Chapter 20
Continuing Issues Regarding Evidence-Based Practice in Practice

In the preceding chapters, we have attempted to show how social workers can use evidence-based practice (EBP) to enhance practice with their clients and how to incorporate the principles and steps of EBP into clinical decision-making processes. We think that the EBP process is a "public idea" that is actively shaping public opinion about health-care practices (Tanenbaum, 2003). It is also shaping funding and administrative practices, research funding priorities, and even research education for mental health professionals. Evidence-based medicine (EBM) and EBP have many supporters. For example, the Open Clinical (undated) organization states that:

For supporters, EBM has three main advantages:

> (1) It offers the surest and most objective way to determine and maintain consistently high quality and safety standards in medical practice; (2) It can help speed up the process of transferring clinical research findings into practice; (3) It has the potential to reduce health-care costs significantly.The approach, however, is not without its opponents. These consider that EBM risks downplaying the importance of clinical experience and expert opinion, and that the conditions under which clinical trials used to define best practice take place are hard to replicate in routine practice. (Benefits section)

Despite many potential advantages, there are also continuing issues regarding the use of EBP in clinical social work practice.

In this chapter, we summarize and review several of the unresolved issues and challenges raised about EBM and EBP. We hope that this review prompts the reader to think critically about EBP and social work. We also hope that this review will prompt discussions with others in the profession and promote solutions that make EBP more optimally useful in practice.

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Challenges to EBP in Practice

There are several challenges to the EBP movement. There are also challenges within the social work profession regarding the adoption and acceptance of EBP. In fact, EBP has been met with resistance by many social workers working in various settings (Bellamy, Bledsoe, Mullen, Fang, & Manuel, 2008; Murphy & McDonald, 2004; Nelson, Steele, & Mize, 2006; Pollio, 2006; Proctor et al., 2007; Rosen, 2003; Trinder, 2000a, 2000b).

Yunong and Fengzhi (2009) point out three preconditions for social workers to accept the EBP model. They state:

> First, research evidence must be relevant to social work practice; otherwise, it is meaningless and a waste of practitioners' time to use it. Second, social work practitioners should have adequate time and financial resources…Third, the benefits for using evidence for social workers should outweigh or at least be equal to the costs of using it… Accordingly, after adopting EBP, their salaries should be increased and their workloads decreased. Otherwise, it would not be reasonable to expect them to accept the EBP approach. (p. 178)

That is, (1) EBP research and practice must be consistent with social work purposes and values and useful in practice, (2) payers and administrators must provide resources and time to implement it fully, and (3) social workers should be compensated for learning and undertaking EBP practice. What follows is a discussion of some of the everyday challenges that social workers and other mental health professionals have documented that they face in using EBP in practice.

Social Justice and EBP

As discussed previously in Chaps. 2, 3, and 4, for many social workers, EBP appears to be at odds with some of the core values of social work. These include inadequately addressing structural issues that may contribute to social justice concerns and further pushing social work toward a limited medical model orientation rather than promoting biopsychosocial and interdisciplinary models (Baines, 2006; Cristofalo, 2013; Murphy & McDonald, 2004; Rosen, 2003; Trinder, 2000a). With a heavy reliance on the medical model to orient practice questions and literature searches, systemic, cultural, and other social diversity issues are not given priority equal to individual pathology. This seems inconsistent with core social work value on social justice. It also devalues social work's unique person-in-environment worldview. Since most EBM/EBP research projects are aimed at individual interventions rather than the systemic causes of mental health problems, the focus of most research remains on the resolution of an individual's deficits rather than on the broader social structures that also contribute to human suffering, such as poverty, racism, or homophobia (Caputo & Mason, 2009). Similarly, EBP research rarely examines sources of strength and resilience in clients. This medical model approach may fail to address needs and practices in many "safety net" settings in which social workers practice to serve vulnerable populations (Cristofalo, 2013). Both Wells, Merritt, and Briggs (2009) and Mapp, Boutte-Queen, Erich, and Taylor (2008) note a racial bias in the lack of attention to populations of color in child welfare research. Social work's person-in-environment perspective and attention to the needs of diverse populations are needed to make EBP more useful in real-world practice.

