environment better if treatments are to have their maximum efficacy (Bhugra et al., 2011). Ethical considerations entail being sensitive to the views, values, and feelings of all the clients. Considering the cultural values of the patients draws their attention to the treatment method. They feel included in the entire process and thus are more willing to collaborate (Lie et al., 2011; Betancourt et al., 2003). This inclusion will promote the ability of the practitioner to follow the laid down protocol when providing the evidence-based intervention, thus promoting fidelity.

Clients who belong to minority groups in the United States are faced with problems that the rest of the population may not have to consider. Clients need providers that have the appropriate education and understanding of their culture and language, and

these providers can be challenging to find (Alegria et al. 2009). Clinicians that do not have the required knowledge regarding their client, or are not prepared to serve them, may experience difficulty establishing relationships (Kelley et al., 2014). Therapeutic relationships play a significant role in determining whether treatment will be effective, regardless of the skill of the clinician (King, 2011). The research to support that treatment with that population must be available. This evidence is vital to the success of treatment, and it is scarce and lacking regarding many minority populations. Aisenberg (2008) noted this absence of information and warned providers not to assume that one group will respond to a treatment, in the same way, another might.

Respecting a client's right to make their own choices is another value of the social work profession (NASW, 2008). Sullivan and Carpenter (2010) found that people experiencing mental illness were prone to coercion simply due to their level of understanding. Starin (2006) identified gaps in knowledge among consumers including diagnoses, treatment, and even that multiple treatments might exist to address their symptomology. Evidence-based practice may detract from the consumer's ability to make decisions regarding their treatment if the clinician does not present all the options. The steps of the model do not require a practitioner to inform clients regarding different treatment options or models. However, the model does not disallow this as a practice either (Hays, 2016). It is up to the individual practitioner to provide services that comply with the ethics of the field.

The NASW Code of Ethics provides standards and direction to social workers on how to provide useful interventions effectively while upholding the values of the field. A

critical value is a direction to participate in research to inform the field regarding their practice and to continue to seek knowledge (NASW, 2008). This ethical guideline provides a statement in support of the use of evidence-based practice. It also provides a guideline for researchers to make evidence available to practitioners. This paradigmatic shift has required changes in supervision as well as practice.

Prior to the push toward empirically supported practice and empirically supported treatments, there were no set rules or procedures to guide clinicians toward the most effective treatments for a given population (Castelnuovo, 2010). Where evidence-based practice provided procedure, empirically supported treatments provide treatment options. An empirically supported treatment is a specified psychological treatment that has documented effectiveness in well-conducted, controlled research with a delineated population (Godley et al., 2011). Empirically supported treatments not only allow clinicians to select what might bring the greatest, or fastest progress, to clients in need but also provide the necessary information to avoid harm (Lilienfeld, 2007). However, practitioners are not always accepting of empirically supported treatments (Teague et al., 1998; Smalley et al., 2010).

Thyer and Pignotti (2011) noted a perception among practitioners and researchers that empirically supported treatment programs are manualized and rigid, often ignoring client needs and individuality. Flexibility among empirically supported treatment can vary from model to model. Some researchers have found that their respondents identified empirically supported treatment to be very flexible in practice (Powell, Hausmann-Stabile & McMillen, 2013). Though the perception of empirically supported treatments

may be negative among some within the field, the pressure to implement them continues to mount from legislative and funding bodies.

The U.S. Surgeon General (2001) called the mental health field to action in increasing access to empirically supported treatment options. These events placed pressure on the mental health profession to disseminate and implement empirically supported treatments (McHugh & Barlow, 2010). Unfortunately, the research has not been conducted in a way that would help provide practitioners with directions on how that might best be carried out (McHugh & Barlow, 2010).

Attitudes toward empirically supported treatments. Empirically supported treatment programs are becoming more widely available and accessible to practitioners, (Stanhope, Tuchman & Sinclair, 2011). Organizations, including the Substance Abuse and Mental Health Service Administration (SAMHSA), have provided digital access to programs, including implementation guides and resources. Guidance on sustainability and maintaining fidelity does not appear to have reached many practitioners (Thyer and Pignotti 2011). While implementation is essential, it is a futile effort if the program cannot be sustained with fidelity to the model. Only by maintaining the tenets of the programming and providing treatment as developed and described within the literature can the expected outcomes be achieved (Bellg et al., 2004).

Though the field of social work has moved toward empirically supported practice, research surrounding supervision and empirically supported practice has not been produced at a rate to match the change (Mor Barak, Pyun, & Xie, 2009; O'Donoghue, 2015; O'Donoghue & Tsui, 2012). However, that does not diminish the importance of

supervision in the implementation of empirically supported practice within the field. Gray, Joy, Plath, and Webb (2012) found the nature of supervision and the lack of preparedness of supervisors to support empirically supported practice among their supervisees to be a problem. Given the aforementioned authoritative nature of knowledge transfer within the profession, it is imperative that supervisors be active in supporting empirically supported practice for it to be successful (Powell et al., 2015).

Gallo and Barlow (2012) suggested that the paradigmatic shift to empirically supported practice may have financial needs to be feasible and Wike et al. (2014) identified many clinicians have not received training nor do they possess extensive knowledge of multiple empirically supported treatments. If they were to use evidence-based practice to determine the best treatment, they might be unable to provide the treatment due to lack of training or skill (Wike et al., 2014). Rather than fight the culture of the profession and the lack of availability of multiple empirically supported treatments in one area, a focus could be made on the implementation of empirically supported treatments. Such a move would allow the research supported treatments to permeate practice, and as they demonstrated efficacy, they would gain more favor and use in the field.

Social cognitive theory (SCT) would support that clinicians that observed the success of treatment, or the praise received by those providing effective treatment would be more likely to use empirically supported treatments (Bandura, 1986a; Bandura, 1995). Whether these were selected due to the process of empirically supported practice or through the word of mouth and authoritative knowledge transfer is less important than

clients receiving appropriate and effective treatment. Though in either case, supervisors must be prepared to provide appropriate, high-quality supervision to clinicians, so they might maintain fidelity to the treatments provided.

Attitudes among mental health practitioners toward empirically supported practice and EST vary. Wiechelt and Ting (2012) identified that many practitioners felt they were forced to use ESTs due to the availability of funding rather than it being the best choice for clinical care. These practitioners tended to report that the implementation of ESTs was poorly planned and unaccommodating. In situations where a funding source demanded the use of ESTs with a specific population, practitioners resented the direction and felt that it resulted in an ethical dilemma as it required a specific treatment where they felt there were more appropriate options (Arnd, Caddigan, & Pozzuto, 2010; Bellamy et al., 2012). With pressure applied to implement ESTs from legislative and funding bodies, many clinicians believe that empirically supported practice takes decision making out of the hands of clinicians and ignores their experience and intuition (Gibbs & Gambrill, 2002; Wike et al., 2014). These external pressures appear to have resulted in the growth of negative attitudes among clinicians.

Leadership within community mental health centers frequently holds negative attitudes toward the use of empirically supported treatments as well (Bond et al., 2014). Briggs and McBeath (2009) indicated that administrators often viewed the implementation of new empirically supported treatments as a strain on organizational culture and had negative implications to the implementing agency. Other researchers indicated that those in leadership positions viewed the potential benefits with skepticism,

questioning if the treatments would provide any benefit over treatment as usual (Harvey & Gumport, 2015). Though groups of researchers found negative attitudes, not all researchers have demonstrated consistent results.

Supervisors who maintain a connection to academic institutions through accepting field placements often had positive attitudes toward the use of portions of EST (Baker-Ericzén, Jenkins & Haine-Schlagel, 2013; Wiechelt & Ting, 2012). Although they tended to have negative views toward empirically supported practice and only tended to use parts of EST rather than implementing with fidelity and this may mean that organizations are not supportive of their use.

Negative attitudes toward empirically supported practice or EST may impact organizational culture in a way that impedes the growth and acceptance of EST. Practitioners with interest in empirically supported treatment may often feel unsupported within their organization (Beddoe, 2011; Shaw & Lunt, 2011). In Beddoe's (2011) research consisting of semi-structured individual interviews and focus groups with 40 social workers, it was identified that practitioners felt that research was not valued, and it felt distant from their everyday work. Austin, Dal Santo and Lee (2012) further noted that, due to negative outlooks on research, practitioners who are research-minded often end up isolated from their peers within an organization. Given the overall lack of structure built to support practitioners who are research-minded, it is hypothesized that the prevalence of them in the profession is low (McBeath & Austin, 2015). Viewed through the lens of social cognitive theory, if the organization does not support behavior, is unlikely to reinforce it, and peers have little interest in it, making them less likely to

reinforce it; it is likely that research-oriented behaviors will decrease over time within an individual practitioner.

Mental health service administrators and empirically-supported treatment. David et al. (2012) noted that the burden of carrying out empirically supported mental treatment programs has been left to the practitioners. However, it is important to appreciate that many health service administrators have recognized the impact of these treatment programs and dedicated their time toward ensuring that they cater to the needs of the customers. One role of mental health service administrators towards practitioners is the provision of an enabling working environment (Baker-Ericzén et al., 2013). A conducive environment facilitates collaboration among all stakeholders where every person is motivated to play their role to the optimum.

Health service administrators have a responsibility towards the process of collecting analyzing and applying data. Organization-level studies have been identified as crucial steps towards findings that affect climate and culture in which the practitioners work (Hemmelgarn et al., 2006). According to Hoagwood and Burns (2005), adoption and full implementation of empirically supported treatment only took place in instances where the culture supports it. Technology, for instance, is only adopted in situations where it solves the problems or meets the aspirations in the social context of the organization (Luxton et al. 2011). The management has the responsibility of initiating cultural change where the social context of the organization does not support adoption of technology related to the empirically supported treatment of mental health patients (Fernando, 2010; Leamy et al., 2011). The management has more influence over the

method, choice and daily implementation of interventions. Therefore, they minimize or maximize the overall effectiveness of medical and clinical procedures undertaken in the facility.

Many sectors have difficulties bridging science and practice (Westen et al., 2012). Mental health brings together a variety of scientific knowledge aimed to benefit humanity. The momentum of scientific discovery and theorization of knowledge has not matched its benefit to humanity (Baker-Ericzén, Jenkins and Haine-Schlagel, 2013); Guzzini, 2013; Sandberg and Tsoukas, 2011). Mental health administrators have a role in ensuring that the potential of science is reflected in practice; this is indeed the essence of empirically supported treatment programs (Hemmelgarn et al., 2006).

Funding of empirically supported treatment programs is partly a responsibility of mental health service administrators (Kakuma et al., 2011; Thornicroft et al., 2010). These individuals bring together other mental health workers, clients, and factors of production to facilitate the smooth provision of the services. Practitioners utilize resources given to them by administrators (Lawrence and Kisely, 2010). The administrators have the responsibility of working together with all the relevant parties towards ensuring that their resource capacity matches with the demands of their clientele.

