Chapter 2

Three Perspectives on Evidence-Based Practice

This chapter will examine evidence-based practice (EBP) from three different vantage points. As discussed in Chapter 1, there are several definitions of EBP, often shaped by the role the individual has within the EBP process. To clinical social workers, EBP is most often understood as a practice decision-making process. This is indeed one key application of EBP. But clinical social workers also understand the impact of EBP in other related contexts. We find it useful to think of EBP from three different perspectives: (1) its application in practice decision making, (2) its applications to health care policy and administration, and (3) its impact on research methods and research funding. To limit discussion of EBP solely to its practice application omits attention to other, broader, issues of interest to clinical social workers. The policies that shape practice delivery, the day-to-day administration of clinical social work practice, and the kinds of research evidence valued in making policy choices are also being affected by EBP. This is the context in which EBP is changing clinical social work practice.

In addition to guiding practice decision making, both evidence-based medicine (EBM) and EBP are being used at a policy level to reshape clinical practice. Cost containment, cost cutting and, in many cases, profit making are shaping the policies that orient health care practice. Beyond shaping policies, EBM and EBP are increasingly being used administratively. Improving the quality of care while reducing costs is the recent mantra of managed care providers. Large-scale research and EBM/EBP provide one valuable framework for examining service quality. At policy and administrative levels, however, EBP may conflict with client preferences and with professional autonomy. The methods of EBP may even be applied to evaluation of individual professionals. To understand EBP requires attention to the overall context in which it is embedded.

From a third perspective, EBM and EBP have begun to alter research priorities in ways that may restrict the variety of research approaches and methods used to understand and evaluate clinical practice. A key strength of EBM/EBP is its use of population level research results based on experimental (or RCT) research designs.

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Yet overemphasis, or exclusive focus, on such research designs may undermine attention to other forms of research and inquiry that are also important to practice knowledge building. In this way EBM/EBP may serve to promote some types of research knowledge while limiting others. Relevant to clinical social work practice, research on understanding persons in situations, on identifying environmental factors that impact treatment effectiveness, and on the processes of clinical practice may be deemphasized in favor of large-scale outcome research. Social work researchers and educators who for the past 30 years have advocated for "many ways of knowing" (Hartman 1994) may find one method is favored, and funded, above all others. Issues of epistemology, ontology, values, and human diversity in research may lose traction while specific methods gain favor.

In this chapter we will explore how EBP is used beyond practice, but in ways that influence how practice is funded and provided. The four components included in the contemporary definition of EBM and EBP may not always be highlighted in policy level and research discussions. The roles of clinical expertise and of client values and preferences may become secondary or even marginal when EBP is viewed from these other perspectives. Our goal is to ensure the context in which EBP is located and shaped are part of how clinical social workers understand this social movement. In turn, clinical social workers may be better able to advocate for themselves and for their clients.

The Policy Level and Administrative Applications of Evidence-Based Practice

There is no question that high quality research evidence, drawn from large samples and appropriately applied in practice, can save lives and improve services. In medicine, efforts to apply evidence-based standards for acute coronary patient care, for sepsis in the use of respiratory ventilators, and even hand washing have all reduced illness and mortality. One study found that strictly following the guidelines for acute coronary care treatment might have reduced patient mortality by 22% after 1 year (Alexander et al. 1998). These guidelines addressed acute use of just three medications. Applying the results of large scale, population based, research can improve service outcomes in important ways. In 2002, large-scale epidemiological research established that the harms of estrogen replacement therapy for postmenopausal women were much more severe than first believed (Women's Health Initiative 2002). These harms were not apparent until a large-scale research project aggregated individual experiences. Routine treatment practices were quickly changed in ways that saved women's lives and reduced overall harm. Even what appear to be small changes, such as routine hand washing, can prove to be very important to improving aggregate outcomes and reducing risks. The importance of such efforts may only become clear when very large groups of people are studied and compared. How EBP is applied at the policy level shapes much of the health and mental health delivery system.

