LIMITATIONS OF EVIDENCE-BASED PRACTICE FOR SOCIAL WORK EDUCATION: UNPACKING THE COMPLEXITY

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Although some academic scholars have called for adoption of evidence-based practice (EBP) as a unifying model for social work education and practice, controversies with the EBP approach for the social work profession still need to be examined. Some of the limitations of EBP to be recognized and addressed before recommending broad changes within social work education are described. Conceptual and definitional limitations include following a medical model, privileging certain types of evidence, and downplaying the importance of theory. Implementation and feasibility limitations include sorting the complexity of research information and providing necessary practice grounding and supervision to facilitate knowledge application. Dialogue on the role of EBP in social work education must continue.

EVIDENCE-BASED PRACTICE (EBP) is a term that is now widely used in social work and psycho-social disciplines. Modeled after evidence-based medicine, a state-of-the-art approach where the focus is on finding appropriate treatments (pharmaceutical, medical, and surgical) for a patient’s medical conditions (Eddy, 2005; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000), EBP within psychosocial disciplines focuses on using intervention approaches with demonstrated effectiveness for a client’s particular presenting problem or condition in collaboration with the client (Gambrill, 1999, 2001). In social work, proponents of EBP link this approach to social work values, noting the ethical imperative to offer clients treatments that are known to work and to use the best evidence available (McNeece & Thyer, 2004). Reviews of EBPs have been published in such diverse social work areas as the substance abuse field (O’Hare, 2002), direct practice in aging (Cummings, Kropf, Cassie, & Bride, 2004), and school-based interventions.
(Franklin & Hopson, 2004), and EBP in these areas appears to be increasing rapidly. Practice guidelines are being developed (Duncan, Solovey, & Rusk, 1992; Howard, Edmond, & Vaughn, 2005; Rosen & Proctor, 2003), and manualized treatments are being published (Fraser, 2004; LeCroy, 2008) in many areas of practice. Social work textbooks with the “evidence-based” label in their titles are becoming commonplace (e.g., Corcoran, 2000; Roberts & Yeager, 2006; Thyer & Wodarski, 2007), and other texts also reference an increasing amount of intervention research on practice approaches. Scholars, educators, and students are affected by these trends, as Educational Policies and Accreditation Standards (EPAS) standards for social work education require schools to incorporate teaching evidence-based practices (Council on Social Work Education, 2004). Across the country, schools of social work are deciding where and how EBP will fit in their curricula.

Whereas the idea of giving preference to practices with empirical support is not new, it is being redefined in today’s social work EBP with renewed fervor. As Kirk and Reid (2002) describe in Science and Social Work, beginning in the 1970s with “the effectiveness crisis” in social work, efforts to make the profession more scientific have received strong academic support, most notably with the scientific-practitioner and the empirical-clinical practice models (e.g., Jayaratne & Levy, 1979 and others). Those models, emphasizing systematic evaluation of one’s own practice and use of research evidence to inform practice, although not adopted wholesale by the practice community, nevertheless have been responsible for introducing a number of innovations into typical social work practice. Behaviorally oriented and cognitive-behavioral treatments (e.g., Thomas, 1967) and time-limited, structured intervention approaches (e.g., Reid & Epstein, 1972) have become commonplace in social work service delivery (Mullen & Streiner, 2004). In the early 21st century, the generalist practice models we teach our students emphasize behavioral specificity in goal setting, skills training, or psychoeducation and regular evaluation of measurable practice outcomes (Hepworth, Rooney, Dewberry-Rooney, Strom-Gottfried, & Larson, 2006). In its latest incarnation, however, EBP focuses more exclusively on using the best available research to make practice decisions.

Two broadly defined conceptualizations of EBP, or the sometimes preferred term, evidence-informed practice, are used. First is a focus on the use of evidence-based practices (e.g., Norcross, Beutler, & Levant, 2006; Roth & Foragy, 2006), also known as empirically supported treatments (ESTs). In this conceptualization, certain practices or intervention programs become established as being effective through intervention outcome literature, either individual studies or systematic reviews and meta-analyses that synthesize and quantify the results of a number of studies. Evidence-based practices may be formally designated by certain government bodies or agencies. For example, the American Psychological Association has a clear set of criteria for categorizing practice approaches as efficacious, possibly efficacious, and so on (Chambless & Hollon, 1998), and lists and databases produced by these bodies are becoming widely available (e.g., National Registry of Evidence-Based Practices and Programs [NREPP], 2007;
Substance Abuse and Mental Health Services Administration [SAMHSA], 2007). A hierarchy of research evidence according to the level of causal inference attributable to the research design of the study, with the randomized-controlled trial, or true experiment, at the top, has been outlined in social work literature (McNiece & Thyer, 2004; Rosenthal, 2006). Some scholars have distinguished evidence-based practices and best practice protocols (Corcoran & Vandiver, 2006). Evidence-based practices are generally based on formal quantitative research support and may be less flexible to individual client or agency-specific modifications, as the goal is to replicate existing treatment protocols found within the research literature or to follow treatment manuals. In contrast, best practice protocols allow for modification in the agency context, even though there may not be evidence to support the effectiveness of such modifications (Hayes, 2005).

