Supporting the well-being of children and families: A snapshot of evidence-based practices in Minnesota

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There is strong interest in funding behavioral health and parent support programs that are proven to improve outcomes for children and families. Minnesota Management and Budget identified 81 evidence-based practices (EBPs) that have been shown to produce favorable impacts on outcomes related to mental health, substance abuse, parenting, or child well-being, especially for families at risk of child protection involvement. In collaboration with the Minnesota Department of Human Services, we surveyed providers across the state to understand the landscape of EBPs that are currently offered in Minnesota, the demand for receiving these services, and the barriers preventing providers from expanding them.

Availability of evidence-based practices

Figure 1: Location of at least one EBP

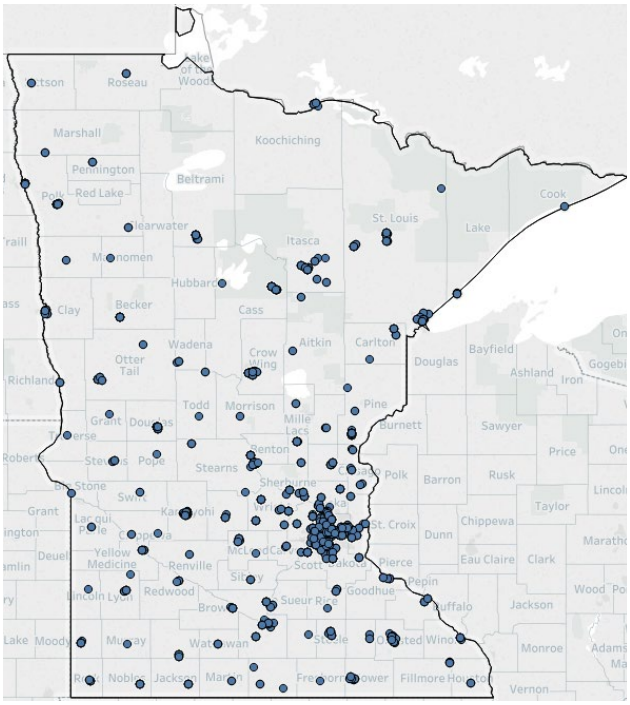


Figure 1 shows a map of the distribution of EBPs across the state where each dot represents a provider location where at least one EBP is offered. Providers in Minnesota reported offering 74 of the 81[1] evidence-based practices that were included in the survey, and EBPs were available in 82 of the 87 counties. Roughly half (49%) of providers reported offering more than one EBP, and typically providers offer between 4 and 5 different EBPs. An interactive version of the map is available at https://mn.gov/mmb/results-first/survey.jsp

We separated the EBPs into three categories (mental health, substance abuse, and parenting support) based on the targeted outcome(s) of the EBP. Figure 2 shows the most commonly offered EBPs. Providers reported offering more mental health and substance abuse services that are evidence-based practices. In general, parent support services had limited availability compared to mental health and substance use EBPs.

Figure 2: Most commonly offered EBPs

Evidence-Based Practice	# of Providers	# of Locations
Mental Health		
Cognitive Behavioral Therapy (Youth)	54	146
Cognitive Behavioral Therapy (Adults)	50	149
Family psychoeducation	41	101
Trauma Focused-Cognitive Behavioral Therapy (Youth)	41	88
Substance Abuse		
Cognitive-Behavioral Coping Skills Therapy	69	149
Relapse Prevention Therapy	49	104
Motivational Interviewing for substance use disorder	49	109
Parent Support		
Healthy Families America	34	34
Nurse-Family Partnership	30	49
Circle of Security	19	25
Motivational Interviewing for child welfare	19	26

Adherence to evidence-based practices

For each EBP, we asked providers whether they offered certain key features for that particular service. Key features included elements such as required training or certification for providers, the setting in which the service is delivered, whether it is group-based or individual, and the duration and frequency. Providing key features is critical to ensuring that the service produces the positive outcomes that have been shown in the research. The provision of key features was self-reported by survey respondents, and was not independently verified.

Of all the EBPs that were reported by providers, they indicated that 20 percent were missing one or more key features. The mostly frequently cited EBPs that were missing key features included Family Psychoeducation (N=18), Mental Health Medication Management (N=16), and 12-Step Facilitation Therapy (N=10). Survey responses also revealed that providers reported adherence to all of the key features for some EBPs, such as Cognitive Behavioral Coping Skills Therapy (N=62), Relapse Prevention Therapy (N=46), and Cognitive Behavioral Therapy (N=44).