The workplace environment is associated with many barriers in the process of adopting new practices (Addis & Krasnow, 2000). Aarons and Sawitzky (2006) noted that poor cultures and climates have a direct influence over the efficacy and efficiency of mental health care and its outcomes in their study of 301 public sector mental health service providers from 49 programs providing mental health services. Aarons and

Sawistzky used a correlational study employing regression analysis to determine the impact of organizational culture on adoption of evidence-based practice. When the organization's ability to connect science and practice is inhibited, its patient goals are hardly attained. Patterson Silver Wolf et al. (2012) noted that the best way of guaranteeing improved healthcare benefits for clients is to ensure that mental health facilities incorporate empirically supported treatment programs into their system. Use of empirically supported treatments would result in a situation where a practitioner ensures the fidelity of the treatment programs by adhering to the aspects of organizational culture (Baker-Ericzén et al., 2013). The culture and climate in which clients are treated will require and encourage the support of mental health workers, service providers, government agencies, family groups, academic institutions and professional associations towards empirically supported mental health treatment programs.

Role of mental health practitioners in the application of empirically supported mental health and treatment programs. Mental health practitioners are usually at the center of treatment programs. They collect data and information, design treatment programs and bring together the other stakeholders for effective implementation of the proposed plans. Mental health practitioners examined in this research are social workers, counselors, and psychologists. Other general healthcare service providers such as physician's assistants, primary care physicians, and nurse practitioners also play an active role in the provision of empirically supported treatment programs (Fisher, 2011). The treatment programs usually bring together one or several of these practitioners.

According to Harvey and Gumport (2015), mounting a workforce that can fulfill the needs and expectations of clients is a challenge for service providers and creators of empirical based treatment programs. The therapeutic relationship is often at the center of these treatment methods. The beliefs and preferences of practitioners impact the efficiency of service delivery. According to Jensen-Doss et al. (2009), evaluating perceptions toward empirically supported treatments, of 197 practitioners, many practitioners find empirical-based treatment programs too structured and technique-focused. Many mental health practitioners are used to traditional treatment methods and may develop a feeling that the contemporary treatment methods do not guarantee a better outcome.

Baumann et al. (2006) found that many practitioners prefer flexible, eclectic approaches. Many respondents indicated that they would like to draw their interventions from a variety of theoretical orientations. Empirically supported treatments may support versatility but within certain limits. Jensen-Doss et al. (2009), there is a need for a study to determine the beliefs and attitudes of practitioners who will implement intervention programs.

Harvey and Gumport (2015) noted that research into the role of beliefs and attitudes of mental health practitioners is limited by a lack of validated measures. This observation partly relates to this research since the investigator could not locate any validated measures or tools that can be used in assessing the perception of mental health practitioners towards barriers to empirically supported treatment programs. Inability to recognize the problems results in cognitive biases that may result in failures or simply

ineffectiveness of treatment (Weisz, Kuppens, Eckshtain, Ugueto, Hawley and Jensen-Doss, 2013).

According to Lilienfeld et al. (2013), there are instances when practitioners confuse invalidated treatment process and validated ones. The former refers to treatment programs that do not work while the latter refers to those which have not been examined. A competent practitioner must be able to differentiate these two and rally the community behind treatments that have been tested at the personal or facility level (Saxena et al., 2007). There are instances where mental health practitioners favor information that confirms their beliefs. This results in a confirmation bias where data and information that has not been confirmed through research finds its way into mental health practices (Kumpfer et al., 2002). There are perceived causal relationships among the masses. The perceptions can easily infiltrate mental health practice when family members and non-medical professionals such as social workers try to impose their decisions on professional health service practitioners (Bronschtein, 2015). More studies are required on how mental health practitioners perceive the influence of these individuals and how they can eliminate its effect on their ability to maintain fidelity to empirically supported practice.

Empirically supported treatment programs require training of all the people involved for efficient implementation. Therefore, the practitioners must be trained before they can impart their knowledge to other people involved in the implementation of empirically supported treatment programs (Edmond, Megivem, Williams, Rochman, & Howard, 2006). The National Research Council (2010) noted that only 30% of recovery assistance programs require training on empirically supported training programs.

Case managers and mental health workers are general practitioners who coordinate the patient's recovery. They help patients access services such as income, social, housing, counseling and treatment supports (Arnd-Caddigan & Pozzuto, 2010). Case managers have varying educational backgrounds, the most common being social worker. They have a responsibility to coordinate the activities of all the other practitioners. It is vital that mental health service providers consider the educational background versatility of individuals playing this role (MacAteer et al., 2015).

Summary and Conclusions

The field of mental health has gone through many changes over time. The introduction of evidence-based practice is continuing to shape the field (McHugh & Barlow, 2010; Stanhope et al., 2011). As the field moves toward greater acceptance and promotion of evidence-based practice, it requires greater access to empirically supported treatments (Gallo & Barlow, 2012; Wike et al., 2014). Therefore, because fidelity plays an integral role in achieving the outcomes promised by empirically supported treatment, a greater understanding of what is preventing clinicians from providing treatment to fidelity is necessary.

To achieve a better understanding of the barriers to fidelity to empirically supported treatment it would be beneficial to understand the barriers from the perspective of those providing treatment. This study will provide an opportunity for clinicians to provide their perspective. The quantitative design employed was based on literature regarding mental health treatment, fidelity, and empirically supported treatments. The next chapter will discuss the research design, the reasoning for the use of the design,

population, sampling method, procedures for recruiting participants, and the analytical procedures to be used to examine the data in this study.

Chapter 3: Research Method

Introduction

This study addresses a lack of understanding within the field of mental health regarding the impediments to fidelity for empirically-supported treatments. Empirically-supported treatments are often implemented but are difficult to maintain. It is important that the mental health field develop a better understanding for why this occurs and strategies to prevent it. This correlational cross-sectional study involved a survey to explore the perceptions of practitioners regarding what barriers are preventing maintaining fidelity for empirically-supported treatments.

This chapter includes an explanation of the research design and rationale, methodology employed in the study, a discussion of validity and potential threats, and proposed ethical procedures. Details regarding the population, recruitment, and sampling procedures are discussed within the methodology section. Additionally, operationalization of variables is also included along with descriptions of data collection and analysis plans.

Research Design and Rationale

This study involved investigating the relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically-supported treatments in mental health. The dependent variable was perceptions of practitioners regarding barriers to maintaining fidelity.

This study involved a cross-sectional correlational design intended to examine the relationships between the independent and dependent variables. A correlational design was best suited to answer the research question as there was not a clear understanding within the field regarding which of the demographic variables may have been related to the dependent variable. Correlational research does not involve determining causality, as the researcher is not manipulating the independent variable. There also exists the possibility that an unknown variable was responsible for observed relationships or changes, which represents a threat to validity in correlational research, particularly in the social sciences.

The study was descriptive in nature, and a cross-sectional design was well-suited. Frankfort-Nachmias and Nachmias (2008) said that cross-sectional designs were appropriate for the assessment of perceptions of respondents. Additionally, a cross-sectional survey allows for gathering a great deal of useful data quickly at very little cost (Rossi, Wright, & Anderson, 1983; Sue & Ritter, 2012). Sedgwick (2014) said cross-sectional studies tend to be faster, easier, and less expensive than alternative methods. Additionally, they have the benefit of no loss of respondents to mortality due to only requiring one interaction during the study. However, Sedgwick (2014) also identified potential drawbacks including nonresponse bias caused by a potential difference between those who choose to participate and those who decline. Due to the point-in-time nature of a cross-sectional study, it is difficult to determine causality. Though a researcher may be able to demonstrate the relationship between two variables, the variables are being examined at the same time, so cause and effect cannot reasonably be determined

(Frankfort-Nachmias & Nachmias, 2008). As this research was not attempting to determine a causal relationship or the origin of perceptions, a cross-sectional study was appropriate.

A time-series design was considered for use in the study. This design would have been useful for measuring change in perceptions over time since the most recent degree was attained. However, the time required to complete a study with this design was not reasonable. Additionally, the correlational and cross-sectional design allows for the researcher to gather information on a number of variables rather than the more restrictive time-series design which focuses on a single change or intervention and multiple measures over time. A panel study was also considered, as it also would have been useful in measuring the change in perceptions over time similar to a time series design but does not require the rigor of a quasi-experimental design. However, this method also has similar drawbacks such as significantly increased times to complete studies and mortality as a threat to validity and reliability of the study. As I have no funds available to offer incentives to respondents for their continued participation, mortality in this study may have been too high. For these reasons, a cross-sectional correlational design was selected.

Methodology

Population

The population being examined in this study was professionals who provide direct care mental health services in the United States. This study focused on social work, counseling, and psychology professionals who provide direct care. These three categories of mental health professionals play vital roles in interventions by providing

psychotherapy, case management, and other psychiatric services. They form the nerve center of mental health services and are in constant communication with other stakeholders such as managers and administrators of facilities, patients, special interest groups, families, and communities (Trotter-Mathison & Skovholt, 2014). The U.S. Bureau of Labor Statistics (2017) estimated there are 123,900 behavioral health social workers in the United States and the estimates for behavioral health counselors and psychologists (omitting school psychologists) were 241,930 and 34,750 respectively.

Sampling and Sampling Procedures

Sampling strategy. A purposive convenience sampling method was selected for this study. Purposive sampling is when a researcher deliberately selects a portion of the population because of a characteristic of the population rather than using a probability or random sample (Laerd, 2015). Purposive sampling in this study was employed to select licensed behavioral health professionals. Convenience sampling involves to a researcher selecting those potential participants that are most easily available (Frankfort-Nachmias & Nachmias, 2008). In this study, participants were contacted through Facebook groups and a university participant pool. The ease of contacting potential participants with no costs made this the most appropriate feasible sampling strategy. This sampling strategy brought some threats to validity due to lack of randomization. A probability sample was considered but ultimately ruled out due to not having a reasonable and cost-effective way to collect contact information for the entire population of behavioral health professionals in the United States.

While the primary sampling strategy employed was a purposive convenience sample, an element of snowball sampling was used as well. Included in the posting on each social media post was a request that the reader share the link with colleagues who may meet the participation criteria of the study. This allowed a greater reach and potential for more participants. Because not everyone who may meet the criteria to participate may belong to Facebook groups or the Walden participant pool, it was important to allow snowball sampling so that it could be more widely shared.

Sample size calculation. Effect size, alpha, and power were determined by using a standard recommendation in the field made by Cohen. These values were confirmed as standard in the social sciences by Grimm and Yarnold. Power analyses was conducted using G*Power software. The analysis was based on the test family of *F*, using linear multiple regression: fixed model, R^2 deviation from zero, with a priori alpha of .05, and power of .95, using nine predictors (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since obtaining most recent degree, and current role in the field), and calculating for a medium effect size (.15). The result of this G*Power analysis indicated a minimum sample size of 166 participants.