A second conceptualization defines EBP as a process whereby practitioners actively engage in seeking, digesting, and critically appraising the latest and best evidence to inform practice with particular client systems and target problems (Gambrill, 2001, 2003; Gibbs, 2003; Rubin, 2007b; Sackett et al., 2000). This is a multistep process consisting of (a) converting information needs into answerable questions; (b) finding the best evidence with which to answer these questions; (c) critically appraising that evidence for its validity and usefulness; (d) deciding how the evidence applies to a particular client and involving clients in the decision making; (e) taking action based on the best evidence; and (f) evaluating the outcome (Gambrill, 2001, p. 167), although other authors have presented alternative steps (e.g., Pollio, 2006). The EBP process has been enabled by broad access to the Internet and the increasing availability online of full-text research articles, systematic reviews of studies, and practice guidelines.

Many schools of social work have begun to incorporate the EBP paradigm into one or more courses (Howard, McMillen, & Pollio, 2003). Some authors now recommend using the EBP process as the conceptual basis of social work education in practice and research (McNiece & Thyer, 2004; Regehr, Stern, & Shlonsky, 2007). A special issue of Research on Social Work Practice on “Improving the Teaching of Evidence-Based Practice” featured papers presented at a symposium in Austin, TX, in October 2006. These scholars generally favored using the EBP process within both the research and practice sequences in schools of social work (Rubin, 2007b). A recommendation made was that schools of social work should abandon the generalist social work practice model and teach only specialized, evidence-based practices, beginning at the foundation level (Howard, Allen-Meares, & Ruffalo, 2007). Also proposed was retooling the research sequence to focus on content necessary to become an EBP practitioner; placing emphasis on skills in searching for evidence to become an informed consumer of intervention outcome research; and reducing coverage of descriptive, survey, or qualitative research or content on single-subject design for evaluating one’s own practice (Howard et al., 2007; Jenson, 2007; Schlonsky & Stern, 2007). Others recommended checking all syllabi to be sure non-EBPs were not being taught and limiting field sites to those that use EBPs (Rubin,
In response to the 2006 Austin symposium, social work faculty leaders in EBP formed the Austin Initiative, with plans to continue meeting and presenting symposia "to improve the teaching of EBP and advance EBP in general" (Rubin, 2007a, p. 630). According to Soyden (2007), the Initiative's purpose is "to transform schools of social work from predominantly opinion-based to predominantly evidence-based institutions of education" (p. 616).

Professional social workers are committed to reflective practice and the use of critical thinking skills in practice-based decision making, using multiple knowledge sources. The EBP literature provides support to these central tenets of good social work practice by suggesting a systematic approach to investigating a problem area and using existing empirical literature to support work with clients and communities. It would no doubt be difficult to find a social work practitioner today, much less a social work educator, who would admit to renouncing the importance of examining existing best practices to inform programming or the benefit of employing critical thinking skills in practice-based decision making with clients.

However, there are controversies regarding both an increased emphasis on using and teaching EBPs and adoption of the EBP process for the social work profession that still need to be examined. Other disciplines have attended to some of these controversies. For example, for health care disciplines, Stout (2005) suggests four specific challenges to implementing EBPs: (a) lack of clinician support, (b) difficulties in converting clinical guidelines into actionable performance measures, (c) poor use of available technologies to gauge the gaps in performance, and (d) inadequate integration of findings into daily operations (pp. 244–245). In the social work profession also, we must address the potential limitations to this approach both for educating students and for current social work practice.

Although some have stated that concerns about EBP are "well established and fully discussed in the literature" (Mullen & Streiner, 2004, p. 113), we believe that now is a good time to revisit and expand on these concerns. A critical examination and discussion of the limitations of EBP as a unifying approach for social work practice and education are necessary before moving forward with sweeping curriculum changes. This article reviews some of the key limitations of EBP and considers the difficult questions that confront social work education in light of the EBP movement.

**Conceptual and Definitional Limitations of EBP**

**Medicine as the Model for Social Work**

The EBP process model is patterned after evidence-based medicine (EBM), yet the disciplines of social work and medicine are quite different. Given these differences, we need to ask whether EBM is an optimal model after which to pattern social work practice and education. As Staller (2006) asserts, "insufficient attention has been paid to adapting EBP to the specific needs and nature of the new professions to which it is being applied" (p. 507). To expect that a practice or process that is adopted for medicine will be equally appropriate or helpful for other professional disciplines is perhaps misguided. This issue was raised by Webb (2001) and by Mullen and
they build a therapeutic relationship, identifying needs, goals, and resources as well as emphasizing mutuality in the relational context.