We also note that most EBM/EBP research discussed in social work is directed to determining treatment outcomes. We have also purposefully adopted this focus in this book. Readers should keep in mind that EBP research can also address prevention programs and even the effects of policies (Oxford Centre for Evidence-Based Medicine, 2016: Rubin, 2008). Another focus of EBP research is the cost-benefit analysis of specific procedures. Yet social justice efforts have not yet been overtly and sufficiently included in the EBP framework, nor in prioritized for funding.

Limitations to Available Research

While we note that EBP has begun to alter priorities for research funding, most treatments and service programs have not been studied using high-quality methods. The large number of specific DSM diagnoses, including their subtypes, means that more than 1000 specific diagnoses would need to be studied to even have a beginning database of "what works" in mental health. In reality most high-quality studies focus, appropriately, on high incidence and high-cost disorders such as depression, anxiety, and schizophrenia. This means that the concerns of many clients, including children and elders, are not well reflected in some Cochrane or Campbell systematic reviews for practice use. For example, Evans, Berkman, Brown, Gaynes, and Weber (2016) note that racial bias is evident in the available research on services for persons who have serious mental illnesses. Clinical social workers will have to search for individual studies on diverse populations which takes considerable time and expert research evaluation skills. There is also no guarantee that at the end of a search, the located and relevant results will offer clear and practical guidance for decision-making.

As social workers, we also think that DSM diagnoses are only starting points for evaluating real-world client needs. We have noted throughout this book that clients with comorbid disorders, with significant social stressors, and who may suffer from socially structured oppression are not yet well addressed by EBM and EBP outcome research. Galea, Tracy, Hoggatt, DiMaggio, and Karpati (2011) used a meta-analysis of the Medline research reports to estimate that 176,000 deaths in the United States in 2000 were caused by racial segregation, 162,000 to low social support, and 133,000 to individual-level poverty. They conclude that "the estimated number of deaths attributable to social factors in the United States is comparable to the number attributed to pathophysiological and behavioral causes" (Abstract). The evidence base on which EBM and EBP rest needs enormous expansion to be optimally useful for practice decision-making. Social work's person-in-environment worldview and focus on vulnerable populations can add significantly to the utility of EBM and EBP research.

There is also little evidence that the use of treatment manuals improves client outcomes. Truijens, Zühlke-van Hulzen, and Vanheule (2018) found no better outcomes with the use of treatment manuals, though they may create somewhat more consistency across settings and individual practitioners. They conclude that "Manualized treatment is not empirically supported as more effective than nonmanualized treatment. While manual-based treatment may be attractive as a research tool, it should not be promoted as being superior to nonmanualized psychotherapy for clinical practice" (Abstract, Conclusions).

Ironically, clinical social workers and others who undertake EBP literature searches often suffer from information overload (Greenhalgh, Howick, & Maskrey, 2014; Tanjong-Ghogomu, Tugwell, & Welch, 2009). Lots of information is available in print and online, but finding truly useful and relevant research results may be all the more difficult due to the sheer volume of available material. Even with sources for high-quality systematic reviews and excellent search tools, finding useful research can be like finding a needle in a haystack. Both the lack of specific research and the volume of available research information combine to make "doing" EBP difficult and time-consuming. Further, the time needed to research the best available evidence may not be compensated in many agency settings.

Realities of Real-World Practice

Other critiques of EBP are that empirically supported treatments (ESTs) do not take into account the "messiness" of real-life practice (Bellamy et al., 2008; Murphy & McDonald, 2004; Nelson et al., 2006; Pollio, 2006; Proctor et al., 2007; Rosen, 2003). One social worker states that highly controlled studies are "irrelevant" and "absurd" (Nelson et al., 2006, p. 404) regarding their utility for practitioners. As discussed throughout this book, EBM/EBP researchers generally seek to study narrowly defined and tightly controlled samples to ensure homogeneity and strong internal validity. Most often, the selection criteria highlight only a single diagnosis or a diagnosis in combination with specific client demographic criteria (most often age and/or gender).

