CHAPTER 20

EVIDENCE-BASED PRACTICE: CAN PRACTITIONERS REALLY BE VALUES-NEUTRAL?

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Much has been written in the past decade about the implementation of the evidence-based practice (EBP) process in social work. This growing body of literature discusses the barriers that prevent social workers from engaging in the EBP process. In this chapter, a summary of this literature provides a starting point for a new discussion regarding the complications created by the practitioners' personal values and religious or spiritual beliefs. We propose what we believe is an important addition to the EBP decision-making model—that of practitioner transparency and self-awareness—to account for the reality that practitioners are not and cannot purport to be "values-neutral" in their incorporation of EBP principles.

Furman (2009) asserts that because EBP is strongly associated with the scientific process, EBP is "value-free and accepted on face value" (p. 82). This quote suggests that, as long as the practice interventions we utilize are rooted in science, our own personal values and beliefs are somehow neutralized—tempered by the "value free" nature of the scientific, evidence-based practice (EBP) process. Consider the last time you engaged with a client for whom you felt a level of personal attachment or affinity; was the work you did (and the interventions you chose) totally devoid of your own personal feelings about him or her? By contrast, consider the last time you engaged with a client or patient who you knew was involved in a pattern of behaviors you objected to on moral grounds; was your service to that client entirely unaffected by your personal values? In instances like these, can we trust that by searching for solutions within the empirical literature and tempering those findings with the circumstances of the client as well as our own clinical experience (i.e. the EBP process), we are ourselves remaining "values-neutral"? This chapter begins with a brief review of the EBP process along with some related literature documenting one type of barrier associated with failure to successfully implement EBP. We will then return to this question, locating it in a context of Christians practicing social work, ultimately seeking to clarify the role practitioner values and beliefs do play in our practice with diverse populations.

Evidence-Based Practice

The evidence-based practice model of decision-making, which originated in the field of medicine (starting as EBM or evidence-based medicine), is perhaps best understood through the pictorial illustration below.

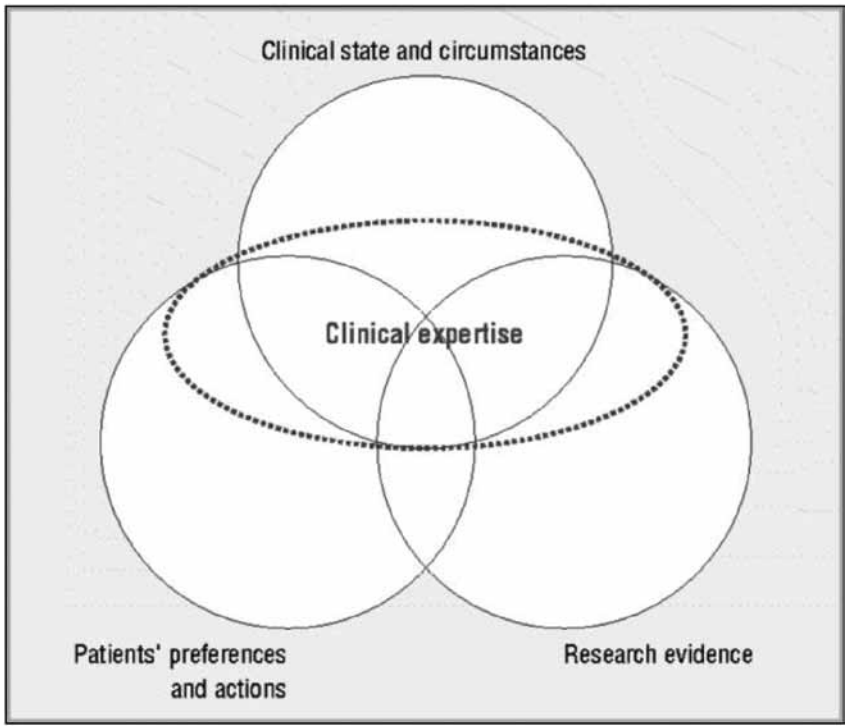

Figure 1: Evidence-Based Practice Decision-Making Model
(Used with permission; Haynes, Devereaux, & Guyatt, 2002)

EBP decision-making integrates what is known from the research evidence, the clinical state of the client[1], and the client's own preferences and actions – all of which is to be informed by the expertise of the practitioner. Regarding the *research evidence*, EBP adheres to a hierarchy of evidence that values systematic reviews and randomized controlled trials (RCTs) over less rigorous experimental designs. This evidence hierarchy encourages greater generalizability of research evidence and promotes a scientifically-oriented process that values rigor over anecdotal evidence (Gibbs, 2003 Kelly, Raines, Stone, & Frey, 2010). The second element of the EBP decision-making model, the *clinical state* of the patient or client must then be used to balance such evidence. The practitioner must carefully assess the level of fit between the research and the individual's situation; for