Social work practice is embedded within social problems or problems of living such as homelessness, domestic violence, and child abuse. These are complex social difficulties that require a person-in-environment perspective and are quite different from the difficulties dealt with in medicine. Clients seeking social work services do so because of a unique combination of situations and symptoms; they are dealing with problems of living for which they need assistance and support. Initially, they may not be able to express or understand everything that is wrong. Different areas that need to be addressed may unfold over time; many approaches may lead to appropriate outcomes. “Goals are modified or adapted, new goals are chosen, each responsive to the individual client’s need as it changes over the span of the intervention” (Pollio, 2006, p. 225).

Finding information to apply to practice may be more difficult for social work than for medicine. Stone and Gambrill (2007) suggest the use of a resource manager within the agency setting, a process used successfully in the United Kingdom by physicians, noting that “line staff can e-mail questions that arise to this person and receive answers and feedback in a timely manner” (p. 115). Here again, the medical analogy may not work as well for social work. If a practitioner e-mails a question such as “How can I get a low-income mother to be motivated to come to a parent group for her children?” the answer might not be as easily obtained as the answer to “What is the best treatment for appendicitis?” The
questions investigated in EBM tend to be organized around symptoms and diseases, and many of them address a narrower focus of practice with clear right or wrong answers. Thus, because it is based on a medical model and EBM, it is possible that EBP might steer students or practitioners to focus on the wrong targets. For example, a family presents with a child who has attention-deficit hyperactivity disorder (ADHD). What is the appropriate social work role? What services would social work offer families with children who suffer from this disorder? The social worker’s role extends beyond cure or “treating” the ADHD itself. The social worker needs to assess the particular situation of that family, their presenting concerns, what they have already tried, what strengths and resources they have, and their need for services and guidance. She may offer the child and the parents a combination of support, information, parenting skills, behavioral management, family therapy, advocacy in the school, physician and program referrals, and case management to monitor and support the family. Key social work skills such as support, understanding, and resource referral do not fit neatly within the EBP process model. Exclusive focus on the EBP aspect of social work service and intervention delivery may inadvertently deemphasize other important aspects of a holistic social work approach.

Assumption of the Outcome Literature Base as the Gold Standard

Over the past 30 years more sophisticated intervention outcome research has become increasingly available, and the evidence base in social work and related practice areas such as psychology and psychiatry has broadened. Reviews such as Reid and Fortune (2003) and Reid, Kenaly, and Colvin (2004) have shown the effectiveness of various types of social work practice. These reviews have documented that the treatments with demonstrated effectiveness tend to be brief, group, skills-focused, intervention approaches. However, there are still significant limitations to the evidence base in social work in many practice areas.

Methodological biases. It is an accepted fact that those approaches with the most evidence of effectiveness also happen to be those that have lent themselves most readily to replication and testing (Fonagy, Roth, & Higgitt, 2005; Kirk & Reid, 2002). A decontextualized review of the literature may lead to misleading assumptions and misinformed practice. For example, practitioners may conclude that what is not represented in the EBP literature is considered “bad practice,” rather than non-published practice. Given that not all human and social problems (or populations) are equally valued, biases may exist in the empirical literature toward those practices that reflect the social values and priorities of funders and others. And given that the social science base will always be empirically incomplete and often methodologically inconsistent across studies and findings, an exact prescription for intervention can never be relied on. The prevalent methodological biases toward treatments that are easier to measure or more likely to garner funding priority mean that many types of practice are simply not well-represented in the research literature. Although the number of intervention studies may be increasing, there is still not enough research evidence to inform practice in some
of these areas—for instance, interpersonal therapeutic approaches, naturalistic studies of social work practice, or effectiveness research in the field under real-life conditions. Practices that are considered to be evidence-based with racially and culturally diverse client groups are particularly underdeveloped and not widely available (Sue & Zane, 2006).

Types of evidence that are privileged in the EBP model. According to the “evidence pyramid” of the validity and importance of evidence sources, true experimental designs, such as randomized controlled trials (RCTs), are considered to be of the highest value within EBP (McNeece & Thyer, 2004; Sackett et al., 2000). Yet these types of studies do not always meet the needs of everyday practice. Concerns with the typical RCTs that inform EBP have been raised surrounding the application of global evidence—average effects—to individuals, who generally differ from the average, which may mask differential treatment effects or yield a poor match between client and treatment (Goldfried & Wolfe, 1998; Kravitz, Duan, & Braslow, 2004).