Procedures for Recruitment, Participation, and Data Collection

Recruitment. I contacted prospective participants through two Facebook groups targeting mental health professionals, Social Work Tutor: Group and Professional Mental Health Counselors, Social Workers, & Psychologists. A posting was placed in each Facebook group as well as the Walden University participant pool (https://academicguides.waldenu.edu/researchcenter/resources/participantpool). In the

announcement, a statement was included asking those who view the announcement to share with others they know that may meet the inclusion criteria for participants.

Data collection. Qualtrics was used as the survey platform for this study. Upon clicking the link to the study, potential participants were taken to the first page of the survey. This page contained inclusion criteria questions including that they are over 18 years of age and currently practicing in the mental health field in the United States. Participants were prompted with a yes or no question to confirm that they meet inclusion criteria. If they answered "yes" to all of the inclusion criteria, they were then taken to the informed consent page. If they indicated that they do not meet one or more of the inclusion criteria, they were exited from the survey and thanked for their consideration.

The second page of the electronic survey was the informed consent (see Appendix C). This explained the purpose of the study, the procedure to be undertaken in the research process, and their rights as participants (Bok, 2017). A question at the end of the informed consent form asked the potential participant if they understand the informed consent and consent to participate in the study or not. If they agreed they would then go to the demographic form and if they did not agree they were exited from the survey and thanked for their consideration. No names or signatures were collected as part of the informed consent process or connected to individual level survey data. This allowed for greater confidentiality of responses as I am not be able to trace responses back to a specific individual as no identifying information was collected.

The demographic form (Appendix D) contained 14 questions to identify characteristics of the respondent related to the research question. Respondents answered

multiple choice questions by selecting which best describes them or inputting a number of years for questions that requested that information. Participants may have chosen not to answer any question in the demographic form and continued with the rest of the form and subsequent survey.

The survey of practitioner perspectives followed the demographic form. The survey contained 32 questions on the perceptions of the respondent towards barriers to fidelity to empirically supported treatment programs. Surveys are cost-effective and thus appropriate for studies undertaken by students (Rossi et al., 2013). Surveys by students are not well-funded like in the case of those conducted experienced practitioners under government agencies or research foundations. In this case, the only costs incurred were those associated with obtaining an online survey software service. This study examined mental health practitioners from different geographical locations. Conducting interviews with the practitioners would have involved traveling and accommodation costs. A questionnaire helped in avoiding such expenses and made data more accessible at little or no cost (Leathers & Strand, 2012).

The data collection process utilized an online interface where the survey was hosted and a link posted for respondents via Facebook and the Walden Participant Pool. The process took four weeks. In the communication, I indicated that the survey would be available for four weeks. A reminder was be sent after the survey had been open for two weeks. Additional emails and time for the survey to be open would have only be used if the minimum sample size had not yet been met.

Instrumentation and Operationalization of Constructs

Demographic form. A demographic questionnaire (appendix D) was developed by this researcher and included questions about age, race, gender, country and state of employment, geographic location, length of time in the field, length of time in current position, degree held, field of degree held, level of license held, discipline of license held, length of time since attaining most recent degree, current role in the field. The demographic questionnaire was developed based on questions that were identified through the review of the literature on the subject (Campbell et al., 2013; Harvey & Gumport, 2015; Kutash, Cross, Madias, & Green, 2012; Lee et al., 2016; Wharton & Bolland, 2012) and on what variables are specified in the research question.

Perceptions of Barriers Survey (researcher designed). This survey (Appendix E) was developed by this researcher based on questions that were identified through the review of literature on the subject (Bellamy et al., 2006; Bledsoe-Mansori et al., 2013; Bond et al., 2014; Briggs & McBeath, 2009; Gallo & Barlow, 2012; Harvey & Gumport, 2015; Wharton & Bolland, 2012; Wiechelt & Ting, 2012; Wike et al., 2014). The questions created address the barriers identified in the literature review and will provide sufficient information to answer the research question. Survey questions were designed using answers with a Likert scale (strongly agree, agree, disagree, strongly disagree). Likert scales are frequently used in social sciences to measure attitudes and beliefs (Jamieson, 2004; Joshi, Kale, Chandel, & Pal, 2015) Likert scales provide a reliable method to convert abstract concepts into quantitative data (Frankfort-Nachmias, & Nachmias, 2008).

Construct validity of the survey was addressed through an F review of the survey questions, survey question design and principal component analysis conducted in SPSS. The questions were sent to a colleague with expertise in fidelity to empirically supported treatments through the Center for Innovative Practice at Case Western Reserve University to examine the survey as an expert reviewer. As an expert reviewer, they were able to provide guidance as to whether the survey represents an adequate measure of practitioner perceptions of barriers to fidelity to empirically supported treatment (Frankfort-Nachmias & Nachmias, 2008). Internal consistency was addressed by having similar questions throughout the survey to solicit information on one topic (Rossi et al., 1983; Sue & Ritter, 2012). Each section has four questions to determine whether the respondent perceives that item to be a barrier to maintaining fidelity to empirically supported treatment. Principal component analysis is often used to examine a data set and reduce the number of factors, simplifying the data (Laerd, 2015).

The survey being used for this study was created to measure the perceptions (opinions) of those who work in the field about what the barriers to maintaining fidelity to empirically supported treatment are, it is not yet known if it will be able to be turned into an instrument to measure this going forward. While construct and content validity were established through expert review, additional statistical analyses was completed once data was collected in order to determine if statistical reliability was evident. This was done in order to be able to make recommendations on if future work should be done to revise the survey or if reliability statistics indicated that this could be used as an instrument to measure the concepts in future studies. Reliability was addressed through

the use of a Cronbach's alpha procedure conducted in SPSS. Cronbach's alpha is a statistical procedure that examines internal consistency and is often used with Likert-type questions (Laerd, 2015). As the perceptions of practitioners were measured with Likert-type responses, this was the most appropriate procedure to determine reliability. While a pilot study was not done in this study, if reliability statistics had indicated issues with the measurement tool, this would be addressed in the limitations of the study and directions for future research in Chapter 5.

The survey was divided into eight sections:

- Measures of practitioner perceptions regarding time constraints.
- Measures of practitioner perceptions regarding lack of available funding.
- Measures of practitioner perceptions regarding organizational or administrative support.
- Measures of practitioner perceptions regarding lack of training.
- Measures of practitioner perceptions regarding lack of supervision.
- Measures of practitioner perceptions regarding staff resistance.
- Measures of practitioner perceptions regarding lack of access to research.
- Measures of practitioner perceptions regarding empirically supported treatment, not fitting clientele being served.

Operationalization of variables. The independent variables were collected through the demographic form. The demographic form items and their associated coding can be found in Table 1.

Table 1

Demographic Information

Question	Answers & associated numerical coding (numerical coding will not be visible to participants)			
What is your current age (in years)?	Actual age in years at time of data collection 99=Prefer not to say (excluded from analyses)			
What is your race?	0=White 1=Black/African American 2=Hispanic/Latino 3=American Indian/Alaskan Native 4=Asian 5=Native Hawaiian/Other Pacific Islander 6=Two or more races 99=Prefer not to say (excluded from analyses)			
What is your gender?	0=male 1=female 2=non-binary gender identification 99=prefer not to say (excluded from analyses)			
In what state do you practice for your primary employment in behavioral health?	Region	Division	State	Name
	1	0	00	Northeast Region
	1	1	00	New England Division
	1	1	09	Connecticut
	1	1	23	Maine
	1	1	25	Massachusetts
	1	1	33	New Hampshire
	1	1	44	Rhode Island
	1	1	50	Vermont
	1	2	00	Middle Atlantic Division
	1	2	34	New Jersey
	1	2	36	New York
	1	2	42	Pennsylvania
	2	0	00	Midwest Region
	2	3	00	East North Central Division
	2	3	17	Illinois
	2	3	18	Indiana
	2	3	26	Michigan
	2	3	39	Ohio
	2	3	55	Wisconsin
	2	4	00	West North Central Division
	2	4	19	Iowa

(table continues)

2	4	20	Kansas
2	4	27	Minnesota
2	4	29	Missouri
2	4	31	Nebraska
2	4	38	North Dakota
2	4	46	South Dakota
3	0	00	South Region
3	5	00	South Atlantic Division
3	5	10	Delaware
3	5	11	District of Columbia
3	5	12	Florida
3	5	13	Georgia
3	5	24	Maryland
3	5	37	North Carolina
3	5	45	South Carolina
3	5	51	Virginia
3	5	54	West Virginia
3	6	00	East South Central Division
3	6	01	Alabama
3	6	21	Kentucky
3	6	28	Mississippi
3	6	47	Tennessee
3	7	00	West South Central Division
3	7	05	Arkansas
3	7	22	Louisiana
3	7	40	Oklahoma
3	7	48	Texas
4	0	00	West Region
4	8	00	Mountain Division
4	8	04	Arizona
4	8	08	Colorado
4	8	16	Idaho
4	8	30	Montana
4	8	32	Nevada
4	8	35	New Mexico
4	8	49	Utah
4	8	56	Wyoming
4	9	00	Pacific Division
4	9	02	Alaska
4	9	06	California
4	9	15	Hawaii
4	9	41	Oregon
4	9	53	Washington

99=Prefer not to say (excluded from analyses) *(table continues)*

What type of area is the city where you are employed?	0=Metropolitan (urban areas with over 50,000 people in a densely packed area) 1=Nonmetropolitan (suburban or rural areas that are not in urban areas) 99=Prefer not to say (excluded from analyses)
How many years have you worked in your current field?	Actual time in field since licensure in years 99=Prefer not to say (excluded from analyses)
How many years have you worked in your current position?	Actual time in current position in years 99=Prefer not to say (excluded from analyses)
What level is the highest degree that you hold?	0=Bachelors 1=Masters 2=Doctoral (Psyc D, EdD, JD, etc.) 3=PhD 99=Prefer not to say (excluded from analyses)
What is the discipline associated with your highest degree held?	0=Social work 1=Counseling 2=Psychology 3=Other 99=Prefer not to say (excluded from analyses)
What degree level is required for your current licensure?	0=Bachelors 1=Masters 2=Doctoral 99=Prefer not to say (excluded from analyses)
What is the discipline associated with your licensure?	0=Social work 1=Counseling 2=Psychology 3=Other 99=Prefer not to say (excluded from analyses)

(table continues)

How many years has it been since you graduated with your highest degree?	Actual time in years 99=Prefer not to say (excluded from analyses)
What is your role in the organization you work for?	0=Direct service 1=Supervisor 2=Manager/administrative 3=Educator 4=Other 99=Prefer not to say (excluded from analyses)

Table 2

Total Score on Survey

Survey area	Question answer coding	Items related to area	Total Score
Time	1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	4 items (score range 4-20)	8 areas x 4 items each area=32 items Possible score range: 32-128
Funding	1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	4 items (score range 4-20)	
Organizational support	1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	4 items (score range 4-20)	
Training	1=Strongly Disagree	4 items (score range 4-20)	

(table continues)

	2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	
Supervision	1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	4 items (score range 4-20)
Staff resistance	1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	4 items (score range 4-20)
Access to research	1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	4 items (score range 4-20)
Fit for clientele served	1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	4 items (score range 4-20)

Data Analysis Plan

Data were collected and stored through Qualtrics, the web-based software which will host the survey. Data were downloaded from Qualtrics for analysis using IBM's Statistical Package for Social Sciences (SPSS) software Version 25. Original data were stored on the Qualtrics site so in the event of corruption or error impacting the data following download the original data were still be available for redownload. An

additional copy of the original data has been stored and will remain unedited for a 5-year period following the study.