1 Although the model uses the word "patient" to describe the individual seeking services, we will use the term more common in social work: "client."

example, is the client too old, too sick, too uncooperative, or too complicated to apply what is known from the literature (Evidence-Based Medicine Working Group, 1992)? It has been documented that engaging in this step allows for a collaborative process with beneficial results for both clinical outcomes and the client-practitioner relationship (Freeman & Sweeney, 2001). The third aspect of EBP decision-making might be the most innovative. More authoritarian models of clinical care may integrate evidence and clinical circumstances but rarely include the *patient's own preferences* into treatment planning. Doing so calls for "techniques of behavioral science to determine what patients are really looking for" (Evidence-Based Medicine Working Group, 1992, p. 2422).

These components of EBP seem to be a natural fit for social work, as EBP urges the social work practitioner to not simply defer to the evidence, but rather to engage in a client-centered process to determine the best course of action for the individual (Sheyett, 2006). In fact, the originators of the EBP decision-making model have, in the last decade, offered an alternative term to describe the intent of their model; in explaining the intersection of the aforementioned three elements (informed by clinical expertise), Haynes, Devereaux, and Guyatt (2002) state that the EBP process "was developed to encourage practitioners and patients to pay due respect – no more, no less – to current best evidence in making decisions. An alternative term that some social workers may find more appealing is *research enhanced health care*" (p. 1349, emphasis added). As such, the EBP process deemphasizes the intuition of the practitioner (Evidence-Based Medicine Working Group, 1992; Gambrill, 2007) by instead encouraging a systematic integration of multiple sources of information in order to arrive at an evidence-informed solution. For social workers, the idea of "research enhanced health care" fits with the Council of Social Work Education's (CSWE) mandate for social workers to engage in "practice-informed research and research-informed practice (CSWE, 2008, Educational Policy 2.1.6).

Despite the seeming congruence of EBP with social work practice, it is necessary to acknowledge the well-documented challenges and barriers that can prevent more practitioners from engaging in the EBP process of decision-making. Some of these barriers are logistical and competency related: practitioners frequently report difficulty in accessing, assessing, interpreting, and applying empirical evidence into their practice (Haynes & Haines, 1998). While such claims may in fact be valid given the scientific rigor of the EBP process, other barriers and reasons cited by practitioners for their underuse of EBP relate more to the perception that EBP ties the hands of practitioners (Haynes, Devereaux & Guyatt, 2002), making them unable to draw on their own practice wisdom (Freeman & Sweeney, 2001). One study exploring this perception noted "how resistant practitioners are to withdrawing established treatments from practice even once their utility has been disproved" (Haynes & Haines, 1998, p. 274). Related specifically to the field of social work, some have identified this tension as a potential ethical debate between EBP and the values of the social work profession – specifically the tendency to value empirically-supported knowledge over the autonomy of the client (Furman, 2009). While all of these barriers and

perceptions raise important questions related to the underutilization of EBP, we wish to raise one more.

Is Evidence-Based Practice Values-Neutral?

There is growing literature on the challenges the EBP process might present to social work values and the National Association of Social Workers (NASW) Code of Ethics (Gambrill, 2007; Gibbs & Gambrill, 2002; Scheyett, 2006). It is true that little was included in the original EBP model regarding professional values. However, there is also nothing specifically depicted in the EBP decision-making diagram about practitioners' *personal values*. Does this mean that we are to believe that practitioner values and beliefs are absent from the EBP process? From its inception, the attraction of the EBP model has been its move away from "authority driven" clinical decision-making (i.e. choosing certain interventions simply because that is what has always been done). However, there seems to have been an accompanying sentiment that EBP ensures that decisions will not be *personally value-driven* either. As such, the EBP process has developed a reputation as being value-free on the part of the practitioner. Gibbs and Gambrill (2002), two of the staunchest advocates for EBP in social work, applaud EBP as distinct from traditional teaching methods that tend to "mix evidence indiscriminately to support a particular position" (Gibbs & Gambrill, p. 462), stating that EBP "controls for clinician bias" (Gibbs & Gambrill, p. 463). However, we know that being values-neutral is a challenge for all social workers, reflected in a rich literature of social workers struggling with moral and ethical challenges (Clark, 2006).