These limitations often translate into a very narrow group of individuals who are actually studied in EBP research. The samples may, or may not, be representative of the larger and more diverse, often multiproblem, populations who apply for clinical services. Results of high-quality studies may be based on samples that are quite different from the typical clients with whom a social worker is working. For example, a clinician is working with a 10-year-old Korean-American girl who has experienced a trauma and now has a diagnosis of post-traumatic stress disorder as well as a severe learning disability. It will be difficult to locate research reports that capture both her complex diagnostic picture and her specific cultural background. For social workers who work with diverse clients, applying the findings from a research study can feel unrealistic or impossible. One social worker in a study regarding the applicability of research findings to her practice stated, "Our kids don't come in nice neat packages. Most have multiple diagnoses, and I don't know what's out there for kids with multiple diagnoses" (Nelson et al., 2006, p. 409). Another stated "The research has to be with out-of-control kids, not control kids" (Nelson et al., 2006, p. 404). These quotes reflect the wariness that many social workers have about how to transfer what is done in a "lab" with what they see in the "real world."

Accessibility of Research

For other social workers, the accessibility of research further limits the use of currently available knowledge. This has two parts. First, social workers find it difficult to locate research findings. Second, they also question their ability to understand and evaluate the research they can locate (Bellamy et al., 2008; Proctor et al., 2007). For example, a study aimed at translating empirically supported treatments (ESTs) into a community-based practice setting. One participating social worker said, "To me, the evaluations of the research, it's like really complicated, and the statistical stuff, to me, I start to zone out." Another said, "I can't see myself going through 15 articles and calculating the effect size" (Bellamy et al., 2008, pp. 63–64). Indeed, EBP research summaries can be very complex and detailed (Rousseau & Gunia, 2016). Most MSW level social work education does not adequately prepare clinical practitioners to critically evaluate research reports including statistical results. The plain language abstracts of Cochrane Collaboration and Campbell Collaboration systematic reviews may be easier to understand, but most still contain many unfamiliar statistics and may omit important caveats about the summarized research.

Further complicating the interpretation of research is that the majority of empirical research articles reporting findings regarding a particular intervention are not written for clinicians but for other researchers (Yunong & Fengzhi, 2009). This makes it a challenge for lay clinicians to understand the findings of different research projects and apply those findings to their own practices. We hope that through this book, we have made the evaluation of the research a bit more accessible and less daunting by sharing various ideas and resources. We also provide readers with research review materials in Chaps. 6, 7, and 8 and in the Glossary. However, the reality is that for many social workers, the prospect of evaluating research evidence remains a difficult and intimidating task. It is also a task that most social work agencies do not support adequately.

We also note that each of the literature searches completed for the cases in this book took no less than 3 hours. Where there was no systematic review, literature searches for individual articles often took much longer. Funding and other supports for the time to locate and to evaluate relevant research literature must be made available to make doing EBP realistic.

Ignores the Expertise of the Clinician

We have emphasized throughout this book that the clinician is the "glue" that integrates the components of the EBP process. Still, many clinical social workers think that EBP ignores the expertise of the clinician. Some clinicians say that "Therapy is still an art" (Proctor et al., 2007, p. 483). Clinicians often believe that researchers do not understand the interpersonal processes that make up clinical practice. Some clinicians say that researchers need to be more informed about the nuances of actual practice and that many research interventions are unrealistic given practice realities (Brekke, Ell, & Palinkas, 2007). In addition, some argue that social work has been built as a profession, "very much around the clinical experience of people" (Murphy & McDonald, 2004, p. 131). The ability to form relationships with clients is seen as central to the work that social workers do in the field. Yet the role of the therapeutic relationship is not often included in EBM and EBP outcome research. The therapeutic relationship and the working alliance are also viewed as key active ingredients in clinical change by many clinical researchers in allied mental health professions. Studies that directly address clinical expertise should be part of EBP research.