Data were collected electronically through the Qualtrics survey tool. Data were downloaded, verified against answers in the Qualtrics system, and checked for missing data and outliers. While listwise or case deletion was considered for the handling of missing data, the risk of omitting too much data, and creating an unnecessary threat to validity was considered to be too great. Analysis of the data involved pairwise deletion and removing data if a particular datum is required to test a specific assumption.

The research question addressed in this study is:

RQ: Are there statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically supported-treatments in mental health as measured by the PBS?

H_0*:* There are no statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically- supported treatments in mental health as measured by the PBS.

H_a*:* There are statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the

field) and professional perceptions of barriers to fidelity for empirically-supported treatments in mental health as measured by the PBS.

Descriptives. Frequencies (descriptives) were used to describe the sample demographics (independent variables) as well as answers to the individual survey items, scores in the combined survey areas, and total score distribution. Information including the mean, median, mode, standard deviation, and frequencies was analyzed to summarize information about the groups and responses in the study (Laerd, 2015).

t-Tests. Independent sample *t*-tests were utilized to determine whether there are statistically significant differences between binary groups in the dependent variable (e.g., between males and females) in order to give further insight into the sample that participated and any differences between groups in their responses. Conducting a t-test allows the researcher to determine whether an independent variable related to a standardized coefficient contributed statistically significantly to the results of a multiple linear regression prediction (Laerd, 2015). The analysis of whether a particular coefficient is significant allows the researcher to adjust the model, and make it more effective (Grimm & Yarnold, 2010).

Correlations/multicollinearity. Correlation analysis was used to determine if there were strong correlations between variables before conducting any multiple linear regression analyses. This correlation analysis was completed in order to determine if there is an existence of multicollinearity between variables that may skew the results of the final multiple linear regression analyses. If there were variables that are highly correlated at the level of .7 or above, one or more of those variables were removed from

the final multiple linear regression analysis to avoid multicollinearity (these variables are considered to rise and fall in the same direction and inclusion of both magnify their influence on the multiple linear regression model which can skew the results).

Multiple linear regression. Finally, multiple linear regression was conducted to demonstrate the strength of relationships between the independent and dependent variables. Multiple regression allows the researcher to determine a model to explain the relationship between variables as well as determine how much each variable contributes to the model (Laerd, 2015). This analysis was most appropriate because there were multiple independent variables that may predict the dependent variable, but it was unknown which and how much each dependent variable may contribute (Field, 2013, Frankfort-Nachmias & Nachmias, 2008).

Threats to Validity

External Threats to Validity

The purposive convenience sampling and snowball methods used in this study produced some threats to validity. Selection bias related to the sampling may have impacted this study in two ways (Campbell & Stanley, 1963; Laerd, 2012). The primary sampling method was through the use of social media. Those individuals who do not use social media, or who are not members of the targeted Facebook groups were unlikely to respond to the survey. The addition of snowball sampling as an extension of that sample was unlikely to address this concern. The sampling frame did not include all mental health professionals, and results may not be generalizable to the greater population of practitioners (Frankfort-Nachmias & Nachmias, 2008). Additionally, there may be

differences between those who chose to respond to the survey and those who opted not to (Frankfort-Nachmias & Nachmias, 2008).

Internal Threats to Validity

A thorough literature review did not reveal any studies examining the perceptions of practitioners toward barriers to fidelity to empirically supported treatments, and I have not disseminated a similar study in the past, thus it is unlikely that exposure to the questionnaire or subject matter presented a threat to internal validity (Laerd, 2012). Due to the cross-sectional nature of the study, history, mortality, instrumental and maturation effects were not threats to internal validity (Laerd, 2012).

Statistical Conclusion Validity

I did not mine the data attempting to determine relationships other than those identified in the hypothesis and followed the stated procedures for data collection and analysis, in an attempt to minimize threats to statistical conclusion validity (Laerd, 2015). Additionally, I ensured that the assumptions required for statistical tests were met prior to proceeding with analysis (Field, 2013). However, as the participants may have accessed the survey from anywhere, the setting in which they responded was not under my control. This may have led to distractions being present that may have impacted their input, and thus represented a threat to statistical conclusion validity (Laerd, 2015).

Ethical Procedures

The study was submitted for approval through the Walden Institutional Review Board (IRB) prior to any recruitment of potential participants. The IRB evaluated the proposed study for value and confirmed respondents would not be at risk, nor any

pressure or coercion was present between myself and the respondents. The consent form which was required to be viewed before completing the survey informed respondents of the importance of the research and the procedures involved. The consent form was presented to the IRB for approval prior to the study being conducted.

This study involved human respondents. As this study was focused on a population of college-educated professionals of varying demographics, this researcher did not specifically recruit vulnerable populations. I had no relationship or ongoing contact with the participants and could not exert any power or coercion. The survey did not contain any sensitive questions, require information that is personal in nature or overly invasive, nor require participants to provide identifying information such as name or email.

The respondents were informed of their rights at the beginning of the study. The respondents had the freedom to become part of the study and withdraw at will. The freedom to withdraw may have been good for the study as respondents who felt that they could not offer honest responses in the course of the study had the freedom to withdraw. Savage and Hyde (2014) noted that giving the respondents freedom when providing information enhances the validity of the findings and recommendations of research. The respondents had the freedom to withdraw from the study without the need of getting in touch with myself or providing an explanation. Respondents had the freedom to decide the prompts to which they responded. The consent form indicated that the participants may leave blank any questions that they felt uncomfortable answering.

All data was anonymous was kept confidential and was accessible only by myself and committee members. I, and dissertation committee members, had access to the data on Qualtrics, and once downloaded all data was kept on password protected and encrypted hardware. As the information requested had no identifiable information, respondents were not be able to contact me to have their information removed from the study. Data will be maintained for a period of five years, after which it will be destroyed.

Summary

This study involved the collection of quantitative data using questionnaires. I deemed online questionnaires as the most effective means of data collection because of the busy schedules of participants. Data collected using questionnaires was imported into the SPSS software then analyzed through multiple linear regression to establish how the variables relate. Chapter 4 includes a presentation of the results after the collection and analysis procedures.

Chapter 4: Results

Introduction

The purpose of this quantitative cross-sectional correlational study was to determine how licensed mental health practitioners perceive barriers to sustaining fidelity for empirically-supported treatments. Eligible participants were United States mental health practitioners who were 18 years of age and over. This chapter discusses changes that occurred in the data collection process and results of the data analyses related to the research question. Tables and figures are provided to demonstrate results of analyses.

This chapter provides data analysis that answers the RQ. Additionally, the analyses in this chapter will demonstrate whether relationships existed between demographic variables and perceptions of barriers among respondents.

Data Collection

IRB approval (06-24-19-0534743) was granted on June 24, 2019. Initial recruitment materials (see Appendix A) were posted to the two Facebook groups indicated in Chapter 3 and the Walden participant pool on June 25, 2019. As of September 15, 2019, there had been only 66 responses submitted. On September 16, 2019 a change in procedures form was submitted to the Walden University IRB in order to request the addition of a post on Reddit to promote the study as well as the addition of a boosted paid advertisement post on Facebook targeted to those who identified as being a mental health professional in the United States on their profile. This change in procedures request was approved by the IRB on October 4, 2019. The Reddit post was made on October 6, 2019, and the boosted Facebook post ran for one week beginning October 7,

2019 and ending October 14, 2019. Data collection ended on October 20, 2019 after the required sample size of 166 usable responses was met.

During the data cleaning process, respondents were removed if they only completed the demographic questions and none of the questions pertaining to perceptions of barriers for empirically-supported treatment. This left 178 respondents who completed at least some of the questions on both the demographic scale and the PBS. However, many respondents did not answer every question. As the research question requires an examination of the total scale, data needed to be added for analysis. Following the identification of subscales, an average was calculated and missing data within a scale was input as the average (rounded to the nearest whole number). Imputation of missing survey data given known responses is an accepted method of data cleaning (Brick & Kalton, 1996). Eliminating responses due to missing data was considered, but it would have left too few responses for analyses to be useful. Following the data cleaning procedures, there were 154 respondents who responded to all questions.

Power analysis was conducted using G*Power after the number of respondents was known in order to check the effect size based on the final sample size. The analysis was based on the test family of *F*, using linear multiple regression, fixed models, and R^2 deviation from zero with a priori alpha of .05 and power of .95 using nine predictors (age, race, gender, geographic location, length of time in the field, degree held, length of time since obtaining most recent degree, and current role in the field), and 154 respondents. The result of this G*Power analysis indicated an effect size of .16. The initial test indicated an effect size of .15, due to a lower number of respondents than the target. A

medium effect size was required to be slightly larger, as the analysis is not as senstive with fewer respondents.

Results

Sample Demographics

Table 3 contains the distribution of demographic information for the sample that participated in my study. The majority of respondents were White (88.3%) and female (88.3), held a master's degree (69.1%), and had a license that required that degree (68.0%). Over a third of respondents were between the ages of 25 and 34 (37.1%), and over a third reported living in the Midwest (37.6%). Over half of the respondents were in the field for two or less years (54.5%), and most were in direct service roles (72.5%).

