# Chapter 9
# Step 4 of Evidence-Based Practice: Collaboratively Discussing Treatment Options with the Client


Step 4 of the evidence-based practice (EBP) decision-making model focuses on actively and collaboratively discussing research results with the client (Drisko, 2017). The goal is to inform the client about identified potentially effective options in order to discuss how these options fit with the client's values and preferences. This requires the clinical social worker to summarize the results of the literature search and evaluation of located relevant research results. It also requires that the social worker state the results to the client in easily understandable language. Active and collaborative discussion allows for exploration of the client's views, values, and preferences. This step of the EBP process fits well with social work's professional values and ethics. This step also has implications for developing a therapeutic alliance and building client motivation. However, it may pose some challenges in practice.

In 2001, Gambrill wrote an article titled "Social work: An authority-based profession." In this article, she argues that for social workers to uphold the values of the profession, they must be transparent in their work with clients and include the "clients in making decisions that affect their lives" (p. 166). This is a key aspect of informed consent and consent to treat. We hope that all social workers strive to work collaboratively with their clients regarding all aspects of any social work intervention process. Step 4 in the EBP highlights this important aspect of social work practice by formally addressing the need to discuss and explore the options with clients. However, in order to address the concerns raised by Gambrill (2001), it is essential that social workers discuss the options *with* their clients, and not just *inform* their clients as to the plan. This step is a crucial factor in diminishing the potential authoritarian or expert stance clinicians may take with clients.

Step 4 distinguishes EBP from traditional medical models and hierarchical "expert" approaches. In this step, the clinician *collaboratively* discusses the research results *with the* client to determine how the potential treatment options fit with the client's values, preferences, and interests while simultaneously always keeping in mind the client's context and unique circumstances. We believe that this step in EBP



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is often overlooked and/or sometimes interpreted as involving a *presentation to the client*, rather than *a dialog with the client*. We hope that after reading this chapter, readers will have a stronger appreciation for importance of having a conversation with the client before making a decision regarding a treatment approach.

## Reasons to Include the Client in the Decision-Making Process

### *Consistency with the* Code of Ethics

There are many reasons to include the client in the decision-making process in EBP (Drisko, 2017). One of the reasons is that our *Code of Ethics* (National Association of Social Workers [NASW], 2017) states:

> Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions. (1.03)

While individuals can interpret this part of the Code in multiple ways, informed consent does not limit the worker to simply stating or explaining a proposed treatment plan. We view this ethical standard as calling for an interactive dialog with the client. Gambrill (2001) states that social workers are "in violation of our code of ethics" (p. 169) if they use an authoritarian or approach in which the clinician informs the client about the treatment approach that is "best" without including the client in the decision-making process. A true interactive dialog with the client about treatment options should continue until a unified decision has been made regarding an intervention plan that is agreeable to both the clinician and the client.

### *Active Collaboration Is Part of Culturally Competent Practice*

Given documented racial and ethnic dispraise in health care, addressing difference is an important part of contemporary social work practice. Culturally competent care has been proposed as one key method for addressing health-care disparities and limitations in research (Smedley, Stith, & Nelson, 2002). Cultural competence in health care is "the delivery of health services that acknowledges and understands cultural diversity in the clinical setting and respects individuals' health beliefs, values, and behaviors" (Romana, 2006, p. 1). It is inherently an individualized process. Active exploration of the client's culture, religion, and personal values is therefore a necessary part of assessment and treatment planning. Contemporary health care has begun to shift toward efforts to include cultural humility, openness, and inquisitiveness toward each individual patient (Ortega & Coulborn Faller, 2011; Romana,

2006; Tervalon & Murray-Garcia, 1998). To do this, the clinician must engage in personal development and learning, as well as introspection and reflection. Co-learning with the client affirms the client's agency and may reduce harmful power dynamics in practice.

In their systematic review of 34 studies, Beach et al. (2005, p. 256) found "excellent evidence that cultural competence training improves the knowledge of health professionals, …good evidence that it improves patient satisfaction…and limited evidence it improves adherence and outcome." Practitioner knowledge and skill can expand or improve with cultural competence and/or cultural humility training. Integrating EBP and cultural humility will take effort and practice but is important to improving service effectiveness (Drisko, 2017).