Both the EBM and EBP movements must be understood in the larger context of macro level models of health care delivery. In the United Kingdom, in Canada, and in the United States, many initiatives drawing on the EBM and EBP models now shape public and private health care funding and delivery. Each of these countries face the very real challenge of containing health care costs while providing services to a large and aging population. In each of these countries policies were developed to eliminate unnecessary health care services and to improve overall outcomes. Note that these macro level goals are fully consistent with the purposes of EBM set forth by Dr. Archie Cochrane. In the United States, a major part of this effort was the expansion of managed care in the 1970s and 1980s. Further, health care providers were viewed as having financial incentives for providing more services than might really be needed. A tension between the interests of health care organizations and profession providers became increasingly evident.

In 1984, a study by Wennberg revealed that the kinds of treatment provided by physicians around the United States varied widely in both diagnosis and in prescribed treatments. Other studies found similar variation in diagnosis and most prevalent treatments by geographic region. Epidemiological and actuarial studies would predict more or less consistent rates of diagnosis and comparable use of treatments across the country. Tanenbaum (1999, p. 758) states that these results were interpreted to mean "that physicians were uncertain about the value of alternative treatments and that their actions were consequently influenced by clinically extraneous factors such as tradition and convenience." In other words, physicians did not explore, weigh, and decide what treatment to use on the basis of the best evidence. Dr. Cochrane's earlier concerns seemed very well founded and still very relevant.

Reed and Eisman (2006) state that this perspective was adopted enthusiastically by the health care industry. "Health care professionals were portrayed as major causes of waste, inefficiency, needless expense…" (p. 14). This argument, combined with claims that physicians would gain financially from providing more services, even if unnecessary, made health care professionals a target for improved management and administrative control. In turn, health care organizations in the United States and also in the United Kingdom and Canada, began initiatives to transfer administrative authority from clinical providers to health plan personnel. These initiatives were intended to standardized care practices and reduce variation in delivered services. They also served to limit access to services and to reduce overall demand, which achieved cost savings for funders. In the United States, health care corporations will gain in profits by reducing service access and costs. This corporate financial incentive, which produced large profits, for for-profit health care companies, is not widely viewed as problematic.

Not only funders but governmental agencies took up this argument. A series of efforts by the United States National Institutes of Health in the 1990s began to promote the importance of teaching health care professionals to use research-based treatments. Emphasizing 'quality over numbers,' they also promoted the use of administrative strategies to ensure that such research-based treatments were used widely and consistently. Governmental support and funding promoted the expansion of administrative control of professional practice in health care. During these years, parallel efforts in the national health system of the United Kingdom and Canada also took place (Trinder 2001c).

Tanenbaum (2003) states that managed care framed the debate over EBP into a "public idea" contrasting good scientific research evidence against faulty clinical judgment. To solve the problem of faulty practitioner judgment, research evidence was used administratively to direct health care practice. A public idea (Reich 1988) is a form of marketing common in political campaigns and product promotion. Complex social phenomena, like drunk driving or health care, are simply framed to highlight certain features of concern. In a public idea, a single, simple summary is presented that includes an image of both the causes of the problem and its optimal remedy. For drunk driving, the public image was one of repeat offenders causing horrible accidents and the remedy was to put such offenders in jail. The limitation of the argument is that, overall, many more drunk driving accidents are caused by everyday people who drink too much—not repeat offenders (though they do pose a problem). Preventive education would likely reduce accidents more effectively than does jailing repeat offenders (Moore 1988). Public ideas simplify complex social issues and may also distort them. Public ideas may give undue credibility to specific approaches to solving complex problems, rendering other useful solutions less prominent or less acceptable. They actively, and politically, shape public opinion.

Tanenbaum (2003) calls EBP a public idea of great rhetorical power. Indeed, who can argue with evidence? What scientific or rational approach remains for those who would argue with 'evidence.' As Brush (January 11, 2010) states, EBP can pit "competent researchers against clinicians." Those who define good evidence have great power and influence. In this instance, those who define the best evidence also have both economic and political power over the services they fund. "We only reimburse for services that are evidence-based" (Lehman 2010, p. 1) provides a powerful rationale for payers to restrict or refuse services without full regard for the needs, values, and choices of the individual client. The public idea of EBP emphasizes only part of a very complex situation.