Table 3

Demographic Variable Frequencies

Variable	Category	Percent
Age	18 to 24	7.1%
	25 to 34	37.0%
	35 to 44	33.1%
	45 to 54	18.2%
	55+	3.9%
	Prefer not to say (excluded from analyses)	0.6%
Race	White	88.3%
	Black/African American	0.6%
	Hispanic/Latino	1.3%
	American Indian/Alaskan Native	0.0%
	Asian	1.9%
	Native Hawaiian/Other Pacific Islander	1.3%
	Two or more races	4.5%
	Prefer not to say (excluded from analyses)	1.9%

(table continues)

Gender	Male	8.4%
	Female	88.3%
	Non-binary gender identification	2.6%
	Prefer not to say (excluded from analyses)	0.6%
Region of Practice (see Appendix G for additional information)	Northeast Region	22.1%
	Midwest Region	37.7%
	South Region	31.2%
	West Region	9.1%
Geographic Area	Metropolitan (urban areas with over 50,000 people in a densely packed area)	45.5%
	Nonmetropolitan (suburban or rural areas that are not in urban areas)	54.5%
Years in Field	0 to 2 years	13.0%
	2.5 to 5 years	27.3%
	5.5 to 10 years	26.6%
	10.5 to 15 years	11.7%
	15.5 to 20 years	11.0%
	20+ years	10.4%
Years in Current Position	0 to 2 years	53.2%
	2.5 to 5 years	33.8%
	5.5 to 10 years	8.4%
	10.5 to 15 years	3.2%
	15.5 to 20 years	0.6%
	20+ years	0.6%
Highest Degree	Bachelors	21.4%
	Masters	69.5%
	Doctoral (PsyD, EdD, JD, etc.)	2.6%
	PhD	6.5%
Discipline of Degree	Social work	43.5%
	Counseling	25.3%
	Psychology	19.5%
	Other	11.7%

(table continues)

Level of Degree Required by Licensure	Bachelors	24.7%
	Masters	67.5%
	Doctoral	7.8%
Years Since Highest Degree	0 to 2 years	34.0%
	2.5 to 5 years	24.2%
	5.5 to 10 years	22.9%
	10.5 to 15 years	8.5%
	15.5 to 20 years	5.2%
	20+ years	5.2%
Role in Organization	Direct service	72.7%
	Supervisor	10.4%
	Manager/administrative	7.1%
	Educator	5.2%
	Other	4.5%

Sample Demographics Compared to Behavioral Health Professions

Race. The participants of the study were primarily White (88.3%), with only a single respondent identifying as Black/African American. The national average for the social work profession is 67.9% White, the counseling profession 70.6% and psychologists 85.8% (U.S. Census Bureau, 2017). Additionally, nationally the averages for African Americans in the social work profession are 21.3%, the counseling profession reports 19.8% and psychologists 6.8% (U.S. Census Bureau, 2017). Thus, my sample had a comparative underrepresentation of African Americans and an overrepresentation of White respondents. Generalizations regarding the impact of racial demographics on perceptions of barriers should be considered carefully.

Gender. Participants of the study were mostly female with 88.3% reporting they identified as female, where the Social Work profession is represented by 81.1% female, counseling 73% female, and psychologists 71.7% (U.S. Census Bureau, 2017). The comparison is somewhat flawed, in that the Census Bureau did not report anything other than male and female while the study included non-binary as an option for respondents. There was an overrepresentation of females in the respondents. This was not a large overrepresentation of social workers, but much greater when compared to psychologists. Generalization may be acceptable but should be approached carefully in regard to psychologists.

Geographic area. I was unable to identify population comparison data regarding the geographic area of respondents. It is unknown if this is representative of the population of mental health professionals. However, the U.S. Census Bureau (2016) reported 80% of U.S. citizens live in urban areas while 54.5% of survey respondents identified working in nonmetropolitan areas. It is unlikely survey respondents were representative of the population of mental health professionals, and generalizations should not be made.

Overall generalizability. Given the information available regarding the demographic characteristics of the population of mental health professionals as discussed above, caution should be used in generalizing this data to the population as a whole (Frankfort-Nachmias & Nachmias, 2008). It is unclear whether differences in the sample were due to the sampling method that I used, as I was unable to identify information regarding the demographic characteristics of mental health practitioners who identify as

such on social media or join social media groups centered on their profession. Thus, available information was not sufficient to make a determination regarding whether recruitment methods were responsible for the differences in demographics within the sample from those in the profession (Frankfort-Nachmias & Nachmias, 2008).

Distribution of Responses on Perceptions of Barriers

Table 4 below contains the distribution of frequencies related to answers related to perceptions of barriers for the sample that participated in my study (See Appendix D for PBS). The majority of respondents indicated that empirically supported treatments (ESTs) required reasonable demands of time (87.1%), funding (82.5%), administrative support (77.5%), practitioner training (96.1%) and supervisor training (92.7%). However, the majority of respondents indicated that they did not have enough time (53.7%) or funding (64.0%) to implement, nor the funding (54.3%) to maintain ESTs.

Table 4

Frequencies of Perceptions of Barriers Item Responses

Requires a reasonable amount of:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Mean Rating
Time	35.7%	50.6%	9.1%	2.6%	1.9%	1.84
Funding	38.3%	44.8%	9.1%	7.1%	0.6%	1.87
Administrative Support	42.2%	34.4%	13.6%	9.1%	0.6%	1.92
Practitioner Training	72.1%	24.0%	3.9%	0.0%	0.0%	1.32
Supervisor Training	53.9%	39.6%	3.9%	2.6%	0.0%	1.55
Have enough to implement:	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Mean Rating**
Time	3.9%	24.0%	18.8%	46.1%	7.1%	3.29
Funding	1.9%	17.5%	18.2%	46.8%	15.6%	3.56
Administrative Support	4.5%	26.0%	30.5%	31.8%	7.1%	3.11
Practitioner Training	3.9%	29.9%	22.7%	37.0%	6.5%	3.12
Supervisor Training	5.2%	31.2%	23.4%	35.7%	4.5%	3.03
Have enough to maintain:	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Mean Rating**
Time	5.8%	25.3%	24.7%	33.1%	11.0%	3.18
Funding	2.6%	19.5%	25.3%	39.6%	13.0%	3.41
Administrative Support	2.6%	29.2%	30.5%	31.8%	5.8%	3.09
Practitioner Training	3.9%	31.8%	20.1%	38.3%	5.8%	3.10
Supervisor Training	2.6%	30.5%	22.1%	37.7%	7.1%	3.16
Not having is a barrier:	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Mean Rating**
Time	42.9%	39.0%	9.1%	8.4%	0.6%	1.85
Funding	45.5%	37.7%	9.7%	7.1%	0.0%	1.79
Administrative Support	26.6%	39.0%	23.4%	10.4%	0.6%	2.19
Practitioner Training	38.3%	44.8%	7.8%	7.8%	1.3%	1.89
Supervisor Training	33.1%	42.2%	18.2%	5.8%	0.6%	1.99

Table 5 demonstrates respondents indicated staff resistance being a barrier (59.5%) to maintaining fidelity to ESTs. Participants indicated disagreement with practitioners having access to necessary research to implement (53.9%) ESTs, though they indicated less disagreement with access to necessary research to maintain (48.7%) fidelity to ESTs. Participants also responded with disagreement that practitioners had access to ESTs appropriate to implement with their clients (54.2%).

Table 5

Frequencies for Perceptions of Barriers Regarding Staff Resistance, Access to Research, and Applicability

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Mean Rating
Do not lead to staff resistance	1.9%	11.0%	7.1%	63.6%	16.2%	3.81
Overcome staff resistance	5.2%	64.9%	23.4%	5.8%	0.6%	2.32
Staff resistance not a barrier	1.9%	16.9%	11.7%	56.5%	13.0%	3.62
Reasonable access to research	36.4%	50.6%	9.7%	3.2%	0.0%	1.80
Have research to implement	3.2%	23.4%	19.5%	42.2%	11.7%	3.36
Have research to maintain	3.9%	24.0%	23.4%	40.9%	7.8%	3.25
Research not a barrier	3.9%	14.3%	13.6%	49.4%	18.8%	3.65
Applicable to populations	40.9%	35.7%	5.2%	14.9%	3.2%	2.04
Good fit for clients	35.1%	44.2%	15.6%	4.5%	0.6%	1.92
Access to ESTs	7.1%	22.7%	16.2%	46.1%	7.8%	3.25
Applicability not a barrier	18.2%	35.7%	24.7%	18.2%	3.2%	2.53

Reliability

Factor analysis. Factor analysis was conducted to determine whether subscales were present through an inductive statistical analysis. Nine subscales were identified ranging from two to five items each (See Appendix E for subscales and scoring). Table 7

contains the subscales identified in factor analysis as well as the Eigenvalue result of factor analysis.

Table 6

Factor Analysis Results and Identified Scales

	Eigenvalue	Number of items	Items
Training and Overcoming Resistance	5.96	5	23-4. Practitioners have enough training to implement ESTs 23-5. Supervisors have enough training to implement ESTs 24-4. Practitioners have enough training to maintain ESTs 24-5. Supervisors have enough training to maintain ESTs 27. Practitioners can overcome staff resistance to implement ESTs
Time and Funding	3.79	4	23-1. Practitioners have enough time to implement ESTs 23-2. Practitioners have enough funding to implement ESTs *(table continues)* 24-1. Practitioners have enough time to maintain ESTs 24-2. Practitioners have enough funding to maintain ESTs
Barriers	2.64	5	25-1. Not having enough time is a barrier to provide ESTs to fidelity 25-2. Not having enough funding is a barrier to provide ESTs to fidelity 25-3. Not having enough administrative support is a barrier to provide ESTs to fidelity 25-4. Not having enough supervisor training is a barrier to provide ESTs to fidelity 25-5. Not having enough practitioner training is a barrier to provide ESTs to fidelity (table continues)

Access	1.96	4	30. Practitioners have enough access to literature to implement ESTs with fidelity 31. Practitioners have enough access to literature to maintain ESTs with fidelity 32. Access to literature is not a barrier to fidelity to ESTs 36. Practitioners have enough access to appropriate ESTs to implement with their clients
Fit for Clients	1.79	3	34. ESTs are applicable to all of the populations I work with 35. ESTs are a good fit for the clients I work with 37. ESTs are applicable to the population(s) I work with and I do not see this as a barrier
Reasonable Resources	1.57	3	22-1. Utilizing empirically supported treatment requires a reasonable amount of time 22-2. Utilizing empirically supported treatment requires a reasonable amount of funding 22-3. Utilizing empirically supported treatment requires a reasonable amount of administrative support
Staff Perception and Resistance	1.33	2	26. Negative staff perceptions of ESTs do not lead to resistance that becomes a barrier 28. Staff resistance is not a barrier to continuing to provide EST to fidelity
Reasonable Demand for Training	1.18	2	22-4. Practitioners have enough practitioner training to maintain EST with fidelity 22-5. Practitioners have enough supervisor training to maintain EST with fidelity
Access to Expertise/Support	1.04	3	23-3. Practitioners have enough administrative support to implement EST with fidelity 24-3. Practitioners have enough administrative support to maintain EST with fidelity 29. ESTs require a reasonable amount of access to research literature

Cronbach's alpha. Cronbach's alpha was run to determine the reliability, or internal consistency, of the overall scale as well as the nine subscales of training and

overcoming resistance, time and funding, barriers, access, fit for clients, reasonable resources, staff perception and resistance, reasonable demand for training, access to expertise and support.