In follow-up interviews and open-ended responses to the survey, providers shared some of the challenges they face in adhering to all of an EBP's key features. A common theme was that the recommended duration and frequency of an EBP was often difficult to achieve, due to low participation, lack of staff time, or the structure of the program (e.g., a 30-day treatment program would not be able to provide 12 weekly therapy sessions). Hiring staff with the background required by a given EBP could be challenging, and some providers reported using staff with less training than recommended (e.g., an individual with a bachelor's degree instead of a master's degree).

Providers indicated that EBPs often require additional documentation to demonstrate adherence to the model. This creates burden for staff and sometimes requires them to record the same information twice. It also creates new challenges for IT systems that need to be adapted or developed to accommodate the new data.

Finally, a few providers voiced a concern that EBPs in general do not allow the flexibility that providers need to address the complex issues their clients face. There is a perception that EBPs offer a one-size-fits-all approach that does not always allow space for providers to use their practice-based knowledge and other clinical training. They expressed interest in tools or guidance that could help them assess their own adherence to the evidence-based practice, including what kinds of adaptations would be permissible while still maintaining fidelity to the model.

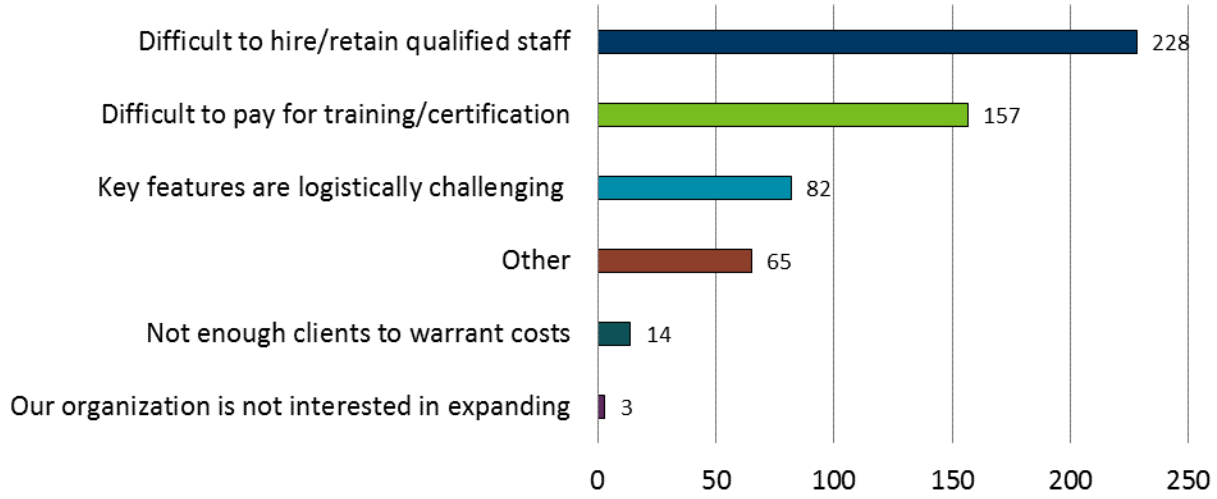
Demand and barriers to expanding capacity

When few evidence-based practices are available, communities may not be able to adequately support children and families who are facing challenges around mental health, substance abuse, and child protection involvement. In order for EBPs to improve these outcomes, they must be accessible and available to the individuals who need them.

In Minnesota, there is a gap between the need for EBPs and their availability in communities. Across all of the EBPs in the survey, providers reported that demand exceeded their capacity to provide services 56 percent of the time. The largest gaps were reported for Cognitive Behavioral Therapy for youth (N=18), Cognitive-Behavioral Coping Skills Therapy (N=18), and Adult Rehabilitative Mental Health Services (N=17). When providers did not have the capacity to serve a client, they reported that they were most likely to refer the client elsewhere or delay services.

Providers cited a number of challenges to expanding their capacity to meet the demand in their communities (see Figure 3). In general, very few respondents reported that they were not interested in expanding existing services or offering new ones. This suggests that most are open to expanding their offering of EBPs, and in fact, providers indicated a number of EBPs that they were interested in offering but were currently unable to do so due to these barriers.