Going even further, some social workers believe that EBP and lists of empirically supported treatments (ESTs) have been created by governmental or other monitoring bodies without regard for the actual needs of the clients or the challenges in implementing the interventions (Baines, 2006; Bellamy et al., 2008). As discussed in Chap. 2, the push by governmental agencies or managed care companies for the use of prescribed empirically supported treatments (ESTs) has created the feeling that clinicians cannot be trusted to design and implement their own interventions; rather they need an administrator or a manual to tell them what to do with their clients (Pollio, 2006). As such, many clinicians have resisted the movement, which they believe dismisses an essential part of their professional identity and expertise (Baines, 2006; Bellamy et al., 2008; Pollio, 2006).

We argue that health-care economics largely drives many efforts to limit professional autonomy individualized client choice. Health-care companies and public regulatory agencies use inconsistent standards to certify lists of ESTs. We have noted that insurance payers may endorse specific treatments despite the fact that Cochrane Collaboration and Campbell Collaboration systematic reviews show little or no support for these treatments. Health-care organization and public funding agencies should follow the lead of organizations that seek transparent and high-quality research results. The standards and decision-making processes of funders should also be open and transparent. That said, funders face the same limitations to finding high-quality outcome studies that clinicians face: there is simply no strong outcome research on many mental health-care issues, especially comorbid concerns, or on diverse populations.

Logistics and Realities of EBP Implementation

Finally, there are concerns among social workers that EBP sounds like a wonderful concept in theory, but the logistics of implementing EBP and ESTs found in the search process render them unrealistic (Rousseau & Gunia, 2016). This is due to time, training, and money restraints that make it too difficult for many agencies to sustain such practices. Specifically, budget restrictions make it difficult for agencies to both fund the actual intervention found to be effective in a search and allow supervision and training time, all of which takes away from the productivity of the workers (Proctor et al., 2007).

Statements that express these sentiments come from two separate studies that interviewed practitioners and agency directors regarding the challenges of implementing and sustaining ESIs within their agencies. One agency director stated, "A treatment may be the best thing in the world, but if we can't fund it, we can't do it" (Nelson et al., 2006, p. 402). Another stated that "Supervision takes people off-line" (Proctor et al., 2007, p. 483). Other clinical social workers and agency directors have noted that high caseloads and the need to maximize billable time do not allow for the luxury of locating and reading research articles and attending training on various ESTs (Murphy & McDonald, 2004; Proctor et al., 2007). Administrative practices, and lack of time and pay, undermine the implementation of EBP.

To use an example to illustrate some of these challenges, imagine a clinician who meets with Chad, a 15-year-old Caucasian male who is involved in the juvenile justice system, has a diagnosis of conduct disorder, and is at risk of being placed out of his home. The clinician is interested in learning about the most effective interventions to help Chad with both the conduct disorder behaviors and to attempt to keep him in his home. After completing an initial search, the clinician finds that Multisystemic Treatment (MST) (Henggeler & Lee, 2003; Schoenwald, Brown, & Henggeler, 2000) appears to be and empirically supported treatment for the client's needs. The demographics of clients included in several outcome studies match with Chad's in terms of race, age, diagnosis, and presenting problem. On all accounts, MST seems like a very appropriate and potentially efficacious treatment for Chad. (We must note that a Campbell Collaboration systematic review of MST by Littell, Popa, and Forsythe (2005) questions its effectiveness regarding out of home placement, arrests, and convictions.)

The clinician's excitement about finding a likely effective intervention is quickly damped once she learns that MST can be conducted only through agencies that have acquired the training and licensing to provide this intervention (Schoenwald et al., 2000). In other words, unless her agency opted to get the training, receives the license, and follows the protocols of the licensing body for MST, she is unable to offer this service to her client. The agency where the social worker works is based in a small rural community, with a very limited budget and staff. It would be economically unrealistic for the agency to pursue the supervision and training needed to become a provider of MST. In the meantime, Chad's challenges remain. In searching for other options in her community, she learns that no local agency is a licensed MST provider. While the clinical social worker has found a good match for Chad and his needs, she is not able to offer him such a service, nor is she able to offer him other evidence-based alternatives within his own community.

The example of Chad highlights that EBP is a starting point in practice decision-making. Clinical social workers must use the best available evidence to inform their clinical decision-making, in conjunction with the client's stated needs, values, and goals. When the research points to only a few likely effective options, there is even more need for clinical expertise in interpreting and synthesizing all of the factors in the client's presentation. While the EBP search process located likely effective treatments for Chad, the practice realities obligated the clinician to revise the search and incorporate the additional information into the clinical decision-making process.