The EBP process is rooted largely in the preferences, rights, and values of the client. Toward that end, the literature describes ethically-appropriate EBP responses to work with highly religious clients (Hasnain, Sinacore, Mensah, & Levy, 2005; Huppert, Siev & Kushner, 2007). We know that a client's religious values, morals, and beliefs can impact preferences for treatment, sometimes by conflicting with empirically-supported interventions. Still, the literature is largely silent when it comes to instances where religious or other moral beliefs of *the practitioner* may yield additional challenges. The EBP process "encourages us to ask, 'How good is the evidence?' and 'Could I be wrong?'" (Gambrill, 2007, p. 449). These are brave questions often left unaddressed as practitioners half-heartedly engage in an EBP-like process while holding tightly to their own values and comfort zones when selecting interventions.

The remainder of this chapter will address this challenge, recognizing that practitioner values and behavior *do* affect the outcomes of care (Evidence-Based Medicine Working Group, 1992). By offering some additions to the traditional EBP decision-making model, we hope to provide a more accurate portrayal of what must happen in order to engage in the scientific EBP process in a way that accounts for the values of practitioners rather than incorrectly assuming the process to be "values-neutral."

New Additions to Conventional Evidence-Based Practice

The additions proposed here build on the traditional EBP decision-making model (Figure 1) based on the understanding that practitioners cannot normally be purely "values-neutral" in their work with clients. In order to ensure that the fidelity of the EBP process is maintained as its originators intended, the model must include intentional elements that remind practitioners to consciously address their own values as well as the values of clients. While these additional elements may have been implied in the original model, we argue for stating and illustrating them clearly so that the practitioner's personal morals, values, and beliefs are not unconsciously impacting the course of treatment. Embedded in these additions is the high value we must place on our own professional integrity; that is, our commitment to search the evidence against our favored views and to consider well-argued alternative views (Gambrill, 2007). This new EBP decision-making model is intentionally "value laden" because we believe that proper EBP process is not as easy as simply "informing" or disregarding our own values, beliefs, tendencies, and intuition. Therefore, by adding in new elements of intentional *self-awareness* and *transparency,* we can maintain our professional integrity while at the same time acknowledging the value laden

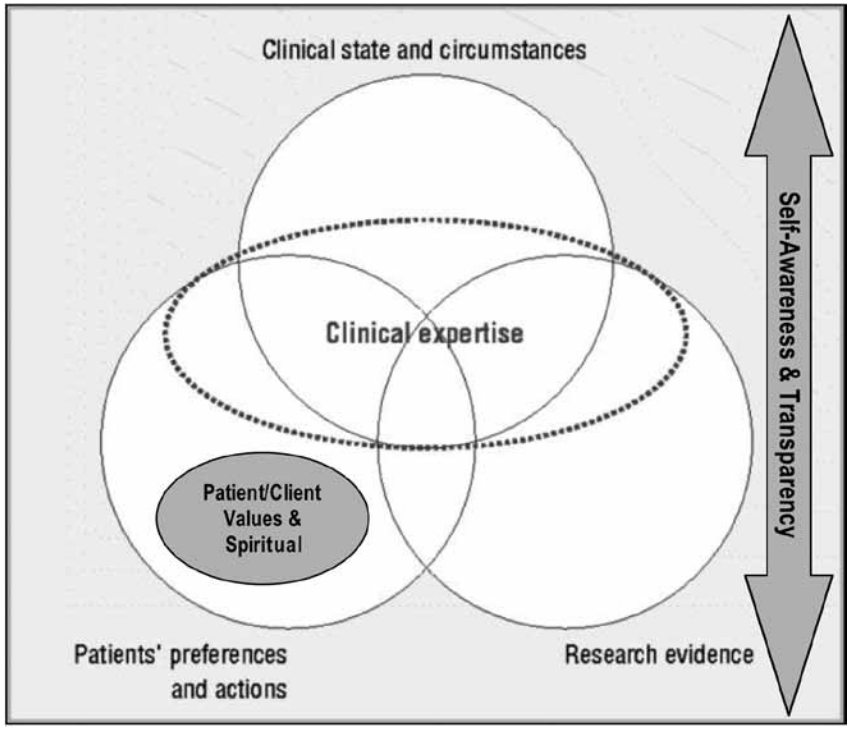

Figure 2: Value-Laden Evidence-Based Practice Decision Making Model
(Adapted from Haynes, Devereaux, & Guyatt, 2002)

nature of work with diverse populations. As seen in Figure 2, the competencies of self-awareness and transparency need to be practiced throughout the entire process of EBP decision-making. There are implications for skillful integration in each aspect of the EBP model. In the remaining discussion of this chapter, we attempt to illustrate what self-awareness and transparency might look like in each of the three main elements of the EBP decision-making process: research evidence, the clinical state, and client preferences.