It is important to note that while we have addressed culturally competent care, other forms of socially structured oppression, including gender, age, ability, and other forms of human diversity, can be similarly explored in Step 4 of the EBP process (Drisko, 2017). These are also areas warning more research to guide practice.

## *Research Support for Active Collaboration with the Client*

In addition to adhering to the *Code of Ethics*, psychotherapy research has demonstrated that "if a client is not attuned to the approach being offered and shows resistance to the treatment, persistently and insistently offering the same approach is not therapeutically helpful and probably is harmful" (Wampold, 2010, p. 54). Therefore, before the intervention process can begin, it is essential that the client and the practitioner be in agreement about the approach that will be used. Without agreement at the start of the intervention, the intervention is less likely to be effective (Høglend, 2014; Wampold, 2010).

## *Including the Client Strengthens the Alliance*

Another reason to include the client in the practice decision-making process is because such action will help to foster a collaborative relationship. Collaborative relationships have been shown to be a critical component in the formation of a strong therapeutic relationship (Horvath & Bedi, 2002). A strong therapeutic relationship or therapeutic alliance has been consistently shown to be one of the most critical factors in producing positive outcomes in treatment (Høglend, 2014; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Hubble, Duncan, Miller & Wampold, 2010; Norcross, 2010; Orlinsky, Rønnsted & Willustzki, 2004; Wampold, 2010). Given the depth of research on the importance of the therapeutic alliance, it is imperative that the clinician work to strengthen it with clients throughout the course of treatment. The therapeutic relationship may be especially important at the beginning of the treatment process. A collaborative relationship that includes the clients

in the decision-making process can strengthen the therapeutic relationship and may increase the likelihood of a positive outcome in treatment.

Huber et al. (2018) report that higher levels of subjective personal agency among clients were "associated with more active involvement and affiliative interaction. The findings support the idea that patients need to feel capable of acting within and having an influence on their therapy to benefit from it" (abstract). Clinicians should carefully work to build and strengthen the client's sense of personal agency during the assessment and treatment planning process.

Anderson, Bautista, and Hope (2018) report that "being a woman, identifying as a sexual minority, and having a therapist low in perceived multicultural competence were associated with increased risk of premature termination [of therapy]. However, the best predictors of premature termination were a weak therapeutic alliance and symptoms of depression" (abstract). It appears that collaboratively developing a strong therapeutic relationship, through active collaboration, is vital to effective treatment for many clients. It may also help identify and address issues of socially structure oppression as they impact treatment.

## *Growing Policy and Financial Support for Active Collaboration with Clients*

There is growing policy and funding support for patient-centered care, including active collaboration with client in treatment planning. In 1999, Towle and Godolphin introduced the concept of "informed, shared decision making" in health care (p. 766). Further, the similar concept of "patient-centered care" was identified in 2001 by the Institute of Medicine as one of its six goals for a twenty-first-century health-care system. Some new financial incentives based on this concept were included in the Affordable Care Act [ACA]. This has increased the importance in patient-centered care in practice. While patient-centered care is assumed to lead to reduced health-care expenditures, it is also intended to help improve outcomes. This is because active patient participation and adherence to treatment plans are also assumed to improve health-care outcomes. In turn, incentives for delivering patient-centered care are developing, and measures of patient-centered care are being refined (Levinson, Lesser, & Epstein, 2010). Patients may also see modest reimbursements for participating in patient-centered care under some insurance plans.

Some preliminary research suggest that patients/clients also prefer patient-centered care. Swenson et al. (2004) found in their experimental study of 250 US patients that "a patient-centered versus a biomedical communication style" (p. 1069) was preferred. In terms of outcomes, Weiner et al. (2013) report that in a study of over 750 patients and more than 130 physicians, attention to patient needs, contexts, and circumstances in treatment planning was associated with improved health-care outcomes. Active collaboration with clients has many benefits.