Table 7

Cronbach's Alpha Value for Subscales

	Cronbach's Alpha
Overall	0.80
Training and Overcoming Resistance	0.83
Time and Funding	0.82
Barriers	0.75
Access	0.78
Fit for Clients	0.79
Reasonable Resources	0.62
Staff Perception and Resistance	0.71
Reasonable Demand for Training	0.61
Access to Expertise/Support	0.54

Group Comparisons (t-Tests)

Independent t-Tests were conducted to determine if there were any statistically significant differences between groups on the overall score on the perceptions of barriers scale for gender, race, education level, licensure differences, and role. There were no statistically significant differences in group scores for gender (p = .37), race (white/non-white p = .93), education level (undergraduate/graduate p = .48), licensure discipline (social work/other p = .59), or role (direct service/managerial p=.14). This indicates that there were not any differences between scores of groups in these demographics that would need additional investigation.

Assumptions of Linear Regression

Multicollinearity. A correlation analysis was conducted to test the assumption of multicollinearity. Multicollinearity occurs when two or more of the independent variables are highly correlated with each other, should they both be included in linear regression the result could be negatively impacted (Field, 2013; Grimm & Yarnold, 2000). The results of the correlation analysis can be found in table 8.

Table 8

Pearson Correlation Values

	PBS	Age	Race	Gen.	Area	Yrs. in Fld.	High. Deg.	Role	Disc.	Deg. for Lic.	Yrs. Since High.
PBS		-0.20	0.04	0.01	0.03	-0.03	-0.05	0.02	-0.06	-0.03	-0.07
Age	-0.20		0.12	0.03	-0.03	0.62	0.21	-0.14	0.19	0.18	0.56
Race	0.04	0.12		0.04	0.02	0.06	0.04	0.04	0.04	-0.10	0.03
Gender	0.01	0.03	0.04		-0.11	0.08	0.12	0.17	0.11	0.06	-0.04
Area	0.03	-0.03	0.02	-0.11		-0.12	0.00	-0.09	-0.02	0.02	-0.15
Years in Field	-0.03	0.62	0.06	0.08	-0.12		0.16	-0.13	0.15	0.10	**0.78**
Highest Degree	-0.05	0.21	0.04	0.12	0.00	0.16		-0.06	0.09	**0.85**	0.10
Role	0.02	-0.14	0.04	0.17	-0.09	-0.13	-0.06		0.13	-0.03	-0.14
Discipline	-0.06	0.19	0.04	0.11	-0.02	0.15	0.09	0.13		0.02	0.10
Degree for License	-0.03	0.18	-0.10	0.06	0.02	0.10	**0.85**	-0.03	0.02		0.10
Years Since Highest	-0.07	0.56	0.03	-0.04	-0.15	**0.78**	0.10	-0.14	0.10	0.10	

Years in field and years since degree had a Pearson value of .78 (p<.001), meaning the two variables were closely correlated. Highest degree held and highest degree required by license had a Pearson value of .85 (p<.001), meaning the two

variables were also closely correlated. One variable from each pair needed to be removed from the regression model, and the two chosen were years since degree and highest degree required by license. years since degree was chosen because it had a Pearson value of .78 with Years since degree and it also had a statistically significant correlation with age (r=.56, p<.001). Highest degree required by license was selected because it shared a Pearson value of .85 and overall level of education would not be represented if the highest degree held was selected. The two variables that were selected to remain in the model were years in field and highest degree held. These variables allowed the research question to be addressed, by including both education and years in the field.

Following the correlation analysis and selection of variables to include in the model, multicollinearity was tested again through variance inflation factor (VIF). There was no multicollinearity as assessed by VIF. No VIF value over 10 was observed among the variables (Hair et al., 2014).

Other assumptions. There was homoscedasticity as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. No outliers were observed in the data, this was assessed by viewing the standardized residual values and studentized deleted residuals. No values were three standard deviations or greater. The assumption of normality was not violated as assessed by visual inspection of the normal P-P plot of regression standardized residual dependent variable.

RQ: Are there statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the

field) and professional perceptions of barriers to fidelity for empirically supported-treatments in mental health as measured by the PBS?

H_0: There are no statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically- supported treatments in mental health as measured by the PBS.

H_a: There are statistically significant relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically-supported treatments in mental health as measured by the PBS.

Multiple linear regression. A multiple linear regression analysis was conducted to determine if there was a statistically significant relationship between the variables indicated in the research question. I used the enter method in SPSS for the linear regression. R^2 for the overall model was 24.9% with an adjusted R^2 of 6.2%. Cohen's f^2 was calculated to be .07 a small effect size according to Cohen. Age was the only variable that was found to be related to overall score on the PBS at a statistically significant level ($p = 0.02$). Therefore, the null hypothesis was not rejected.

Table 9

Linear Regression Results

Model	β	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	T	Sig.
(Constant)	96.01	14.91	-	6.44	0.00
Age	-0.52	0.22	-0.46	-2.32	**0.02**
Race	0.07	2.02	0.00	0.03	0.97
Gender	6.77	4.48	0.20	1.51	0.14
Area (rural etc.)	-1.50	2.81	-0.07	-0.53	0.60
Years in field	0.33	0.29	0.22	1.12	0.27
Highest degree held	3.25	2.22	0.20	1.47	0.15
Role	-1.59	1.32	-0.15	-1.20	0.23

Summary

The independent sample t-tests demonstrated that there were no statistically significant differences between demographic groups. Correlation analysis indicated that there were two statistically significant strong relationships between two pairs of variables. The two variables were removed to ensure multicollinearity did not impact the results of the multiple linear regression. Assumptions of homoscedasticity and normality in the data set were met, and no outliers were present. Multiple linear regression revealed one statistically significant relationship between demographic variables (age) of the respondents and perceptions of barriers among mental health professionals, so the null hypothesis is not rejected. Chapter 5 will include implications of the results of the study as well as recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative cross-sectional correlational study was to determine how licensed mental health practitioners perceive barriers to sustaining fidelity for empirically-supported treatments. I conducted a survey of mental health practitioners across the U. S. in order to determine relationships between professional demographics (age, race, gender, geographic location, length of time in the field, degree held, license held, length of time since attaining most recent degree, current role in the field) and professional perceptions of barriers to fidelity for empirically-supported treatments in mental health as measured by the PBS. Primary data were collected from respondents who are active practitioners in mental health across the United States through an online survey.

This study was conducted to provide further information that might be used to inform use of scarce resources. While it is unlikely to create change on its own, it is an important step in understanding perceived fidelity barriers for empirically-supported treatments. It was determined that most demographic variables were not statistically significant in terms of perceptions of mental health professionals, although age was found to be related at a statistically significant level to PBS score. Although not my primary purpose, it was determined that the PBS is a statistically reliable instrument that may be able to be used in the future to further investigate this topic. This chapter will discuss limitations in terms of generalizability and interpretation, recommendations for future research, and implications for social change.

Interpretation of the Findings

Examining results through the lens of the social cognitive theory, and given prior research, some potential explanations for the responses can be proposed. An experienced clinician may be less likely to attempt to use a new treatment due to their experience and success in the past with different skills (Taylor & Betz, 1983). If those skills were not easily translated or perceived to be similar enough to the new treatment, the clinician may be less likely to attempt this new behavior (Lee et al., 2016). It is important to note years in the field did not have a statistically significant relationship with perceptions of barriers, as only age was found to have a relationship with the dependent variable at a statistically significant level. Wiechelt and Ting (2012) found that time available to practitioners decreased as they had more experience in the field, which would reinforce the idea that experience also shares a relationship with perception of barriers. This may be because the majority of participants (87.6%) had been in their current position for 5 or less years. Years in current position was not related to perceptions of barriers at a statistically significant level, but age was.

While I was unable to confirm a statistically significant relationship between demographic characteristics and perceptions of barriers to maintaining fidelity for empirically-supported treatments other than age, a number of findings were revealed. One finding was that 87.1% of respondents agreed or strongly agreed that the time required for empirically supported treatments was reasonable. However, 28.3% of respondents did not believe that they had enough time to implement and 31.2% could not maintain those treatments with fidelity. This indicates dissonance in terms of demands

being reasonable but not having enough resources to meet those demands. Time was indicated as a barrier by 81.9% of respondents, even though demands on time were perceived as reasonable which was different from conclusions of other researchers. Wharton and Bolland (2012) indicated time constraints for practitioners were related to lack of funding, and treatments may be chosen based on what can be done quickly and efficiently even if they do not work as well. This may be because mental health is a field where amount of funding is closely related to the time spent with clients. However, respondents in this study appeared to perceive these as reasonable demands, regardless of identifying them as barriers. Wike et al. (2014) identified that time was limitation associated with empirically-supported treatments, thus practitioners must dedicate more time to these treatments than others they may use.

Perceptions regarding funding were similar to time, which again may be related to the fact that these two barriers are tied closely together in the mental health field. A majority of respondents (82.5%) indicated that the amount of funding required to provide empirically-supported treatments was reasonable but indicated that they did not have enough funding to implement (64%) or maintain (54.3%) fidelity. The majority (83.2%) also indicated that funding was a barrier to fidelity for empirically-supported treatments, even though the demands of funding were reasonable. This trend continued with questions related to administrative support, practitioner training, supervisor training, and access to research. Respondents appeared to have the perception that resource requirements were reasonable, but the resources were not available to practitioners, so they were barriers. This may mean that mental health practitioners do not perceive they

have adequate support to be successful in these areas. Austin, Dal Santo and Lee (2012) identified research-minded practitioners as often being isolated from their peers.

Wiechelt and Ting (2012) reported research recommendations as being key to practitioners setting goals and Gallo and Barlow (2012) noted research provided motivation for practitioners to achieve the outcomes found in research literature. However, I found that respondents did not believe that they had adequate access to research related to empirically-supported treatments. This means that participants may be indicating that they do not have enough information about these treatments, resources needed, or barriers that may exist in relation of these treatments. I did not ask questions specifically about knowledge involving these treatments or how comfortable they were implementing these treatments, so this may be an area of study that researchers may need to collect data on in the future to put responses to the PBS in context. The use of empirically-supported treatments is dependent upon the goal for better care and outcomes for individuals receiving treatment, but if resources and knowledge and understanding are too scarce, clinicians may not have the necessary motivation to put these treatments into practice.

Respondents reported slightly fewer perceptions of barriers when it came to maintenance compared to implementation of empirically-supported treatments. This held true in terms of time (44.1% versus 53.2%), funding (52.6% versus 62.4%), and administrative support (37.6% versus 38.9%), but not practitioner training (44.1% versus 43.5%), and supervisor training (34.3% versus 36.7%) where respondents reported slightly less agreement.