Moreover, RCTs are so highly controlled that they could be said to lack “external or ecological validity” (Persons & Silberschatz, 1998, p. 128). These studies are often characterized by exclusion criteria that omit clients with multiple problems; reliance on a strict duration of treatment or number of sessions; and either a manualized treatment approach, which fails to address all of the issues of real-life clients, or a less-detailed description of a treatment approach, which makes replication by regular practitioners impractical. For instance, Westen, Novotny, and Thompson-Brenner (2004) found that most controlled treatment studies excluded potential clients exhibiting comorbid disorders. Because estimates of comorbid disorders are quite high, many of these studies are limited in their generalizability to typical clinical practice. And the corollary is that the necessity of maintaining strict treatment fidelity, keeping the treatment brief, and so forth, produces interventions in experimental studies that do not resemble actual clinical practice (Goldfried & Wolfe, 1998; Westen, Novotny, & Thompson-Brenner, 2005). Although efforts are underway to increase research funding and studies that include clients with more comorbid conditions and take place in real field settings (Rubin & Parrish, 2007a), proponents of EBP too often fail to acknowledge such clear limitations to how evidence from these so-called gold standard studies can be applied to practice.

Other concerns have been raised surrounding the choice of control or comparison conditions used in RCTs, particularly no-treatment or attention-placebo control conditions (Kendall, Holmbeck, & Verdun, 2004). For instance, a convincing argument can be made that evidence of a legitimate treatment’s superiority compared with a bogus treatment, which is intrinsically designed to fail (e.g., attention-placebo condition), does not tell us much about the treatment’s effectiveness (Westen et al., 2005). And finally, a number of authors in social work and psychology have noted that experimental outcome studies tend to be designed by proponents of the approaches, introducing an element of bias in the design, conduct, and interpretation of these studies as a result of the effects of “investigator allegiance” (Gellis & Reid, 2004; Kirk & Reid,
2002). Thus, results of experimental evaluations may be less informative and objective than we realize (see, e.g., Gorman, 2002).

**Difficulties in Defining Evidence-Based**

Practitioners, educators, and administrators do not agree on definitions of EBP (Rubin & Parrish, 2007b). Although some authors have decried the loosening of evidentiary standards as EBP becomes a buzzword in social work and related disciplines (Rubin & Parrish, 2007b; Shlosnky & Gibs, 2004), others are concerned that strict criteria to define evidence-based may end up excluding important and effective social work practices. As an example, Franklin (2007) describes her work with solution-focused therapy, which she notes is not yet considered an evidence-based treatment, but argues that developing a promising treatment model has a rightful place in social work research and scholarship.

**Common factors.** A related definitional limitation of the EBP model is that intervention studies usually test one practice model or procedure as a package, but variations on that model, perhaps including some but not all of the treatment elements, may not have been formally evaluated in the literature and, thus, will not be acknowledged as EBP. For example, interviewing and relationship skills such as active listening, reciprocal empathy, discerning and confronting discrepancies, and reframing form the basis for the social work generalist practice model (e.g., Hepworth et al., 2006). These generalist practice skills derive from a number of traditions in social work and have been shown to be important elements of psychosocial practice. Precisely those social work skills that work from problem to problem and client to client, the nonspecific factors, have impact on the outcomes of treatment (Drisko, 2004). The relationship between worker and client, the therapeutic alliance, has been demonstrated to have significant influence across numerous studies (Norcross & Lambert, 2006; Wampold, 2001). In fact, research on treatment outcomes suggests that four factors can account for much of the improvement in clients: client or extratherapeutic factors (40%); relationship factors (30%); placebo, hope, and expectancy factors (15%); and model/technique factors (30%) (Duncan & Miller, 2000; Hubbel, Du, & Miller, 1999). Thus, nearly half of the outcome relies on fundamental skills and abilities that must be fostered in social work apart from the type of treatment offered.

It is not clear that the EBP perspective fully takes into account the importance of these nonspecific factor skills and abilities. There are two important points here. First, we are concerned with the matter of emphasis and presentation to our students. The EBP process emphasizes use of evidence rather than use of good social work interview technique giving the impression to students who do not know about practice that evidence is the key to good practice. Second, we notice a failure of scholars to acknowledge in writings on EBP that generalist practice skills, the nonspecific factors, are evidence-based. Although social work practice textbooks present general practice skills, some social work scholars continue to state that the social work professor conducting work that is of unknown effectiveness and not evidence-based (Gambrill, 19 2001; McNeese & Thyer, 2004). This discn
ancy points to the difficulty in unpacking the evidence used in practice. Stone and Gambrill (2007) review school social work texts to assess the extent to which they provide evidence in discussing school social work practice. They conclude that there is limited evidence presented in social work textbooks and suggest such books may be overshadowed by electronic information, one rationale being that text reviews of research are outdated too quickly (Stone & Gambrill, 2007; Thyer, 2004). However, textbooks are usually updated every few years, and more important, the crucial common practice skills have already established evidence. When social work scholars fail to recognize that common factors make up many EBPs as well as the basis of social work generalist practice skills, and that these factors may be, in fact, evidence-based in their own right, they do not give credence to transferable skills or components of interventions that can be used or applied in a flexible way. Helping social work students develop their fundamental knowledge and skill base is just as important to good practice as being updated on recent knowledge derived from the evidence base. We should acknowledge that good practice is derived from fundamental knowledge and skill as well as newly discovered knowledge and skill.

**Complex and contradictory evidence.** A further difficulty with the EBP process is how to evaluate complex studies and sort through contradictory reviews. Randomized controlled trials of the same approach frequently offer discrepant findings, particularly given the use of multiple outcome measures (De Los Reyes & Kazdin, 2008); reviews of research studies in a given area may also be equivocal or contradict each other. For example, social work has embraced multisystemic therapy (MST; Henggeler, Melton, & Smith, 1992) as an evidence-based intervention (Kazdin & Weisz, 2003). More recently, a systematic review (Littell, 2005) of MST has raised significant questions about the evidence of effectiveness for this widely accepted intervention. Assertive community treatment (ACT; Drake et al., 1998), another well-studied and established practice model, has also been criticized for methodological shortcomings and possibly coercive practices (Gomory, 2005). However, the “information cascade” has already placed both MST and ACT into the EBP category, and they are widely cited as exemplary models of EBP (NREPP, 2007). Even though one reviewer found evidence lacking, many other reviewers have reached different conclusions. We must acknowledge the complexity of applying systematic reviews to advance evidence-based knowledge.

In addition to MST and ACT, a number of other multicomponent programs such as integrated dual disorder treatment (Drake et al. 2001) and dialectical behavioral therapy (Linehan, 1993) are considered to be evidence-based (NREPP, 2007; SAMHSA, 2007). These programs tackle some of the most challenging social work problems that exist and consist of several parts that are often delivered by more than one practitioner. However, multicomponent programs require sophisticated methodological designs to tease out component-specific effects and, therefore, it is not surprising that quality evidentiary support with the appropriate detail necessary to comprehensively answer effectiveness questions about multicomponent programs is scant.
With this degree of complexity in the literature, how do we teach our students and train our practitioners to be able to discern between harmful practices that exist, best practices that have empirical support but that have not been comprehensively tested with all practice parameters, and those practices that hold informal or anecdotal promise but have not yet been empirical support? What is the value-base that undergirds a particular area of knowledge development? How do we manage biases that contribute to knowledge gaps in the formal literature base of our profession and in other disciplines from which we borrow knowledge? These questions need answers as we advance EBP into the day-to-day practice of social work.

**Deemphasis on Human Behavior Theory and Theories of Change**

Theory is an integral part of the knowledge, skills, and abilities needed for professional social work practice. Polansky’s classic article (1986) about the value of a good theory noted that theory offers tentative explanation about what occurs, why it occurs, and predictions about what may occur in the future. Just as theory guides research, it can guide practice. Social workers with a framework for understanding human behaviors, human problems, and methods to help and change are able to enter into the social work relationship with clients prepared to begin the work. They can be confident that they have a working hypothesis about what may be going on with the client and an idea of how they might proceed, albeit a tentative one. What role will theory play in education for evidence-based social work practice?

As we see it, although theory undergirds specific EBPs such as cognitive behavior therapy, the importance of theory is not clearly articulated in the EBP process model. EBP appears to offer social work students and practitioners resources to access research and practice guidelines but it offers no theoretical underpinnings on which to base activities in practice such as conceptualizing a problem or assessing client needs. The theory piece appears to be largely omitted because of the privileged status of “what has worked” in research studies with similar target problems or types of clients. This may lead to unfortunate oversights in practice. For example, a social worker attempting to provide a preventive intervention for teenage HIV and STDs might search the literature and find “programs” with some evidence of effectiveness. However, knowledge of relevant human behavior theory might suggest the use of cognitive dissonance, which addresses how to increase behaviors in participants who are not motivated to change their behavior. A cognitive dissonance strategy to teenage prevention of HIV and STDs is to develop a peer-based program whereby the teens teach principles of prevention and safe condom use to others, creating conditions of dissonance for their own behavior. Substantial empirical evidence exists for the use of cognitive dissonance theory and behavior change (Aronson, Fried, & Stone, 1991; Kelly et al., 1997), yet this type of evidence would not likely be found in a systematic search for evidence on prevention of HIV or STDs.

We see this as an area for significant attention because it may facilitate the application of EBPs to the practice context. Examining the underlying theoretical framework in
evidence-based searches opens up the opportunity for modifying and adapting the evidence to better accommodate existing practice challenges. For example, a social worker working in a substance abuse outpatient facility might be intrigued by the strong evidence to support motivational interviewing (MI) techniques in obtaining early client commitment and treatment engagement, but may view such techniques as limiting in their emphasis on personal change over person–environment transactional change. However, incorporating an expanded theoretical approach from public health to explain human motivation, such as the theory of reasoned action (Ajzen & Fishbein, 1980), allows the practitioner to more effectively understand the influence of social norms and relational configurations that contribute to behavior change and allows the practitioner to adapt or expand the MI techniques accordingly.

Without understanding the reciprocal interactions between theory and the evidence base, there is a danger that we will be training technicians who know how to find research studies and follow directions in practice guidelines rather than developing independent professionals who can appropriately apply and adapt such knowledge to their practice context (Goldstein, 2007). Critical thinking skills of social work students and practitioners may decrease, rather than increase, if the result of the EBP movement is reliance on rote prescriptive literature searches with less attention to the harder work of how to critically evaluate, appropriately apply, and effectively employ such best practices. This requires the work of integrating theoretical knowledge (much of which has been empirically derived by social scientists and clinicians through research), experiential knowledge, and knowledge about the current client situation. Research knowledge and “evidence” that supersedes these other important sources of knowledge may not provide sufficient guidance for professional practice.

**Barriers and Concerns with Implementation of EBP**

Although EBPs are found in social work textbooks and described on practice Web sites, converting all of social work education and practice to the EBP model would be an enormously complex undertaking. Being attentive students of history, we can examine lessons learned from the scientific practitioner (SP) movement in the 1980s and 1990s, which failed to capture the interest and the hearts of everyday social workers. Its most ardent proponents did not address the implementation problems nor gain the buy-in of many practicing social workers in the field, who did not see the need for or the appeal of the SP model in everyday practice, even though a subset of academic social work scholars displayed a zealous certainty about adopting the model and incorporating it into social work education (Kirk & Reid, 2002; Wakefield & Kirk, 1996).

We see a similarity to the EBP process movement. Are we overestimating the potential contribution of EBPs and the EBP process for social work? Some have cautioned that the current situation regarding EBP in social work veers toward “methodological fundamentalism” (Staller, 2006, p. 509). Is there adequate evidence that EBP as a process can be successfully applied to social work practice? Without this evidence should we proceed with a wholesale
acceptance of the movement? Will the EBP movement uphold some of the very authority-based propositions it claims to critique? Several feasibility and implementation issues present serious impediments to wide-scale adoption of EBP as a unifying conceptual model in social work practice.

**Interpretation of Research Evidence**

First, interpreting evidence from research studies or reviews is complex, time-consuming, and difficult, and we believe the literature on EBP in social work has underestimated this. Social workers with bachelor’s or master’s degrees do not have the training in research design and statistics that scholars with doctorates have, and even these scholars have difficulty interpreting the intervention outcome literature. The skilled and thoughtful critical review required is beyond the capabilities and interests of most practitioners, who are busy with the actual day-to-day work of seeing clients and being change agents. Although master’s-level students can learn much about intervention research that will help them in interpreting research evidence, expecting that the master of social work curriculum can add enough content on research design and statistics for students to seriously evaluate studies is perhaps not realistic. This added material would inevitably lessen the weight given to other important aspects of social work education, even other research methodologies such as survey or qualitative research. Systematic reviews and meta-analyses of the literature by the Campbell and Cochrane collaborations and many others are helpful in obtaining summaries of the intervention studies in a given area, but they also can be very difficult to interpret and are not necessarily geared toward practitioners’ needs.

**Application of Knowledge From Research to Practice**

A second related issue is that of transfer of knowledge. The whole notion of “transportability” of EBP has emerged (Reid & Colvin, 2005; Schoenwald & Hoagwood, 2001). Application of knowledge often does not lead to appropriate actions. Knowing about and knowing how are different, and it is unclear how the EBP approach helps to bridge general knowledge acquisition with specific skill application. Indeed, the perplexing gap in knowledge transfer has been of concern for some time (see U.S. Department of Health and Human Services [USDHHS], 1999). Questions emerge about individual intervention studies and their clarity as guides for practice. Do they give adequate guidance on worker activities? Is there enough detail to allow replication in the field with real clients? Related concerns have been raised about manualized psychosocial treatments. Practice guidelines are proposed as an antidote to the difficulty of interpreting research literature (Howard et al., 2005; Rosen & Proctor, 2003) and are available for certain disorders (e.g., American Psychological Association, 2005). Yet experts agree that finding the evidence and implementing it according to directions from practice guidelines and treatment manuals is unlikely to be successful without the undergirding of important knowledge and skills, precisely because social work practice is interactive in nature and process oriented (Witkin & Harrison, 2001). Kendall and Chu (2006) acknowledge the limitations found in treatment manuals for
guiding practice and have noted that EBP needs to incorporate “flexible” practice. They define flexible practice as “a construct that assesses the therapist’s adaptiveness to the situation at hand while he or she is adhering to the instructions and suggestions in the manual” (p. 211).