## Factors to Consider During the Conversation

After completing the literature review process, it is imperative that the clinician consider how the various treatment alternatives are "compatible with the attitudes and values of the client. If not, the client is likely to be resistant to what is being presented" (Wampold, 2010, p. 53). In order to reduce resistance, research suggests it is important for clinicians to match therapeutic approaches to individual characteristics of the client. These include personality, cognitive abilities, and coping styles. Such matching addresses the fit of the treatment alternatives to the client rather than to the disorder (Wampold, 2010). As such, when a clinician presents the results of a literature search to a client, the clinician must consider how the various interventions align with the individual characteristics of the client. In fact, one of the guiding principles of EBP for social workers published by The Institute of the Advancement of Social Work Research (2008) is that the EBP process must be adapted and personalized for clients based on their culture, interests, and circumstances. Social workers do not view clients merely as "diagnoses." Rather, social workers view clients using a person-in-environment perspective (Kondrat, 2008) and should at all times consider the context of their clients' lives.

To that end, we offer the following points for clinicians to consider when presenting the options found in the practice research literature. These points are not meant to be an exhaustive list but rather a number of starting points to help clinicians think about the unique characteristics of their client. These questions help clinicians appraise how well the alternatives under consideration match with the client or client system.

### *Guiding Questions to Consider*

- What is the composition of the client system and how does that effect the definition of the client or client system?
- Where does the power lie within the client system or family?
- Is the identified client a minor? If so, with whom do you discuss the options? Does the age of the minor influence this decision? Who gets to make the decision about treatment?
- Is the identified client an older adult who has other adult family members involved with the client's care? Are you legally able to talk to those family members?
- What are the client's cognitive capacities?
- What are the client's beliefs about what helps in treatment?
- What are the values of the client regarding issues that may shape treatment? Culture? Race or ethnicity? Gender identity? Sexuality? Class and opportunity? Special abilities or limitations?

- What are the client's views about religion and spirituality? How do these views influence the client's understanding of the problem? How do these influence the client's views about healing, and how it occurs?
- Are there any language barriers that might impact either your ability to effectively communicate with your client? Are there any language barriers regarding homework or other tasks within the treatment?
- Are there any external factors that might influence a client's ability to participate in treatment, such as financial status, immigration status, access to services, disabilities, transportation, child care, employment responsibilities, caregiving responsibilities, or other such factors?
- What were the client's previous experiences with treatment (if any)? What worked and what did not? Was any aspect of treatment unacceptable to the client?
- What is the severity of the presenting problem? What is the urgency or acuity surrounding this issue?
- How able is the client to engage in the potential treatments due to the current challenges?
- Are their multiple disorders or presenting problems with which the client is struggling? What is main priority of the client?
- How motivated is the client? Is the client eager to participate in treatment or feeling forced to participate? How well do the treatment requirements match with the client's level of motivation?
- What is the client's view of a helper? An expert? A partner? An enemy? How are clinicians viewed within this framework?
- Are clinicians seen as trustworthy individuals? As experts?
- How is the system in which you work viewed by the client?
- What influence might personal history or cultural beliefs have on the client's views regarding how acceptable it is to receive help from an individual outside of the family?

## *Additional Questions to Consider Regarding the Clinician and Setting*

- Are there aspects of your personal values and beliefs that shape your interpretation of the information? Are they in tension with professional values?
- Do you have any values or significant personal experiences that influence your view of this particular client? The client's age? Race/ethnicity? Gender identity? Sexual orientation? Class? Immigration Status? Legal Concerns? Other factors?
- What is your level of expertise regarding the various alternatives you are suggesting?
- Are you able to present the information clearly and concisely?

- Can you or others at your agency provide each of the proposed evidence-based alternative treatments?
- Is there appropriate supervision and support to for you to deliver the treatment alternatives fully?

Discussing treatment alternatives with the client involves many considerations. Most of these issues are addressed in the assessment process and should be familiar to the clinician. However not all points of sensitivity and concern will be identified during the assessment process. New issues and specific concerns may arise as client and clinician dialog about treatment alternatives.