Nearly all of the barriers I identified in the literature review and incorporated into the PBS were also perceived to be barriers by a majority of the respondents (time, funding, administrative support, practitioner training, supervisor training, staff resistance, and access to research). However, there was not universal agreement among participants on what the barriers were. Respondents were less likely to report administrative support (67%) and supervisor training (73.5%) as barriers than practitioner training (81.8%), time (82.4%) and funding (84.1%). While the discrepancy between reasonability of demands for resources and availability of resources may lead to questions regarding perceptions of support, these results could be perceived as feeling more support from their supervisors than the mental health system overall. The mental health and counseling field is built upon an authoritative structure, where practitioners are trained by and learn from the experienced people in the field (Gambrill, 1999). This concept is confirmed by the social cognitive theory where practitioners are likely to take on the behaviors and related attitudes of those perceived as successful (Bandura, 2014; Lent et al., 1994). A lack of perceived support from the system at-large, while feeling support from direct supervisors may indicate an insulation within the field from outside influences, further reinforcing the authoritative system already present.

The single barrier that respondents did not report perceiving as a barrier was applicability to the population being served. This is a somewhat unexpected result, as the provision of empirically supported treatments to diverse populations has been described by researchers as an ethical issue facing the field. Several researchers reported that applicability was a notable problem with empirically supported treatments (Aisenberg,

2008; Bhugra et al., 2011; McNeece & Thyer, 2004; Zayas, Drake & Johnson-Reid, 2011). However, it would appear that the practitioners who responded to the survey did not share that assessment as only 21.7% of respondents indicated that this was a barrier to the provision of ESTs. There are a number of possible reasons for this result, including practitioners viewing the population they serve as applicable, lack of diversity in populations served in the sample, differences in those sampled in this study and those studied in other research, lack of understanding on the topic by respondents, or others. However, this is an important issue that warrants further study as the availability of applicable empirically supported treatments for all populations may have a significant impact on the mental health field.

Limitations of the Study

This study had a number of limitations to its validity, reliability, and generalizability. As the study was correlational, causation cannot be determined . While age shared a statistically significant relationship with perceptions of barriers, it cannot be said that age caused perceptions to change. Next, this study involved closed-ended questions that limited the discretion of respondents to provide information. It is possible that there were barriers that I did not include in the PBS that would have been important, and respondents could not provide that information because of the instrument used. The sample of respondents also presented a number of limitations.

The purposive sample used may not have been representative of the population in a number of ways, and given the demographics of the respondents, it is clear that it was not. Several groups were underrepresented in the sample, including African Americans,

men, and those practicing in urban settings. Thus, it is unlikely that the results are generalizable to the greater population of mental health professionals. This may have been due to the sampling method, but demographics regarding the population of social media users who are mental health practitioners are not available for comparison. While the sample lacked diversity, it is also unclear what populations were served by the respondents of the study. As noted in the previous section, respondents were unlikely to report applicability to the population served as a barrier but the population they serve was not asked in the survey. That piece of information may have been important to how the respondent answered the question.

Additionally, the sample suffered due to being smaller than was ideal. As the number of respondents who completed the entirety of the PBS was too small, data cleaning procedures were necessary to ensure analyses could be completed. The sample was also collected entirely from the Internet, resulting in a limitation as only those with Internet access were able to participate. Finally, in regard to the sampling method, there may have been a limitation regarding differences between those who completed the survey and those who chose not to.

The PBS was created for use in this study, and thus presents some limitations regarding validity and reliability. The scale was reviewed by a content expert and based upon a thorough review of the literature but has not been rigorously tested for psychometric properties. In regard to reliability, the subscales initially proposed were found to have poor internal consistency. In response to this finding a factor analysis was conducted to identify more reliable subscales. While this addressed the internal

consistency for this study, it is important that these subscales are retested in future studies and with larger sample sizes to ensure these are reliable measures.

Finally, respondents indicated a lack of access to research, which may have represented a lack of information and understanding about empirically supported treatments. If they were lacking basic information necessary to answer the questions in an informed way, their perceptions, and thus their responses in the PBS may have been skewed. As the PBS did not address this information, it may be an area for future studies to improve upon, to provide added context to the responses collected.

Recommendations

I examined the perceptions of mental health professionals and while participation was open to a diverse population, that diversity was not reflected in those who responded. The respondents were disproportionately White, female, and social workers when compared to the broader mental health provider population. Further research exploring the perceptions of men, African Americans, and psychologists in relation to barriers to sustaining fidelity to empirically supported treatments may be beneficial. This could be achieved with future studies targeting specific groups of individuals or a study using accessing much larger.

Discrepancies between the respondents' perceptions of reasonable demands for resources and perceptions of those resources being unavailable to practitioners were a notable finding. While this was a small sample, and it was not the purpose of the study, it may have highlighted an issue that warrants future study. Lent et al. (1994) reported professionals are less likely to maintain interest, set goals or attempt professional

behaviors that they do not believe they will be successful in. If lack of support undermines a professional's perception of possible success, then their work and the care they provide to clients could be negatively impacted (Allen et al., 2004). Therefore, future research in the area of resources and perceptions of practitioners should be conducted in order to determine if greater understanding of resource allocation and availability could improve practitioner satisfaction and perception of support.

Finally, I was contacted by multiple professionals during the data collection stage. They had been excluded from the study due to leaving the profession, being retired, or not being in the United States. They appeared to be passionate regarding their feelings on this topic, and believed they had important information to provide. While they may not have been appropriate for this study, it may be beneficial to further this research by having a future study where those who are no longer actively engaged in the profession as some of these barriers may be why they left. It would also be important to study those who practice in different countries than the United States to determine if views on the topic are different internationally.

Implications

I sought to bring about positive social change through conducting this study in relation to directing future inquiry, informing educational efforts, providing information that would assist in addressing barriers, increasing the rate of sustainability for empirically supported treatment, and ultimately to client care. These implications ranged from short to long-term and across the micro, mezzo and macro levels. With recognition

this is only an exploratory study and is unlikely to bring about change on its own, each of these implications for social change may be realized eventually.

There are a number of directions that can be taken from this research to further the knowledge of the field on this topic. The results of the study may add to the general understanding of the barriers to fidelity to empirically supported treatment and can inform future researchers on possible directions for their research. Additionally, the PBS was created as part of this study and other researchers may want to use this instrument to continue to measure the concept of barriers to fidelity to empirically supported treatment. If others use this instrument it can also help to further establish validity and reliability (Frankfort-Nachmias & Nachmias, 2008).

This study highlighted a single factor (age) that shared a statistically significant relationship with perceptions of barriers to fidelity to empirically supported treatment. That information could be a basis to create educational materials to older professionals or ensuring that those professionals are being included in efforts to expand and maintain empirically supported treatments. The information could also be used to enhance educational efforts to demonstrate that all professionals can be successful in the use ESTs regardless of age and experience. While further research to confirm these findings is necessary, it is an initial step in informing the field.

Sustainability of empirically supported treatments and improved care to clients are both long-term implications if this work is continued, enhanced, and expanded upon. The field faces scarce resources and would benefit from ensuring that treatments that are implemented are able to be sustained (Saxena et al., 2007). Continuing to understand the

why and how that can best be achieved is imperative, and this research can provide information to support that goal. If resources are better managed, and empirically supported treatments can be maintained to achieve the outcomes associated with their use, care to clients can be improved (McHugh, et al., 2009; Norcross, 2002).

Conclusion

Practitioners' perceptions of barriers are likely to impact whether or not they will engage in and maintain fidelity to empirically supported treatments. These treatments often provide the best outcomes for clients receiving care. Thus, their use is important in the mental health field. Additionally, a great deal of time and funding go into their implementation. Sustaining these important and effective services serves to ensure that these resources are not wasted. A full understanding of the perceptions of barriers is beneficial in ensuring fidelity is maintained, and these treatments remain available to the populations that need them. The findings of this study may contribute to the that understanding.

This study provided a few key points that may provide some benefit to the knowledge base surrounding empirically supported treatment in mental health. As professionals age, they may perceive more barriers to fidelity. This finding should be followed up on with a larger sample that can be generalized to the entire population. Another finding is professionals may be feeling a lack of support and resources in order to implement effective treatment strategies. A majority of respondents reported professionals did not have enough time, funding or access to the research needed to provide empirically supported treatment. As these are the same treatments have been

identified as the most effective in helping clients, this paradox is concerning and deserves the attention of researchers and the field. Further understanding and research is necessary to provide the support professionals need to help those they work to serve.

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Appendix A: Recruitment Post

Dear mental health professionals,

I am a PhD student at Walden University and have been practicing in the mental health field for approximately 15 years. I am conducting a survey on your perceptions of barriers to maintaining empirically supported programs. Empirically supported programs, for the purpose of this survey, are defined as: mental health interventions that, through controlled clinical research, have demonstrated statistical, clinical change.

The collected data will be used for completion of my dissertation. Your responses are extremely important. The survey should take around 10 minutes to complete. All responses will be anonymous. If you would like to take the survey, please click the link below, or copy the URL into your browser:

<<insert link>>

Additionally, if you have colleagues you believe would like to complete this survey; please share the link with them.

Appendix B: Inclusion/Exclusion Questions

Do you currently work in the mental health field in the United States? Yes, No

Are you over 18 years of age? Yes, No

Appendix C: Demographic Form

Please input information or select the response that best applies to you.

1. What is your current age (in years)? ___ years
2. What is your race? White, Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Asian, Native Hawaiian/Other Pacific Islander, Two or more races, prefer not to say
3. What is your gender? Male, Female, Non-Binary Gender Identification, Prefer Not to Say
4. In what state do you practice for your primary employment in behavioral health? AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY, prefer not to say
5. What type of area is the city where you are employed? Metropolitan (urban areas with over 50,000 people in a densely packed area), Nonmetropolitan area (suburban or rural areas that are not in urban areas)
6. How many years have you worked in your current field? ____ years
7. How many years have you worked in your current position? ____ years
8. What level is the highest degree that you hold? Bachelors, Masters, Doctoral, PhD
9. What is the discipline associated with your highest degree held? Social work, Counseling, Psychology, or Other

10. What degree level is required for your current licensure? Bachelors, Masters, or Doctoral
11. What is the discipline associated with your licensure? Social work, Counseling, Psychology, or Other
12. How many years has it been since you graduated with your highest degree? ___ years
13. What is your role in the organization you work for? Direct service (spend more than half of your time providing behavioral health services directly to, or on the behalf of, clients), Supervisor (spend more than half of your time providing supervision or guidance to direct service providers), Manager/Administrator (spend more than half of your time monitoring service provision, budgets, compliance issues, etc), Educator (spend more than half of your time educating behavioral health students or conducting research), other.