In addition to concerns about application and transfer of information (i.e., availability of research studies, guidelines, and practice descriptions), we also do not have a clear idea of standards to be used in assessing practitioner training and competencies for applying specific EBP practices. Although some EBPs articulate practitioner competencies needed for implementation, others do not, and for those that do, it is not clear how adherence to skill-level requirements could be monitored in the day-to-day operations of an agency culture.

**Competent and Confident Practice**

In the EBP model, social workers are encouraged to take a nonauthoritative stance and to admit uncertainty (Gambrill, 1999, 2001, 2003). The client is seen as a full partner, and the social worker determines how to work with each client based in part on client values as well as the research evidence available. The social worker is essentially starting anew with each type of client or target problem. On the one hand, every type of human services interaction is better if it is individualized to the needs of the particular client and situation. However, at the extreme, the EBP process model suggests that a social worker attempting to use the best available evidence could end up trying to conduct cognitive behavioral therapy with some clients, motivational inter-

viewing with others, behavioral rehearsal at skills training with others, family psychoeducation with others, and interpersonal psychotherapy with still others. But constant trying to do new things may not lend itself competent practice and may work to undermine the confidence of the worker, which could directly affect client outcomes.

Practice models and methods require solid understanding and supervised training; Social workers, like any professionals, are likely to function better when they are engaged in approaches with which they are comfortable and well-trained. But where do EBPs as a process draw the line? Is it acceptable for a practitioner to have a favored method of working? Is there a set of skills that can be transferred from case to case, the nonspecific generalist practice skills? Zayas, Gonzales and Hansen (2003) have thoughtfully addressed this question, suggesting that social work has the process of engagement and termination down pat, but we need to use EBPs for the middle portion of treatment. To our knowledge, they are among the few scholars writing about EBP recently to credit social work’s unique and positive attributes that are already in place and that we can build on. Most writers about EBP have largely ignored the issue of continuity of skills and methods that may contribute to a sense of competence and comfort among practitioners.

Before becoming professional social workers, MSW students have just 2 years to absorb practice knowledge, try out their skills under supervised conditions, and reflect on and process these experiences. Might it not be more practical, and more realistic, to give students an in-depth practice experience that
they can carry with them and apply to much of the work they do? As previously discussed, practitioner variables, including competence, relationship skills, and alliance with the client, are among the nonspecific factors related to obtaining positive client outcomes. In this sense, it is the social worker’s influence that provides the condition for client change to take place (Duncan et al., 1992). Social workers attempting to implement practice approaches without having the time, supervision, and solid understanding of the approaches will be less apt to be authentic with clients, satisfied with their work, or confident in their abilities—that is, less apt to be effective practitioners.

**The Role of Clinical Decision Making (Practice Wisdom)**

Although writings on the EBP model in social work assert that clinical wisdom and expertise remain important (e.g., Mullen & Streiner, 2004), we do not have a clear template for how practitioners will balance clinical wisdom with available research evidence. How does this look in practice? A number of authors have made valiant efforts to address this issue (McNeill, 2006; Pollio, 2006), but as their reported experiences suggest, it has not been easy. To our knowledge, there is little hard data on the way EBP works in practice. Schonberg and Stern (2007) state the following:

> It takes a great deal of clinical skill to successfully integrate current best evidence with client preferences/actions, clinical state/circumstances, and the practice context. Indeed, this coming together is the hardest part of the endeavor and is also the one we know the least about. We must be honest about our current limitations. EBP is an emerging approach, and it will take considerable time and effort to make it work. (p. 608)

We agree with this statement. But future generations of social workers will not automatically gain “practice wisdom” without good teaching in practice, above, beyond, and aside from anything to do with seeking out research evidence. As Goldstein argues, EBP: taught in isolation, “separated from the core principles that define clinical social work broadly defined do not provide students with a holistic approach to practice that helps them make professional judgments” (2007, p. 20). Failure to adequately offer those crucial clinical skills (e.g., skills in assessment, engagement, goal setting, monitoring) and failure to take into account real-life messiness and the highly interactive nature of practice, mean we are at risk of sending into the world social work graduates who are poorly prepared for the realities of practice.