When clinical practice is simply seen as a product in need of repair, its complexity and its many merits are minimized or ignored (Schwandt 2005). While controlling health care costs is an issue almost everyone would support, it can be undertaken in a manner that does not divide funder and practitioner. As we shall see, the image also suggests a great deal more certainty about 'what works' than may be found in treatment outcome research.

It is also important to note that the policy level focus on EBP emphasizes research results but does not address individual client needs and circumstances, nor does it address client values and choices. It also omits attention to the pivotal role of clinical expertise and first-hand clinical assessment. The policy and administrative perspective on EBP appears to be based on a very different understanding of EBP than is the practice decision-making model of the McMaster Group. Population-based research results are widely applied to critique the individualized actions of clinical practitioners. Administrative judgment may also replace the assessment of clinical social workers and other providers who have different training, qualifications, and much greater access to the individual client.

Mace (1999) states that the United Kingdom's National Health Services views EBP as a cornerstone of the effort to include quality assurance in the responsibilities of providers. While few would argue with quality services and professional accountability, funders, clients, and professionals may differ on what constitutes the best available services for a specific client in a specific situation. They may differ on what is the key problem, on what treatments and related services are appropriate to address it, and on what constitute suitable measures of treatment outcome. Administrative attention to the aggregate needs, and to cost cutting, may not always fit with ethical and appropriate client-specific decision making. There are important differences of perspective between people focused on large-scale, aggregate outcomes, and others focused on specific outcomes for a single client. Yet, at the same time, service costs and quality must be reviewed to control costs for all. There can be, at times, an understandable tension between the practices and goals of administrators and practitioners.

As we can see, EBP is actually a complex social movement. This means that the way EBP is understood, and the elements of EBP that are emphasized, will vary with the particular purposes of the author or speaker. It is important that clinical social workers bear mind that EBP can have a different 'look' depending on the focus of the speaker. Yet in practice, the key influence is the clinical expertise of the social worker who must integrate the client's clinical circumstances, particular values, and views with the best current research knowledge in making practice decisions.

Using Evidence in Evaluations of the Performance of Professionals

In addition to administrators potentially using EBP to influence and direct how services are delivered to clients, evidence-based arguments are being used politically and economically to evaluate, and hire or fire, individual professionals. For example, during the summer of 2010 the *Los Angeles Times* published a series of articles regarding the performance of public school teachers in Los Angeles (*Los Angeles Times*, undated). The series included the online, public, posting of the evaluations of approximately 6,000 teachers. The names of the teachers were also posted. These evaluations were paid for by the public school system and some people argued that they were open information. However, the teachers and their union officials stated they believed the evaluations were personal information to be used privately within the school system. Reputations were affected in a very public forum, with little opportunity for response by individual teachers.

Another aspect of the debate centered on a "value-added analysis," a research model that ranked teachers impact on student achievement (Dillon 2010).

The results of this statistical analysis were then used to decide whether or not teachers should be fired or rehired. In effect, teachers would retain or lose their jobs based on their evaluations, which were linked to the measured achievement of their students. Some people argued that teacher quality was crucial to student achievement. It is, of course, difficult to argue that some teachers are more effective than are others. Still, opponents of the model argued that many other factors, including student nutrition, degree of parental support, and prior 'social promotion' of students who had previously not demonstrated grade appropriate achievement all distorted the evaluations. They argued that to put all the responsibly for student performance on the teacher was neither valid nor fair. Here, outcome measures (the student's annual achievement) were interpreted and used as key measures of the teacher's competence, dedication, and effort. Notably, researchers spoke for both points of view (Dillon 2010).