Questions Related to Modifying the Intervention

Another challenge faced by social workers is whether modifying an intervention is appropriate and allowed in EBP. That is, must an EST be used only in full, exactly as the authors describe it? Many ESTs and ESIs, like multisystemic therapy or Linehan's dialectical behavior therapy (DBT), have strict treatment protocols that have been followed in efficacy studies to make for internally valid research. In the field, however, the realities of practice come into play. In practice it is up to the clinician to determine whether such interventions can be modified for the client's benefit. Questions include how, when, where, and in what situations should the intervention be modified.

> If we decide that there were some approaches or interventions that were useful, there is still a whole piece missing, and that is how we would actually implement–with whom, why, when–and that's not in the literature, that's where the creative part is. (Bellamy et al., 2008, p. 66)

Clinicians often make modifications to a treatment in order to combine the art and science of clinical practice (Graybeal, 2007; Messer, 2004; Pollio, 2006; Weinberger & Rasco, 2007). After doing so, however, can the clinician be confident that the modified intervention maintains the essential ingredients needed for it to be effective?

The clinician-researchers who have developed intervention models often work hard to ensure that only those individuals who have been trained and supervised in the model can legitimately state that they are actually using the model in practice. They do this to protect the treatment fidelity of the model. Such treatment models include MST (Schoenwald et al., 2000) and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro & Maxfield, 2002). Yet, by copyrighting these interventions and certifying trained providers, they have become less accessible to many clients and clinicians due to financial, training, and supervision challenges.

If a clinical social worker uses a copyrighted treatment that he or she has learned about, and modifies it based on the needs of the client, can it still be labeled as the original model? If it does *not* prove to be effective with that client, did the model fail or was it the *way in which* the model was implemented that was ineffective?

Practice anecdotes indicate that clinicians and agencies do frequently modify copyrighted and detailed treatment protocols. These vary from minor alterations in content or timing of delivery to using only the group components of models that originally included both group and individual components. While modifying treatments may be common in practice, it is unclear how such modification fits with the EBP model. Delivering a modified treatment without research support may be a way of avoiding or evading EBP. It is also unclear if a modified treatment might open clinicians to legal suit for malpractice or for violation of professional ethics. This would appear to be a greater risk if the original treatment plan identified a specific model which was not fully delivered. Funders might also challenge payment for modified treatments. The issue of if, and if, how much, modification to ESIs is allowable in EBP remains minimally explored and unresolved.

Motivation to Use EBP

A critical factor in the implementation of EBP is the motivation of the practitioner to use it. Rousseau and Gunia (2016) outline several factors that impact practitioners' motivation to implement EBP in their practices. They argue that the most important factor is the practitioner's behavioral beliefs. These "represent a favorable or unfavorable attitude toward the behavior, perceived behavioral control reflects an individual's belief that he or she is capable of the behavior, and normative beliefs reflect perceived social norms regarding the commonality of the behavior" (p. 676). Rousseau and Gunia say that when all three of these are high, the individual's intention is expected at the strongest level. (Note that these are quite similar to the preconditions for doing EBP that Yunong and Fengzhi (2009) set forth for social workers doing EBP describe at the beginning of this chapter.)

Rousseau and Gunia (2016) state that "Behavioral beliefs reflect the extent to which a behavior is seen as beneficial" (p. 676). They report that the perception is based on the practitioners' knowledge level of EBP, whether they perceive that there is a significant economic or psychological cost and whether they perceive that stopping their practice of non-EBP-based interventions is more difficult than adding in EBP. In other words, the more knowledge they have about EBP and the less of a burden they perceive it to be, the more motivated they will be to adopt EBP in their practices. (Note, too, that the client's values and preferences are not mentioned in this summary.)