**Agency and Practice Constraints**

Agency needs, missions, and mandates, input from supervisors and administrators, and resource limitations all factor into how social workers practice. Practitioner and client acceptance and other aspects of clinical utility, such as organizational processes that may facilitate or impede implementation, are important in contextually analyzing the feasibility of EBP. Writing about child welfare, Whiting-Blome and Streib (2004) argue “Unfortunately, no one evidence-based progra
engagement has solid evidence as a practice that may enhance reunification. Individualized planning is not only a federal mandate, but also represents good practice and should be done with engaged families. But if the worker has large caseloads and short time frames and the agency favors computer-generated plans, organizational expectations may thwart implementation of engagement strategies deemed successful through studies. (p. 613)

Singer (2006) provided another relevant example when he attempted to implement an EBP protocol but discovered some of the EBP procedures were against agency policy.

Human services agencies and practitioners are faced with many issues. A survey of agency-based field instructors found lack of time was the top barrier to implementation of EBP (Edmond, Rochman, Megivern, Howard, & Williams, 2006). McNeill (2006), writing about implementation of EBP, states,

I suspect many clinicians would find it a daunting task, particularly if they do not have all of the requisite skills such as those needed to gain access to the literature and analyze the quality of existing knowledge. In the fast-paced world of many clinical settings, social workers need feasible strategies that allow them to balance the many competing demands on their time and resources. (p. 148)

There is a great deal of human need that professional social workers heroically try to meet every day. Requiring the use of the EBP process or sanctioned EBPs will not change this and may be counter-productive in some instances.

Inequities in Implementing EBP

The social and economic justice implications related to implementation of an EBP approach across populations, settings, and organizations have not been adequately addressed. Reliance on EBP may set up barriers to service that discriminates against those clients and agencies with less economic means, decreased human and social capital, and minimal personal or organizational influence. What type of agencies will have the appropriate resources to keep up with researching the latest literature and implementing practice updates? What other aspects of organizational capacity will be diminished in EBP implementation efforts and at what human cost to which populations in which organizational settings? As a practice matter, how much time should agencies devote to active searches for evidence? In an era of cost containment, who will pay for such efforts?

How will incorporation of EBP processes be implemented in fair and equitable ways across agencies, populations served, and communities (e.g., urban vs. rural; private- versus
public-funded; well-connected vs. isolated organizations)? Will insurance companies begin uncritically supporting a short list of certain EBP protocols without attention to differential application according to gender, age, race, ethnicity, or culture, particularly if such differential specification is missing from the empirical literature? Will there be disproportionate referring out of ethnic and minority groups on whom such EBPs have not been conducted, if practitioners cannot ensure competency with such groups? Will such treatments be denied to groups who might benefit from the treatment because the research has not extended to these groups? Or will such treatments be blindly applied to diverse groups despite the lack of empirical support?

The practical complications of becoming an EBP agency or practitioner have not been fully addressed and raise difficult questions about implementation. Technological resources for the EBP model are not consistently available in practice settings (Rubin & Parrish, 2007a). Many agencies do not have the up-to-date Internet connection that is needed to do extensive online searching and downloading. Most do not subscribe to the research databases that universities and social work faculty members are fortunate to access. Manualized treatments are frequently available only to those who can pay the cost of the manuals as well as the cost of training and licensure. Both interpersonal psychotherapy and multysystemic therapy are managed by organizations that sell manuals, training, and licensure through the organization. The proprietary nature of many of these endeavors means that they can be costly for agencies and individual practitioners. As EBP becomes valued, the proprietary nature of our society may inhibit its full-scale implementation. How can social work as a profession respond to this challenge?

**Conclusions**

As social work researchers and teachers of social work practice, we are very much in favor of establishing the evidence base in social work practice through a variety of research approaches and clinical and case reporting as well as teaching students about research evidence, how to access and interpret it, and how to apply it within a solid conceptual framework for practice. We favor the definition of the social work practitioner as lifelong learner, open to new knowledge and evidence to inform practice. However, as outlined in this article, we believe there are significant limitations to EBP and that EBP should not replace much of what is already in place in social work education and practice. This is a question of emphasis. Skills in finding and interpreting research evidence are among many other very important skills for students of social work. We caution against making broad changes to the curricula at schools of social work to incorporate the process of EBP, as these changes risk diminishing theory, knowledge of human development, practice skills, and clinical teaching.

Good social work practice, and by extension, good social work education for future practitioners, needs to be grounded in theory and practice skills overlaid with in-depth training in selected intervention approaches. It is an ethical responsibility to our students and the profession to offer the skills they will need to begin practice competently and confidently. It is important to recall the mistakes
and missteps of the past as we move forward with EBP. We wish to see the dialogue about EBP in social work education avoid ideological rhetoric. A focus on both the advantages and limitations of EBP is needed as the social work profession begins to incorporate EBP content into its curriculum.

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