Similar efforts to grade teacher performance using student test scores are underway in New York state (Otterman 2011). Teachers, using their political power, tried to expand the base from which judgments about their effectiveness were made. Noting that student performance was influenced by parental support, including adequate nutrition and sleep, they argued parents should also be evaluated. Florida state representative Kelli Stargel filed a bill that would require elementary school teachers to evaluate parents based on the quality of their involvement in their children's schools (Postal and Balona 2011). In parts of Alaska and in Pennsylvania, parents are fined if their children are frequently truant (Associated Press 2010; Levy 2011). There is considerable developmental research supporting the view that parental support is an important factor in child development and school performance. However, solutions to resolve these concerns often prove complex and multifaceted. More administrative oversight of professionals may not prove sufficient or effective in improving service outcomes. Nonetheless, the public idea of EBP may suggest such actions.

In mental health care, managed care companies sometimes profile individual clinical practitioners (Panzarino and Kellar 1994). The number of clients, types of disorders, number of sessions, and often the client's satisfaction are tracked and recorded. This information may be used to drop clinicians from company 'panels' and are, in effect, ratings of clinician performance or cost-effectiveness. It is not hard to imagine that the administrative use of EBP could both shape the nature of treatments clinicians can use and perhaps become a part of how a clinician's performance is evaluated.

States and some insurance providers are already establishing lists of what they consider to be empirically supported treatments or best practices. For example, the Minneapolis Veterans' Administration (VA) Health Care web site (2010) usefully lists evidence-based treatments for several disorders. Practicing clinical social workers also report their states and private insurance payers frequently suggest evidence-based treatments for specific disorders (Arnd–Caddigan and Pozzuto 2010). They also state that, in some cases, payers may refuse to authorize certain treatments for specific disorders due to what the payers claim is the lack of a sufficient evidence base for the proposed treatment.

It is important to note that neither lists of empirically supported treatments, nor best practices are necessarily based on kinds of evidence and methods used in EBP. How clinician effectiveness is conceptualized and measured will matter greatly to clinical social workers, much as it does to Los Angeles public school teachers. The administrative uses of EBP are an important driving force in its rapid adoption and promotion. EBP can also be used administratively and economically in ways that are still developing.

Of course, it *is* appropriate to use evidence in the evaluation of professional performance. No one would seriously argue that performance should not be tied to evidence. The issue is what kinds of evidence are most informative and how we understand them in context. To evaluate the quality of a teacher solely by the performance of his or her students may overrate the impact of a teacher. It surely diminishes the impact of social contexts including adequacy of space, materials and equipment not to mention the child's family supports and social circumstances. Similarly, clinical social workers often work with clients with multiple disorders and stressors that may directly impact the client's ability to engage in treatment and demonstrate 'success.' The appropriate use of research evidence requires fair and comprehensive models that fit with our best ideas about how complex systems work. Values, critical thinking, and theories all have a place in the optimal selection and use of research evidence (Gambrill 2000).

It is very important to consider how, and by whom, the term EBP is being used. Administrators, funders, researchers, and mental health clinicians may have different goals and information needs. Clinical practitioners may look for situation-specific treatment planning help, while researchers dispute what constitutes the 'best' methods to generate evidence, and payers seek to limits costs while maintaining service quality. Each of these endeavors has real merit. Each endeavor is also multifaceted and complex. Yet the view of EBP each perspective generates is somewhat distinct. Let us next consider the research perspective on EBM and EBP.

Evidence-Based Practice, Many Ways of Knowing and Qualitative Research

Tanenbaum (2003) argues that EBP is a public idea that purposefully shapes public perception. Several authors call EBM and EBP a social movement (Goldenberg 2006; Hansen and Rieper 2009; Trinder 2000a). We argue that a third perspective on EBP suggests it may also be an effort to shape, and perhaps to restrict, how science and research evidence are understood and valued. EBP may be the next research paradigm (Duggal and Menkes 2011; Guyatt et al. 1992). Paradigms shape how research is designed, funded, and taught. The impact of changes in research paradigms extends well beyond the university. Nespor (2006, p. 123) states that paradigms are results of "tensions and conflicts that stretch outside the university to state bureaucracies, pressure groups, big corporations, community groups." Paradigm debates may start within the academy, but their impact is much more widespread. As noted in the first section of this chapter, the impact of EBP may have profound economic and political consequences for mental health practice. To frame this perspective on EBP, we begin with some recent history on the debates regarding what Hartmann (1994) calls “many ways of knowing” that took place in social work and allied fields in the 1980s and 1990s. Note that this is the same time period in which EBM and EBP first became prominent.

Until the mid-20th century, there were few challenges to the centrality of the scientific method and knowledge as guides for the professions, including social work. In the early 1900s, a philosophy called logical positivism was promoted as a way to build mathematically based laws or models that accurately represented the world. In the hard sciences, such scientific laws had proved useful for over 200 years. However, the underlying justifications for the ‘truth value’ of scientific theories began to be challenged. In 1962, Thomas Kuhn published *The Structure of Scientific Revolutions*, a book that argued science was, in part, socially determined and did not progress solely through test and analysis. Kuhn argued that Western scientific knowledge had developed through a series of revolutions or ‘paradigm shifts’ where the framework through which scientists viewed the world changed radically. The newer paradigms routinely proved incompatible or incommensurate with the older ones. One widely cited example is the paradigm shift from a Ptolemaic or Earth centered view of the solar system to a Copernican or Sun centered view of the solar system. Scholars following Kuhn argued that human influences and power structures shaped scientific knowledge. Still more differing points of view about both *how* we know and the *value* of science arose during the 1970s and 1980s. The view that science is a social construction and is shaped by economic, political, and cultural forces became more prominent in both the social and hard sciences.

In the late 1980s and 1990s, the so-called ‘science wars’ contrasted science with other ways of knowing (see Flyvbjerg 2001; Nelkin 1979; Ravtiz 1997). The differences were both about epistemology—ways of knowing—and about research methods. Postmodernist scholars pointed to social knowledge as a social construction that is situated in a particular time and place, and shaped by the economics, politics, and social norms of the times (Foucault 1964; Lyotard 1984; Rorty 1979). They doubted that ‘objective’ methods could produce social ‘truths’ (Quine 1963). Feminist and cultural scholars noted how the interests and voices of women were often omitted or minimized in scientific scholarship (Belenky et al. 1986; Harding 1986; Nelson 1993). Indigenous scholars noted how the very different ways of knowing of aboriginal peoples was devalued and omitted in scientific scholarship (Tuhaiwai Smith 1999). Critical scholars noted how political interests shaped research funding and the application of research results (Foucault 1964; Habermas 1990). Some scholars advocated that research should include social action (Fals-Borda and Rahman 1991). For some, the kinds of work that constituted research expanded.

Arguments affirming the value of small sample, intensive research were also made during this time. Some scholars argued that clinically relevant and import research often used methods quite unlike those most valued in EBP. Rustin (2001) points out that a lot of valuable clinical and developmental research is small scale and intensive in format, rather than large scale and extensive. He points out how Ainsworth's Strange Situation test helped generate a typology of attachment styles that later proved to hold up in many different countries and cultures. Intensive study of a few mothers and children led the way to an innovative approach to understanding attachment and the consequences of its disruption. Rustin further notes how Stern's in-depth studies of babies and mothers pointed out that babies possess many more perceptual and meaning-making capacities than had previously been identified. Rustin argues for methodological pluralism and shows how clinical insights at the micro level can benefit many forms of research. EBP's focus on large-scale research has value, he states, but is not the only approach to productive clinical research.

Along similar lines, Tonelli (1998, 2001), a physician working with respiratory disease, argues that clinical experience and physiologic rationale are two types of medical knowledge that differ in kind from population-based epidemiological evidence. Tonelli believes their devaluation in EBP reflects a conceptual error. This is because clinical expertise, physiologic rationale, and epidemiological research are distinct kinds of knowledge that do not belong on the same graded hierarchy. Many kinds of evidence may have relevance to clinical decision making. Buetow and Kenealy (2000) and Buetow and Mintoft (2011) argue that EBM too severely limits the use of nonscientific knowledge, including patient intuition, that may complement, and enhance EBP decision making.

There are many kinds of research and knowledge that might extend, complement, or enhance EBM and EBP. Many of the more formal and well-developed forms of knowledge development are collectively known as qualitative research. Qualitative researchers argued for the merits of their approaches and methods in these 'science wars.'

During the 1990s many social workers advocated for greater attention to qualitative research (Gilgun et al. 1992; Popay and Williams 1994; Riessman 1994; Rodwell 1998; Shaw 1999; Sherman and Reid 1994). Qualitative research is frequently portrayed as a simple dichotomy contrasted with quantitative, statistical research in social work textbooks. More accurately, qualitative research consists of a wide-ranging family of related research approaches and methods. Qualitative research has many different purposes and draws on a range of different epistemological or philosophical premises (Drisko 1997). It emphasizes discovery, context, witnessing, understanding meaning, understanding process and can include social action, and even can aspire to liberation. Qualitative research is widely used to develop, refine, and even to test theory. Advocates for expanding attention to "many ways of knowing" (Hartman 1990) promoted the use of nonquantitative research approaches. In social work and allied fields, the number of publications using these methods increased dramatically during the 1990s and early 2000s.

More recently, Goldenberg (2006, 2009) argues that EBP is based on a dated positivist epistemology that promotes science as objective, despite many cogent critiques of positivism over the past 90 years. Specifically, she argues that the methodological standards of EBP actually serve to obscure the inevitable subjective elements that shape all human inquiry. Citing the work of Kuhn and Quine, she points out that theory is always underdetermined by data; meaning that our backgrounds will always shape our observations. Further, she states that "our theory choices are never determined exclusively by 'the evidence'." (2006, p. 2623). She states that "orthodox empiricists" exclude any acknowledgment of the historical, gendered, and locational differences among knowers in favor of views that are disembodied and "distinctly androgenic" (2006, p. 2625). Goldenberg notes that "In the current age where the institutional power of medicine is suspect, a model that represents biomedicine as politically disinterested or merely scientific should give pause" (2006, p. 2621).

Whether or not, and if so, how, EBM and EBP will include different "ways of knowing" is uncertain. Indeed, EBP hierarchies of evidence continue to locate the results of case studies and qualitative research on the lowest levels of evidence. As attention is directed to quantitative outcome studies, other research purposes and methods are actively or implicitly devalued. In this way, EBM and EBP may represent a social movement to restrict certain kinds of research and to privilege other forms. Popay and Williams (1998, p. 35) call this the "Gingerbread Man Threat"; that qualitative researchers will be gobbled up by their better funded and more powerful quantitative colleagues. In effect, the EBP research hierarchy resolves the science wars by omitting many kinds of research, mainly due to its dependence on population based, quantitative, and experimental studies. In this way, EBP may be viewed as a backdoor action in a long-term academic and economic disagreement.

The choice to devalue qualitative research has both a clear rationale and some serious consequences. The purpose of the research hierarchy is to promote research results with strong internal validity, or the ability to make cause and effect claims. This is one way to document the quality of research results. On the other hand, it allows very little room for change and innovation as social needs, conceptual systems, and diagnoses change over time. The EBM/EBP research hierarchy does not address what innovations to explore when treatment prove ineffective or how new treatment models would be created.

Greenhalgh (2010, p. 163) points out that qualitative research "is not just complementary to, but in many cases a prerequisite for… quantitative research…" That is, the concepts, diagnosis and treatment model tested for effectiveness in EBM and EBP research are routinely developed and refined using qualitative research designs and methods. Without openness to qualitative research, there is no way for new ideas, new disorders, and new treatments to be developed. To some authors, it is shortsighted to relegate qualitative research to the lowest levels of evidence, especially because the results of such research may profoundly shape the substance of later quantitative studies.

Popay and Williams (1998) argue that qualitative research may be viewed as either "enhancing" EBM and EBP or as "different" from them. Black (1994) points out several ways in which qualitative research can enhance EBM and EBP. He states it: (1) can help researchers understand how and why interventions work,

(2) can help identify new variables and hypotheses for future study, (3) can help clarify unexpected results from quantitative studies, and (4) can help improve the accuracy and relevance of quantitative research. Yet, Popay and Williams see even greater potential in qualitative research's differences from quantitative research. They note it: (1) can help identify "taken for granted" aspects of health care and of potential risks, (2) can help professionals understand the experience and meaning of being a patient and of receiving a diagnosis, (3) can provide different sources of information and perspective from clients and important others (including subjective assessments of outcome), and (4) can explore the impact of agency practices and complex policies on clients. In this way, qualitative research helps identify what EBP may miss, omit, or render invisible. Qualitative research can complement EBM and EBP as well as enhancing them.

Trinder (2000) notes that the Cochrane Collaboration had begun a Qualitative Interest Group. She states that it is vital "that qualitative and other research designs be accepted and valued on their on terms, rather than fitted awkwardly and inappropriately into an existing framework" (p. 237). However, a decade later the role of qualitative research in EBM and EBP is still unclear (Nelson 2008). Greenhalgh (2010) points to standards for quality in qualitative research, but does not address how qualitative research fits with the larger EBM model. Gould (2010) argues for greater inclusion of qualitative research into EBP while pointing to the first two practice guidelines in the United Kingdom that integrate qualitative evidence. The Cochrane Qualitative Interest Group offers conference workshops on specific methodological topics, but the larger question of how qualitative research is valued and included in EBM and EBP remains unanswered.

In social work, Rubin (2008) states that qualitative research may be the appropriate source for answers about client's experience with illness or social challenges. This may prove to be one important use for qualitative research. Gilgun (2005a) points out that better conceptualization of patient values and patient preferences would help clarify key aspects of the EBM and EBP process. She adds that professional expertise and the personal experiences of the professional also deserve conceptual elaboration and further study. Petr (2009) offers a variation on EBP that emphasizes the voices and views of clients as the basis for determining effectiveness. His multidimensional approach to EBP expands the narrow focus on symptoms to include other areas of interest to clinical social workers and clients. Qualitative researchers, and many clinical investigators using qualitative research methods, make valuable contributions to the practice knowledge base.

The EBM/EBP hierarchy of evidence and research designs has many merits. It is one valuable way to enhance practice decision making and, in the aggregate, to make the best use of limited health care resources. Still, critical thinking is required to ensure that the assumptions embedded in the EBM/EBP model are fully understood and recognized. As a social movement, EBM and EBP advocate for the use of specific techniques and specific kinds of evidence. These merits have strong supporters as well as some cogent critiques. Clinical social workers must consider both the strengths and the limitations of EBM and EBP research methods as they impact on practice.

Summary

In this chapter we have explored how EBP is not solely a practice decision-making process. We argue that EBP can be viewed from three different perspectives that point out different aspects of the social movement that is EBM and EBP. The practice decision-making process is the core of EBP. From this first perspective, EBP adds to the responsibilities of clinical social workers. Yet from policy and administrative perspective, EBP is a way to increase accountability and reduce costs while improving service outcomes. At its worst, it may also restrict both client and professional autonomy, and replace them with administrative oversight. The large-scale methods of EBP may also be applied to the evaluation of individual professional performance. From a research perspective, EBP seeks to generate population level outcome studies that can identify effective treatments and reveal possible risks. Yet EBP may also reduce attention to important epistemological, value, and contextual issues that shape research. Qualitative research and other nonquantitative ways of knowing are devalued in the EBP evidence hierarchy and in related research funding. These methods may produce knowledge that can be useful to direct clinical practice and to administration and policy efforts. Critical thinking about the EBP model and its application is appropriate.

A Starting Point for the Mental Health Practitioner

A very useful starting point for mental health practitioners is to learn about the EBP practice decision-making process and to be able to use it to inform treatment planning. Still, practitioners must use this information in combination with professional expertise and critical thinking to meet the needs and interests of clients. Clients, too, must be active participants in the EBP practice decision-making process.

In the next chapter we will explore the several steps of the EBP practice decision-making model. This model organizes the practice application of research results to direct clinical social work practice.

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