## *Key Dimensions of Client Input in Clinical Decision-Making*

### Client Preferences and Wishes

As discussed in Chap. 4, it is possible that the practitioner and the client may have different views regarding what to address in treatment or what alternatives may be most effective. It is also possible that there are times when both the client and the clinician agree on the presenting problem but have different views on how to address it. In other words, it is possible that the treatment alternatives proposed by the clinician based on the review of the literature are all incompatible with the values and preferences of the client. For example, for a client with an anxiety disorder, a clinical social worker determines through a thorough literature review that a cognitive behavioral treatment (CBT) has the strongest empirical support for addressing the client's concerns. However, this particular client has had a prior CBT treatment. She did not find it effective and does not believe it will be useful to her at this time. At this point, the clinician must make several important decisions based on professional expertise and knowledge of the client. Is more information needed? Should the clinician ask for more information about the prior treatment and its quality? Should treatment alternatives with lesser research support be offered to the client? Could a modified version of CBT be used to accommodate the client's concerns? Would such modifications undermine the evidence base supporting this treatment alternative? Are such modifications appropriate and ethical? Should the client be referred to another therapist who can give her what she wants? Is this ethical and clinically appropriate?

Unfortunately, there is no definitive answer as to what to do in this situation. We offer the following recommendations to help guide clinical social workers in this process.

1. Ensure that you have completed a thorough assessment. Obtain more information as needed.
2. Listen to the client's concerns and see what she or he feels would be most helpful.

3. Ask additional questions regarding the client's concerns about the proposed model to better understand why the model is not helpful.
4. Discuss other treatment options based on the literature search and discuss the evidence or support of these models. Repeat the literature search if more options need to be identified. (But be sure to explain the differences in research support for the effectiveness of each option.)
5. Decide in discussion with the client what treatment alternative has the best combination of evidence, "buy in" from the client, and fits within your expertise to deliver it competently.
6. If you and the client cannot agree on an approach that (1) fits with the views of the client, (2) that you believe will be effective based on your understanding of the literature, and (3) that you are competent to deliver, then you and the client must discuss if you are the best professional to provide services. If the answer to this question is no, then ethically, you are responsible to refer the client to another agency or professional who is more qualified to provide the type of treatment the client is seeking.
7. Document the conversation in the client's record.

We believe it is essential that the decision-making process with the client be transparent (Gambrill, 2001). In addition, treatment alternatives must be discussed with the client using language that the client can understand (Walsh, 2010). The social worker should ask for the client's feedback about the proposed treatment alternatives and how they fit the client's own values and preferences. Through collaborative discussions with the client regarding treatment alternatives in the EBP practice decision-making process, clients will be more engaged and more hopeful and often have increased motivation for the treatment process (Wampold, 2010).

## Safety Concerns

There are times when a client may suggest a treatment that poses risk of harm or has been shown to be ineffective for the presenting problem. In this situation, the National Association of Social Workers obligate social workers [NASW] *Code of Ethics* (2017) to refuse to provide such a service. "Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics" (NASW, 2017, 4.01.c). While it is important to listen to the client, and their preferences, the *Code* also states:

> When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm. (1.04.c)

A social worker's primary duty is to his or her client. Therefore, if after reviewing the literature and evidence, the client proposes treatment options that are known to be ineffective or potentially harmful, the social worker must refuse to provide such

services. The social worker must also explain the reasons behind the refusal. Such conversations must also be documented in the client's record.

## Summary

"It is the client who makes therapy work" (Wampold, 2010, p. 103). This is a simple but powerful statement illustrating the important role each client plays in the success of a treatment intervention. To increase the client's willingness to work and engage in the work of treatment, the client must believe in and feel part of the intervention process. A simple yet powerful way clinicians can engage clients early in treatment is to have them actively and collaboratively participate in practice decision making. Step 4 of EBP makes discussion of treatment alternatives with the client a key part of the treatment planning process. By doing so clients will understand all their options and hopefully feel that the treatment they select to is one in which they had an active role in choosing.

Some authors frame this step of the EBP practice decision-making process in a more "top-down," expert manner. We believe this step of the EBP process can be critical to maximizing client motivation and participation in treatment. We also believe in an active and thorough dialog with the client fits well with social work values and ethics. Research results increasingly support its merits. Without client participation and expression of wishes and preferences, the process of EBP is not complete. The client's preferences and circumstances must be included for EBP to be a success in clinical social work practice.

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