

What Is Evidence-Based Practice?

Anyone who stays abreast of the current social work or psychology literature has recently encountered the phrase “evidence-based practice.” Current issues of the major professional journals are replete with references to this concept. On the one hand, the meaning of this phrase seems self-evident. It suggests an approach to clinical practice that is informed by some type of evidence that the intervention being used is effective. But what constitutes “evidence” of effectiveness in clinical practice? Further, how does one know whether the intervention under consideration has been demonstrated to be effective? And, finally, what are the implications of the movement toward evidence-based practice for service delivery in child welfare agencies such as Casey Family Services?

The term evidence-based practice actually comes from the medical field, where practitioners are increasingly under pressure by managed care to demonstrate that a particular procedure has been proven to be the most effective one in treating a specific disease or condition. In this context, the most effective procedures are considered to be those that have proven effective in randomized clinical trials (RCT). Randomized means, of course, that patients in a study are assigned to treatment and control (no treatment) groups based only on chance and not on some attribute of the patients, such as who is the sickest. In drug trials, the no-treatment group is given a placebo that looks like the drug being tested but in reality is nothing more than a sugar pill.

Clinical trials are usually “blind” studies, meaning that even the investigator does not know who is receiving the experimental treatment until the end of the trial when outcomes for the two groups are compared. This is to prevent the researcher from accidentally influencing the results of the RCT by assigning patients with certain characteristics to one of the groups (i.e., the sickest patients to the control group, making the experimental regime look more effective than it really was). The RCT is considered to be the gold standard of scientific validation.

When RCTs are not possible in medicine, such as in surgical procedures where it is not possible to randomly assign patients to treatment and no-treatment groups and to keep the researcher “blind” as to who is receiving the treatment, alternative methods of determining the effectiveness of a particular procedure are used, often involving comparing different approaches to treating a disease over time in a large number of cases. Lumpectomy emerged in this way as an acceptable treatment in some forms of breast cancer.

Many who argue for using only evidence-based treatments in medicine suggest that to do otherwise is unethical. They cite medical practices and procedures once widely used and believed effective that were discovered through RCTs to not only be ineffective but to be actually harmful to patients. Using treatments that are not supported by scientifically rigorous research is a violation of professional norms according to this viewpoint. Thus, according to this school of thought, it is

incumbent upon healthcare providers to keep abreast of the latest research findings in their areas of practice and to adapt their methods of treatment accordingly.

Evidence-based practice depends on translation of evidence into practice guidelines, or “best practice” models. The Cochrane Collaboration is an international nonprofit network that collects and disseminates up-to-date research findings in the healthcare field. It grew out of the belief in evidence-based practice of medicine but has expanded its focus to all forms of healthcare, including behavioral health.

Others argue that evidence-based practice discourages innovation and the use of nontraditional treatment methods. Further, it favors those approaches that have been the most rigorously tested, which may reflect preferences of research funders for the cheapest and easiest, or most profitable, treatments. Further, even treatments that are supported by extensive research are not necessarily the most effective in individual situations. There is concern that the push for evidence-based practice devalues the training and experience-based judgment of the individual practitioner, supporting technical rationality at the expense of artistry in diagnosis and treatment.

Despite these concerns, there is general agreement across professional disciplines and fields of practice that all forms of therapeutic intervention, whether medical, psychological or social in nature, should be informed by evidence from the most rigorous research available. Although the gold standard of the RCT is difficult, if not impossible, to implement in most social treatment settings, alternative strategies for accruing the evidence required to inform practice decisions are available. These include cohort or case-control studies which are more common and easier to implement in “real life.” There is growing expectation that the best available evidence from external sources will be taken into account when planning and conducting any form of psychosocial intervention.