Figure 3: Number of times providers reported each barrier



In follow-up interviews, providers reported that they were often unable to offer competitive wages for qualified staff and noted a shortage of qualified staff statewide, both of which limit their ability to expand their use of EBPs. This is especially true for EBPs that require in-home services, and for those that include a medication component and necessitate partnerships with physicians or psychiatrists. Initial and ongoing costs of training and certification (including travel, lost billable hours, and fees) were sometimes prohibitive. Providers used various strategies to address these barriers, including creating partnerships with other community organizations, seeking charitable contributions, and seeking grants that could cover some of the costs of training and certification.

Opportunities for supporting and expanding EBPs

The results of the survey point to a few areas that could benefit from additional support. First, there are a number of EBPs that many providers reported offering with all of the key features, but they reported not being able to meet the demand in their communities. Some examples include Trauma Focused- and traditional Cognitive Behavioral Therapy, Adult Rehabilitative Mental Health Services, Motivational Interviewing, and Healthy Families America. These services are already being provided with adherence to the model, and there are children and families waiting to receive them. Supports for providers to scale-up these EBPs would help to ensure that a greater number of Minnesotans could benefit from them.

Second, there are some EBPs for which providers reported lacking the full capacity to meet the demand and some difficulty providing the service with all of the key features. Although these EBPs are offered in many communities, the implementation quality may not be high. Despite this, there is demand for the EBPs and interest from providers in receiving support to bolster their fidelity because of the evidence of effectiveness for these services. Some examples include Family Psychoeducation, Mental Health Medication Management, 12-Step Facilitation Therapy, and The Incredible Years. Providers may benefit from technical assistance to increase their adherence to the specific requirements of these EBPs, as well as financial support (e.g., grants for certification and training, increased reimbursement rates) to expand their capacity.

Methods

Minnesota Management and Budget, in consultation with the Department of Human Services, conducted an online survey and qualitative interviews to collect the information described in this brief. We selected the 81 evidence-based practices because a) they align with the prevention activities described in the federal Family First Prevention Services Act (FFPSA), which became law in 2018, and b) they have sufficient rigorous research demonstrating effectiveness on outcomes related to mental health, substance abuse, parenting, or child well-being. FFPSA allows federal reimbursement for a set of evidence-based services aimed to prevent children from being placed in out-of-home care. The federal government is currently in the process of determining which services will qualify for reimbursement.

We asked survey respondents to indicate which of the 81 EBPs they offer. For each service they offer, they answered questions about whether they provide all of the key features, their capacity and demand for the EBP, and any barriers to expanding their capacity to offer the EBP.

We sent the survey to the authorized agents of mental health clinics, licensed treatment programs, residential facilities for adults and children in the state of Minnesota, and other therapeutic providers who self-identified as offering EBPs and requested to fill out the survey (N=415; response rate was 35%). We also sent the survey to 84 county human services offices (response rate for counties was 62%). Finally, we invited 493 programs affiliated with Help Me Grow (e.g., Head Starts, schools, Early Childhood and Family Education programs) to respond (response rate for this group was 9%). In total, the survey was sent to 992 respondents. The survey was open from December 2018 to March 2019.

We supplemented the survey data with information from the following sources: inquiries to the purveyor organizations that provide certification for some of the EBPs, information about Minnesota Department of Health grantees who provide EBPs, DHS licensing information indicating organizations that provide medication assisted therapies, and a similar survey that we conducted of county human services offices in the summer of 2018 (this survey only asked about EBPs in the parent support category). Based on this information, we supplemented the data for 43 providers.

Finally, to more deeply understand the challenges in offering these EBPs, we conducted a 30-minute telephone interview with 18 individuals who represented a range of providers offering a variety of different EBPs.

A list of the 81 EBPs is available here: https://mn.gov/mmb-stat/results-first/list-of-ebs.pdf. For more information, please contact ResultsFirstMN@state.mn.us.

[1] Although part of the survey, two services were not included in this analysis. Crisis Text Line was not included because it is administered statewide and available in all Minnesota counties. Family Guided Routines Based Intervention and Caregiver Coaching was not included because it currently does not have sufficient rigorous research demonstrating effectiveness.