Rousseau and Gunia offer a variety of suggestions for how to increase practitioners' motivation levels, including offering an EBP mentor, creating ties to leaders in the field who have favorable opinions, and practicing EBP in order to increase a sense of self-control and self-efficacy. In addition, they also emphasize the importance of creating a culture where EBP is “normal” within the organization and implementing policies and practices that reinforce a structure where EBP is emphasized. These include supervisory sessions emphasizing EBP and offering trainings and peer support where EBP is discussed and emphasized (Rousseau & Gunia, 2016). Racially, Yunong and Fengzhi (2009) add that compensation for professional work is also needed to motivate use of EBP in practice.

Social Workers Compared to Other Professionals in the EBP Movement

Whether due to the concerns discussed above or to other issues, social workers have lagged behind other mental health and medical professionals regarding their training and knowledge of the EBP principles and empirically supported practice models (Brekke et al., 2007; Murphy & McDonald, 2004; Weissman et al., 2006). In a national study of accredited training programs in psychiatry, psychology, and social work, Weissman et al. (2006) found that social work programs required the least amount of training and supervision in ESTs in comparison to the other disciplines. This is despite claims by many social work programs that they provide strong clinical training. The authors concluded that “There is a considerable gap between research evidence for psychotherapy and clinical training. Until the training programs in the major disciplines providing psychotherapy increase training in EBT [evidence-based therapy], the gap between research evidence and clinical practice will remain” (p. 925).

This lack of training in social work programs surrounding EBP and the use of ESTs may have negative consequences for social workers who work in multidiscipline settings. In one study at a community hospital that delivers services through interdisciplinary teams, researchers surveyed the different disciplines about their perceptions of the knowledge base of the other professionals (Murphy & McDonald, 2004). Of all of the professions included, social work was the only one for which respondents raised concerns regarding a lack of knowledge and skills in using EBP. This puts social workers at a disadvantage when compared to other professionals on the same team. One nurse in the study stated that social workers “come from a non-medical background and they fit into teams, but often operate differently…it’s pretty airy fairy” (p. 134). A physiotherapist stated in reference to social workers “some of them just don’t have any real evidence base…they seem not to” (p. 134). The social workers themselves identified that their lack of knowledge of EBP “problematic” for them in their work settings and they felt that concerns were raised about the “validity of social work practice” on their teams (Murphy & McDonald, 2004, p. 132). One social worker stated that “Professionally we are being devalued because we’re unable to compete in that context” (p. 134).

Including Human Diversity in EBP

Social worker's professional values include an explicit focus on the needs of diverse and vulnerable populations. Several areas need further research to be optimally useful in practice: Cristofalo (2013) calls for more attention to vulnerable populations using "safety net" services who are disproportionately persons of color; Hemsing, Greaves, and Poole (2015) note that underserved women are routinely not offered basic health services such as smoking cessation help; Caputo and Mason (2009) note how family composition impacts client's use of services; Tsai et al. (2018) note racial bias on medical wards; Wang, Wong, and Humbyrd (2018) point out that payer eligibility requirements may limit medical services to people with other preexisting conditions who are disproportionately people of color. The list goes on. To be optimally useful, and to motivate social workers to do EBP, many and intersecting areas of human social diversity need to be much better represented in outcome research.

Summary

The continuing issues raised above by clinical social workers and the profession's relationship with EBP are indeed challenging. We believe that in order for social work to remain a respected profession, it must find a way to balance the criticisms and concerns of EBP with the strengths presented in this book. As discussed previously, social workers are viewed by other professionals as having less knowledge of EBP when compared to other health and mental health professionals (Murphy & McDonald, 2004). In order for our profession to be seen as relevant and knowledgeable in today's current practice climate, social workers must embrace the tools needed to practice within an EBP context. We also need to take leadership is exploring these unresolved issues related to applying EBP in everyday clinical practice. Outcome research explicitly including populations of color; women; lesbian, gay, bisexual, and transgender populations; children; and elders is all needed.

Our goal in this chapter is to clearly present the challenges of doing EBP. We have already pointed out its many strengths through this book. We also provide in Appendix B a summary listing of both the strengths and the limitations of EBP. Learning, and critically examining, EBP will help clinical social workers understand its complexity from several different perspectives. We hope that readers will be motivated to think about how to help individual practitioners, and the profession as a whole, address these concerns.

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