One example of evidence-based practice, from the adult mental health field, is the use of family psychoeducation, which has been found in multiple studies to reduce relapse rates and facilitate recovery of persons with chronic mental illness (Dixon, McFarlane, Lefley, Luckstead, et al., 2001). A best practices model of family psychoeducation has been developed through extensive research. This model includes emotional support to family members, education about mental illness, provision of resources during periods of crisis and building problem-solving skills. Today, an agency planning a treatment program for adults with chronic mental illness would be hard pressed not to incorporate family psychoeducation with these elements.

Evidence-Based Child Welfare Practice

Like practitioners in other fields, those who work in the field of child welfare want to employ the most effective interventions possible in helping families create safe, stable and nurturing child rearing environments. However, the kinds of interventions used in child welfare settings do not easily lend themselves to testing

using methods borrowed from the hard sciences such as RCTs. Most clinicians and administrators in child welfare agencies have a difficult time with the notion of randomly assigning clients to treatment and no-treatment control groups. Adaptations have been made to the RCT design, such as using novel treatment v. treatment-as-usual groups, and treatment v. delayed treatment waitlist groups.

However, these and other adaptations carry particular threats to the validity of study findings that decrease the power of the evidence they produce. Some efforts have been made to use random assignment in studies of child welfare interventions, such as in studies of intensive family preservation services based on the IFP model developed by the Behavioral Science Institute in Tacoma, Washington. This intervention model has been more extensively studied than almost any other form of child welfare treatment, and, yet, the findings regarding its effectiveness in preserving families and preventing child placement are mixed.

One fairly recent study carried out in Illinois of family preservation services delivered by the public child welfare agency in that state attempted to randomly assign families at high risk of child placement in out-of-home care to two treatment groups, one receiving family preservation services and the other receiving the usual mix of child welfare services. Although the researchers who carried out this study have claimed that it showed no difference between family preservation services and “business as usual,” there were so many flaws in the study that it is difficult to draw any conclusions from it at all.

Two particular flaws in this study color many studies of service effectiveness in child welfare. One was that there was no common understanding across service sites as to what constituted family preservation services. Every county division of the state child welfare agency was left to define what it meant by this intervention approach. Without some definition of and control over the particular service delivered, it is impossible to claim that the intervention lacked effectiveness. Further, there was no attempt to control for the services families received outside the child welfare system. Families, particularly in the usual services group, may have been linked to other agencies that provided placement prevention services, greatly enhancing the effects of the usual and customary child welfare services.

The Illinois study of family preservation services illustrates the difficulties in developing evidence-based practice models in the child welfare field. Our interventions frequently lack clear definition and structure. We are so trained to individualize our clients, and to appreciate their unique strengths and needs, that it is sometimes difficult to generalize and rationalize an intervention strategy. We believe so strongly that “one size doesn’t fit all” that we resist incorporating research findings regarding the effectiveness of a specific treatment approach or strategy into our practice framework.

For example, there is research supporting the effectiveness of time limits in treatment as well as for establishing specific, well-defined treatment goals. Many of

us struggle with both of these issues, believing our clients are so vulnerable, with so many life difficulties, that they do not benefit from structured models of treatment. Yet, research suggests otherwise – that it may be those multiple problem families who often appear chaotic and disorganized and in a constant state of crisis, who benefit most from highly structured intervention approaches.

Our clinical experiences, and beliefs drawn from those experiences, are necessary, but not sufficient, bases for developing best practice models. Remember, not so long ago our whole approach to treating children with autism was based on the belief that this disorder was caused by maternal rejection. Embarrassing, isn't it?

The child welfare field is a long way from developing the kind of well-defined, well-tested interventions that may support evidence-based practice in medicine. Yet, we are beginning to acknowledge the importance, even the ethical imperative, of examining our approaches to working with clients. Our mandate for exploring and refining our practice does not come from outside sources such as managed care, however. It emerges from our commitment to our clients and to developing safe, stable and nurturing families for children. And, while the gold standard of the RCT may continue to elude us, we can and should use the most rigorous and appropriate methods available to test and refine our practice.