Appendix D: Perception of Barriers Scale (PBS)

Definitions:

Empirically Supported Treatment – Those specific treatments that have demonstrated efficacy in controlled, rigorous, research experiments with specific populations.

Fidelity – The provision of a treatment as designed and demonstrated effective in research.

Administrative Support – Backing by supervisors, managers and administrators demonstrating a culture of acceptance or promotion of empirically supported treatment.

Intent:

I am interested in your perspective on the barriers to implementing empirically supported treatment with fidelity in community-based mental health.

Please rate your level of agreement with the following statements:

Organizational Support

1) **Utilizing empirically supported treatment (EST) requires a reasonable amount of _____.**

a) Time Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

b) Funding Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

c) Administrative Support Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

d) Practitioner Training Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

e) Supervisor Training Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

2) Practitioners have enough _____ to <u>implement</u> EST with fidelity.

a) Time Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

b) Funding Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

c) Administrative Support Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

d) Practitioner Training Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

e) Supervisor Training Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

3) Practitioners have enough _____ to <u>maintain</u> EST with fidelity.

a) Time Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

b) Funding Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

c) Administrative Support Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

d) Practitioner Training Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

e) Supervisor Training Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

4) **Not having enough _____ is a barrier to continuing to provide EST to fidelity.**

a) Time Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

b) Funding Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

c) Administrative Support Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

d) Practitioner Training Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

e) Supervisor Training Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

Staff Resistance

5) **Negative staff perceptions of EST's <u>do not</u> lead to resistance that becomes a barrier.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

6) Practitioners can overcome staff resistance to <u>implement</u> EST with fidelity.

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

7) **Practitioners can overcome staff resistance to <u>maintain</u> EST with fidelity.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

8) **Staff resistance is <u>not</u> a barrier to continuing to provide EST to fidelity.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

Access to Research

9) **Empirically supported treatment (EST) requires a reasonable amount of access to research literature.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

10) **Practitioners have enough access to research literature to <u>implement</u> EST with fidelity.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

11) **Practitioners have enough access to research literature to <u>maintain</u> EST with fidelity.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

12) **Not having enough access to research literature is <u>not</u> a barrier to continuing to provide EST to fidelity.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

Client population

13) **Empirically supported treatments (EST) are applicable to all of the populations I work with.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

14) **EST is a good fit for the clients I work with.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

15) **Practitioners have enough access to appropriate ESTs to implement with their clients.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

16) **ESTs are applicable to the population(s) I work with, and I do not see this as a barrier to fidelity.**

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

Appendix E: Scoring the PBS

Scoring items:

Items on the PBS are scored as follows: 1 = Strongly agree, 2 = Agree, 3 = Neutral, 4 = Disagree, and 5 = Strongly Disagree.

The exceptions to this are, questions 4a, 4b, 4c, 4d and 4e are scored in reverse: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree.

Total PBS Score:

The total score for the PBS is attained by adding all scores together, as identified in the scoring items section. Scores will range between 32 and 160. Where a higher score indicates identifying more barriers, and a lower score indicates identifying less barriers.

Subscales:

Training and Overcoming Resistance

A score for this subscale can be attained by totaling the scores for items: 2d, 2e, 3d, 3e and 6. The score for this subscale should be between 5 and 25.

Time and Funding

A score for this subscale can be attained by totaling the scores for items: 2a, 2b, 3a, and 3b. The score for this subscale should be between 4 and 20.

Barriers

A score for this subscale can be attained by totaling the scores for items: 4a, 4b, 4c, 4d, and 4e. The score for this subscale should be between 5 and 25.

Access

A score for this subscale can be attained by totaling the scores for items: 10, 11, 12, and 15. The score for this subscale should be between 4 and 20.

Fit for Clients

A score for this subscale can be attained by totaling the scores for items 13, 14, and 16. The score for this subscale should be between 3 and 15.

Reasonable Resources

A score for this subscale can be attained by totaling the scores for items 1a, 1b, and 1c. The score for this subscale should be between 3 and 15.

Staff Perception and Resistance

A score for this subscale can be attained by totaling the scores for items 5 and 8. The score for this subscale should be between 2 and 10.

Reasonable Demand for Training

A score for this subscale can be attained by totaling the scores for items 1d and 1e. The score for this subscale should be between 2 and 10.

Access to Expertise/Support

A score for this subscale can be attained by totaling the scores for 2c, 3c and 9. The score for this subscale should be between 3 and 15.

Appendix F: Survey as It Appeared in Qualtrics

Exclusionary questions

Do you currently work in the mental health field in the United States?

- Yes
- No

Are you over 18 years of age?

- Yes
- No

Informed Consent

CONSENT FORM

You are invited to take part in a research study about your perceptions toward barriers to maintaining empirically supported treatments in mental health practice. The researcher is inviting mental health professionals, over 18 years of age, who are practicing in the United States to be in the study. I obtained your name/contact info via Facebook groups (Social Work: Tutor, or Professional Mental Health Counselors, Social Workers & Psychologists) or the Walden Participant Pool . This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Chris Streidl, who is a PhD candidate at Walden University. You might already knowthe researcher as a colleague, but this study is separate from that role.

Background Information:

The purpose ofthis study is to determine howlicensed mental health practitioners perceive barriers to sustaining fidelity to empirically supported treatments.

Procedures:

If you agree to be in this study, you will be asked to:

- Complete an online survey that will take approximately __ minutes.
- Complete the survey only once.

-

Here are some sample questions:

- How many years has it been since you graduated with your highest degree?
- Utilizing empirically supported treatment requires a reasonable amount of time. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
- Empirically supported treatments are applicable to the population I work with, and I do not see this a barrier to fidelity. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree

-

Voluntary Nature of the Study:

This study is voluntary. You are free to accept or turn down the invitation. No one at Walden University will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as stress or becoming upset. Being in this study would not pose risk to your safety or well being.

This study will benefit the field by providing information that may be used to direct future inquiry, and may assist in enhancing organizations' abilities to maintain fidelity to empirically supported treatment. This would allow resources to be managed more effectively.

Payment:

There is no payment associated with the completion of this survey.

-

Privacy:

Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. Even the researcher will not know who you are. The researcher will not collect nor use your personal information for any purpose outside of this research project. Data will be kept secure by only the researcher and dissertation committee chair having access through password protection. All data that is downloaded for analysis will be kept on encrypted devices. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email at christopher.streidl@waldenu.edu. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 612-312-1210. Walden University's approval number for this study is **IRB will enter approval number here** and it expires on **IRB will enter expiration date.**

Please print or save this consent form for your records.

Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it, please indicate your consent by Answering "Yes, I agree" on the following question.

Do you consent to participating in this study?

- ○ Yes, I agree
- ○ No, I do not agree

Demographics

Please input information of select the response that best applies to you.

What is your current age in years?

What is your race?

- ○ American Indian/Alaskan Native
- ○ Asian
- ○ Black/African American

- Hispanic/Latino
- Native Hawaiian/Other Pacific Islander
- White
- Two or more races
- Prefer not to say

What is your gender?

- Male
- Female
- Non-Binary Gender Identification
- Prefer not to say

In what state do you practice for your primary employment in behavioral health?

- AL
- AK
- AZ
- AR
- CA
- CO
- CT
- DE
- FL
- GA
- HI
- ID
- IL
- IN
- IA
- KS
- KY
- LA

- ME
- MD
- MA
- MI
- MN
- MS
- MO
- MT
- NE
- NV
- NH
- NJ
- NM
- NY
- NC
- ND
- OH
- OK
- OR
- PA
- RI
- SC
- SD
- TN
- TX
- UT
- VT
- VA
- WA
- WV
- WI
- WY
- Prefer not to say

What type of area is the city where you are employed?

- Metropolitan (urban areas with over 50,000 people in a densely packed area)
- Nonmetropolitan (suburban or rural areas that are not in urban areas)

How many years have you worked in your current field?

How many years have you worked in your current position?

What is the highest degree that you hold?

- Bachelors
- Masters
- Doctoral
- PhD

What is the discipline associated with your highest degree held?

- Social Work
- Counseling
- Psychology
- Other

What degree level is required for your current licensure?

- Bachelors
- Masters
- Doctoral

- PhD

How many years has it been since you graduated with your highest degree?

What is your role in the organization you work for?

- Direct Service (spend more than half of your time providing behavioral health services directly to, or on the behalf of, clients)
- Supervisor (spend more than half of your time providing supervision or guidance to direct service providers)
- Manager/Administrator (spend more than half of your time monitoring service provision, budgets, compliance issues, etc)
- Educator (spend more than half of your time educating behavioral health students or conducting research)
- Other

Organizational Support

Definitions:
Empirically Supported Treatment - Those specific treatments that have demonstrated efficacy in controlled, rigorous, research experiments with specific populations.
Fidelity - The provision of treatment as designed and demonstrated effective in research.
Administrative Support - Backing by supervisors, managers, and administrators demonstrating a culture of acceptance or promotion of empirically supported treatment.

Intent:
I am interested in your perspective on the barriers to implementing empirically supported treatment with fidelity in community-based mental health.

Please rate your level of agreement with the following statements:

Utilizing empirically supported treatment (EST) requires a reasonable amount _____.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Time	O	O	O	O	O
Funding	O	O	O	O	O
Administrative support	O	O	O	O	O
Practitioner training	O	O	O	O	O
Supervisor training	O	O	O	O	O

Practitioners have enough _____ to implement EST with fidelity.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Time	O	O	O	O	O
Funding	O	O	O	O	O
Administrative support	O	O	O	O	O
Practitioner training	O	O	O	O	O
Supervisor training	O	O	O	O	O

Practitioners have enough _____ to maintain EST with fidelity.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Time	O	O	O	O	O
Funding	O	O	O	O	O
Administrative support	O	O	O	O	O
Practitioner training	O	O	O	O	O
Supervisor training	O	O	O	O	O

Not having enough _____ is a barrier to continuing to provide EST to fidelity.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Time	O	O	O	O	O

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Time					
Funding					
Administrative support					
Practitioner training					
Supervisor training					

Staff Resistance

Negative staff perceptions of EST's do not lead to resistance that becomes a barrier.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Practitioners can overcome staff resistance to implement EST with fidelity.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Staff resistance is not a barrier to continuing to provide EST to fidelity.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Access to Research

EST's require a reasonable amount of access to research literature.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Practitioners have enough access to research literature to implement EST with fidelity.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Practitioners have enough access to research literature to maintain EST with fidelity.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Not having enough access to research literature is not a barrier to continuing to provide EST to fidelity.

- Strongly agree
- Agree
- Neutral

- Disagree
- Strongly disagree

Client population

EST's are applicable to all of the populations I work with.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

EST's are a good fit for the clients I work with.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Practitioners have enough access to appropriate EST's to implement with their clients.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

EST's are applicable to the population(s) I work with, and I do not see this as a barrier to fidelity.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree