

Evidence-Based Practice and Social Work Education: A View from Washington

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The words “evidence-based practice” (EBP) are currently permeating the delivery of health care, education and human services. This is affecting teaching and scholarship within the disciplines that educate micro- and macro-level practitioners for the broad array of services encompassed within these systems and it is also impacting policy and funding decisions and how services are delivered. The focus for Thyer and Corcoran as well as this symposium hosted by the School of Social Work at the University of Texas, Austin is on improving the teaching of evidence-based practice in social work. And the questions that need to be addressed are how? For what purpose? What are the expected outcomes? And can we and should we come to agreement on what we mean by evidence-based practice.

For Corcoran teaching evidence-based practice includes teaching about the history of science and social work and he covered three key areas: An historical perspective on how innovations slowly wend their way into practice; an attempt to discern the many levels and varying qualities of what is considered ‘evidence;’ and a congratulatory note to the young social work profession in adapting to an evidence-based practice approach so early in its history. Corcoran also asserts that evidence-based practice should be taught throughout the curriculum, and most certainly in research classes.

Thyer focuses more on the question of evidence-based macro-practice – do we teach it? Do we research it and if so how? Are evidence-based government-funded

services possible? Does the government use evidence in making decisions? Is social work adequately and appropriately involved in the national discussions about practice guidelines and the establishment of lists of evidence-based programs, treatments and/or interventions?

Thyer's point that much of the discussion about evidence based practice focuses on clinical interventions is valid. To some extent, evidence-based practice in social work morphed from the evidence-based medicine movement. With a focus on outcomes for individuals, the Institute of Medicine (IOM) defines "evidence-based medicine" as the integration of best researched evidence and clinical expertise with patient values" (IOM, 2001). While this may be the origins, the current environment has taken the words "evidence-based" and applied them to policy, program, research, and interventions – suggesting that we need to consider the empirical base and think critically about the services provided to social work clients from every perspective.

Thyer also raises concerns about the definition of EBP, noting that the *Social Work Dictionary's* definition is very narrow, defining EBP as practices emerging from "evidence derived from **randomized controlled** outcome studies and **meta-analysis** of outcomes studies....." This definition might be welcomed by the Coalition for Evidence-based Policy of the Council on Excellence in Government (see <http://www.excelgov.org/index.php?keyword=a432fbc34d71c7>) that advocates for the government to support evidence-based practices and policies. The high powered Coalition with a prestigious advisory board views randomized controlled studies as the gold standard and has several working papers recommending that policy and funding decisions be based on the findings of randomized controlled trials (RCTs). The Coalition

helped develop guidance for the Office of Management and Budget entitled *What Constitutes Strong Evidence of a Program's Effectiveness?*

(http://www.excelgov.org/admin/FormManager/filesuploading/OMB_memo_on_strong_evidence.pdf). This memo “points to the randomized controlled trial (RCT) as an example of the best type of evaluation to demonstrate actual program impact.” The memo includes several examples where an RCT finds different outcomes than a program evaluation. However those agencies that fund evaluations of programs do not have the funding resources to actually carry-out RCTs. More on this later in discussion of policy.

In regard to types of evidence, Thyer asserts that forms of evidence besides RCTs are not only useful, but are more prevalent and might even be more appropriate. This includes all of the sources of evidence as cited by Thyer citing Strauss, Richardson, Glasziour & Haynes, 2005, including qualitative research. There are many areas of practice and policy where there have been no RCTs nor would an RCT be appropriate. In fact there is concern about RCTs in health, mental health and social services when the ‘usual’ treatment is known to be inferior services. There are also concerns that new treatments that are tried in an RCT might be harmful. At a recent meeting at the National Institutes of Health (NIH), that was touting the outcomes of several large scale clinical trials, it was mentioned that if there was a clear finding that something was not working during a trial it would be stopped so that participants would not be subject to a clearly inferior outcome.

Even if one does consider RCTs the ‘ultimate’ evidence, RCTs also have shortcomings. McCall & Green (2004) suggest that other research methods should complement experimental designs because although RCTs have strong internal validity

they may have limited generalizability to real world situations. And one of the reasons they have strong internal validity is that they encompass a narrow scope and usually exclude participants who have co-morbidities - a common attribute of social work clients.

“Research Designs for Complex, Multi-Level Health and Program Interventions” a symposium convened jointly by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC) and the Agency for Healthcare Research and Quality (AHRQ) tried to address this issue of RCTs in the real world. The convening examined research strategies beyond individual random assignment in RCTs– including those that use random assignment at the group or community level, community-based participatory research strategies and methodical systematic research reviews in order to develop more generalizable findings.

In regard to strengths of evidence, Corcoran wants to make sure that his students are able to be able to discern the value of different types of evidence. With the internet, blogs and personal websites, students today have access to so much information, thus they need to have excellent skills to be able to understand the differences between reliable and unreliable sources of input to a particular problem. The role of librarians and information specialists in social work education programs is increasingly important. Students also need to develop a clear understanding of the difference between a review of the literature and a review of research. Perhaps learning how to do a search for research findings, clinical guidelines, evidence-based clearinghouses, etc. should be part of each student’s orientation. Also important is to develop skills to analyze research findings so as to be able to carefully examine the quality and the strength (effect) of the research.

Unfortunately in many areas we have not developed a strong ‘evidence’ base because we have done small studies, often with convenience populations, or program evaluations of varying quality. Perhaps lack of funded support for research, high teaching loads and lack of research resources has kept many in academia away from large scale studies that use common and validated measures and that can be replicated in multiple sites. IASWR’s systematic review of research on retention of child welfare workers found little consistency across studies, even among retention studies of CalSWEC students in different regions of California, making it difficult to report that there is “strong” evidence (Zlotnik, DePanfilis, Daining & Lane, 2005).

Social workers may also be less involved, thus far in RCTs because many RCTs have had very defined samples and social workers’ clients often have complex and multiple problems that exclude them from eligibility. As NIH and the Substance Abuse and Mental Health Services Administration (SAMHSA) say that they are moving toward translational research from the bedside to the community and research moves beyond efficacy and effectiveness to implementation research, social work research opportunities should increase. The NIH Program Announcement to examine “Social Work Practice and Concepts in Health” <http://grants1.nih.gov/grants/guide/pa-files/PA-06-081.html>, (RO1) provides such a potential opportunity. The growing number of clinical trials attempting to involve real world complexities and increased support for community-based participatory research strategies provide opportunities to use a social work perspective in growing the evidence base.

Both Corcoran and Thyer touch on the relevance of evidence-based practice for policy and for teaching policy. They also distinguish the evidence based practice process

as defined by Gibbs (2003) and others, and evidence-based practices (or empirically supported interventions) that are deemed evidence-based practices through various websites and clearinghouse. Many health and human service practices, programs and interventions have not been the subject of RCTs, and as stated previously, testing of many social interventions may not lend themselves to RCTs. However, there is increasing support by the government to create clearinghouses and registries of effective programs and practices that have been developed (see Table 1) indicating that policy decision-makers are also engaged in dialogue about the value of evidence-based practices.

A note of caution is however necessary. There is some concern that all of the discussions in Washington, DC and state capitols about EBP and some of the policy documents that tout the value of RCT evidence over other levels of evidence may have negative impact on funding and support for social programs. One concern is that even when there is a well documented EBP to fit a certain situation it may not be used because of insufficient funding to support the service, the lack of adequate training of staff or the conflict that the intervention might have with other treatments. Another concern is that in tight fiscal times, policy makers might decide to defund valuable programs because there is no RCT that has proved the programs effectiveness. A third concern is that the distinction between a program having no effect on a particular outcome is often confused with a program having a negative effect. These are all important issues to take into consideration when thinking about “evidence-based policy-making.”

Also in regard to policy, Corcoran notes that the state of Oregon requires evidence-based interventions in several fields. Policy decisions such as Oregon’s led the

National Association of Public Child Welfare Administrators (NAPCWA) to develop the *Guide for Child Welfare Administrators on Evidence Based Practice* (NAPCWA, 2005). Policy-makers interests in programs that are “evidence-based” has led the state of California to support the California Evidence-Based Clearinghouse for Child Welfare (<http://www.cachildwelfareclearinghouse.org/>) which is housed at the Chadwick Center at San Diego Children’s Hospital. One of the first major activities for the Clearinghouse was to come to terms with what levels of evidence would be used and how they would be described. The decision was to create six levels which can be found in Table 2.

In Thyer’s discussion of the fourth step in EBP, to integrate findings from our critical analysis of the available evidence-base and apply it, he uses the example of the intensive family preservation program funded by the federal government in the early 1990s prior to “scientifically credible evidence that these programs were effective” (Thyer, 2006). Having been personally involved in a five year effort with other national organizations to develop the legislative framework that resulted in the passage of Public Law 103-66, the Family Preservation and Support Services provisions of Title IV-B of the Social Security Act, it might be useful to more fully discuss this policy option and evidence-based policy-making. President Clinton did not just decide to fund the programs; they were funded through the passage of bi-partisan legislation that was supported by the Clinton administration. The legislation was intended to address the fact that funding incentives favored placement over services to children and families in their homes. The creation of model programs, the move toward more family-centered and preventive programs, the results of some research and program evaluations led to the

creation of the federal program. It was not evidence-less, but it was not based on large-scale RCTs.

The legislation specifically included a set aside so that the programs could be evaluated rigorously, and the random-assignment evaluation results are an excellent example of a program that seemed to have similar outcomes to those in the control group (HHS, 2002). Thus the outcomes of family preservation were not negative, in fact families in the treatment group perceived that they were functioning better than those in the control group, and only one model, the Home Builders model, as implemented in 4 states was examined. Teaching evidence-based child welfare practice and/or policy would help students understand that there is often a disconnect between policy intention and policy implementation, and that funding, qualification and competencies of staff and high caseloads are all factors that impact desired outcomes.

Evidence-based practice might be considered the buzzwords of the new millennium, or an important way to ensure that clients receive services that are guided by the “best available evidence,” or it might be a great incentive for improved research by social workers and expanded understanding by social work students of the relevance of research to practice and policy. While there might be multiple definitions and we need to differentiate the process of evidence-based practice from evidence-based practices, social work students from beginning BSW students to advanced doctoral students need to be committed to providing the best available services at the individual, family, group, and community levels, and developing the best social policies, based on the best research evidence, guided by client/community values and culture and professional ethics and professional knowledge and skills. It is not enough to teach the evidence-based practice

process, to undertake high quality research, to teach students to critically think, we all must also teach students and faculty and practitioners to be advocates for the funding, not just of the research, but of program funds so that that services can be implemented in the way that they were intended.

References

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Table 1: California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale

1. Well Supported – Effective Practice

- There is no clinical or **empirical** evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specify components of the service and describes how to administer it.
- Multiple Site Replication: At least two rigorous **randomized controlled trials** (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, **peer-reviewed** literature.

- In at least two of the RCT's meeting criteria for "C" above, the practice has shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.
- Outcome measures must be [reliable](#) and [valid](#), and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of the evidence supports the [effectiveness](#) of the practice.

2. Supported – Efficacious Practice

- There is no clinical or [empirical](#) evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.
- At least two rigorous [randomized controlled trials](#) (RCTs) in highly [controlled settings](#) (e.g., university laboratory) have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, [peer-reviewed](#) literature.
- In at least two of the RCT's meeting criteria for "C" above, the practice has shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.
- Outcome measures must be [reliable](#) and [valid](#), and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the [efficacy](#) of the practice.

3. Promising Practice

- There is no clinical or [empirical](#) evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describe how to administer it.
- At least one study utilizing some form of control (e.g., [untreated group](#), [placebo group](#), [matched wait list](#)) has established the practice's [efficacy](#) over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, [peer-reviewed](#) literature.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

4. Acceptable/Emerging Practice – Effectiveness is Unknown

- There is no clinical or [empirical](#) evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.
- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from child welfare or related systems and their parents/caregivers.
- The practice lacks adequate research to empirically determine [efficacy](#).

5. Evidence Fails to Demonstrate Effect

- Two or more [randomized controlled trials](#) (RCT's) have found the practice has not resulted in improved outcomes, when compared to usual care.
- If multiple outcome studies have been conducted, the overall weight of evidence does not support the [efficacy](#) of the practice.

6. Concerning Practice

- If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served; and/or
- There is a reasonable theoretical, clinical, [empirical](#), or legal basis suggesting that the practice constitutes a risk of harm to those receiving it, compared to its likely benefits.

TABLE 2: Examples of Evidence-Based Clearinghouses or Reports

- Blueprints for Violence Prevention – OJJDP identification of research-based effective programs <http://www.colorado.edu/cspv/blueprints/index.html>
- CDC Community Guides – Guide to Community Preventive Services (Community Guide) at the U.S. Centers for Disease Control and Prevention conducts systematic reviews of available scientific literature to determine what this evidence shows about the effectiveness of public health interventions. Since the late 1990s, a team of researchers at the Community Guide has conducted systematic literature reviews of the effectiveness of various community level interventions in preventing violence, primarily violence by and against juveniles. www.thecommunityguide.org
- The Coalition for Evidence-Based Policy *sponsored by the Council for Excellence in Government*
<http://www.excelgov.org/displaycontent.asp?keyword=prppcHomePage>
- Science-based Prevention Programs and Principles: Effective Substance Abuse and Mental Health Programs for Every Community
www.modelprograms.samhsa.gov.
- Cancer Control PLANET (Plan, Link, Act, Network with Evidence-based Tools)
<http://cancercontrolplanet.cancer.gov>
- Emerging Practices in the Prevention of Child Abuse and Neglect (Caliber Associates, 2003, <http://www.calib.com/nccanch/prevention/emerging/>)
- [NASMHPD Research Institute's Center for Mental Health Quality and Accountability](http://www.nri-inc.org/CMHQA.cfm) created these web pages to provide all stakeholders with a comprehensive overview of EBPs, including the latest research and current state and community activities surrounding adoption, implementation, and sustainability. <http://www.nri-inc.org/CMHQA.cfm>
- What Works Clearinghouse
Funded by the Department of Education to provide educators, policymakers, and the public with a central, independent, and trusted source of scientific evidence of what works in education.
<http://www.w-w-c.org/>