Regarding the *research evidence* component of the EBP decision-making process, the incorporation of self-awareness and transparency on the part of the practitioner is critically important for maintaining the fidelity and scientific rigor of the EBP process. There is a danger, largely ignored in the existing literature on EBP, of practitioners – consciously or unconsciously – limiting the scope of their research within the context of their own values and clinical preferences. In other words, the practitioner may not look for the potential disconfirming evidence that might challenge existing preconceptions of the social worker or the client (Raines, 2008). To address this danger, our adapted EBP decision-making model stresses the importance of practitioner self-awareness in the course of the search of the research literature. Gibbs and Gambrill (2002) have briefly described ethical reviews of the literature: "Ethical reviewers seek all published and unpublished research that meets standards for inclusion in a review, regardless of whether that research supports or refutes their assumptions" (p. 470). We argue that the only way to truly ensure that one's search of the literature is so inclusive is to engage in an ongoing process of self-awareness. The danger of limiting our search within our own values becomes even more challenging when the process of searching the literature fails to yield conclusive research findings.

When empirically-supported interventions cannot be located, the guidance in existing EBP literature instructs practitioners to inform clients of the lack of evidence in the literature and then suggests that "helpers describe *their hypothetical views* about problem-related factors and related service implications" (emphasis added, Gibbs & Gambrill, 2002, 460). While our experience with EBP tells us that this is sometimes necessary, we have some discomfort with the likelihood that – especially given the inherent power imbalance between the social worker and the client–that the client may blur the practitioner's "hypothetical views" with the idea of evidence. In order to ensure that, in the absence of empirically-supported interventions, the personal biases and values of the practitioner do not wrongly communicate empirical support and certainty to the client, the need for transparency and humility is crucial. Transparency at this point in the EBP process requires that practitioners articulate those "hypothetical views" in a way that leaves no confusion between preference and fact.

The need for self-awareness and transparency also holds strong implications for the understanding of the *clinical state*, the next component of the EBP decision-making process. For those in the social work profession, we are called to employ culturally-competent practice with diverse populations in which the dignity and worth of each individual person is supremely valued, regardless of any personal characteristics or lifestyle. However, if we allow ourselves a

moment of complete humility and honest self-awareness, each of us can recall at least one client or group of clients for which our own personal judgment conflicted with our client's life choices. Especially when we are considering the role of values, beliefs, and morals (and even more so when we think specifically of religious beliefs and values), practitioners must acknowledge those biases. If one of the three components in arriving at EBP decisions for intervention with clients is the clinical state of the client, then we must take the time to identify and acknowledge when our personal values, beliefs, and morals have an impact on the way we interpret and judge a client's situation. For example, some practitioners have personal values, whether related to their religious beliefs or not, regarding homosexuality, abortion, addiction, childbearing, childrearing practices, health, and hygiene. When considering the role of self-awareness in regard to the clinical state, we are simply reminding practitioners to be aware of those biases because no practitioner is as "values-neutral" as we purport to be. The use of transparency regarding these judgments may be problematic and should be engaged in very carefully. While referral of a client may be necessary, it may not be appropriate to be entirely transparent with the client regarding the practitioner's judgment of the client's lifestyle or behavior choices.

There are important implications of both transparency and self-awareness within the realm of the third component of the original model – *client preferences and actions*. Much has been written in recent years about the need for spiritual assessment in clinical social work practice (see Hodge, 2001). Some studies have estimated that between 43% and 62% of mental health clients identify religion and/or spirituality as playing highly beneficial roles in their lives (Sheridan, 2004). Given the potential value a client's spirituality may give to his or her clinical experience, "a sensible clinician, whether or not he or she is spiritual in any way, will realize that any purpose-giving, optimistic belief system that is relevant to a client, must, as a matter of sound practice, be acknowledged, explored, and reasonably integrated into the clinical process" (Hoyt, 2008, p. 225). As such, we are suggesting the addition of one more element to the original EBP decision-making process. Within the context of the client preferences and actions piece of the decision-making process, we argue for the central importance of an intentional time of assessment of the client's own values and spirituality. Engaging in an assessment of the client's values and spirituality relates directly to the practitioner's own processes of self-awareness and transparency by a) opening the door for a clinical process that ensures clients will not be "caught between secular and spiritual outlooks" (Gotterer, 2001, p. 187), b) increasing the transparency of the decision-making process by inviting in this important element of the client's life, and c) providing the practitioner with valuable information about the client that may or may not align with the values, beliefs, and morals he or she holds dear. Understanding the beliefs and values of the client, the practitioner can then compare his or her own beliefs and values in order to identify points of connection or discordant beliefs (Tan, 2010). Especially when discordant belief patterns exist between the practitioner and the client, if left unchecked, the EBP decision-making process becomes skewed, biased, and more unscientific than we may realize.

Implications and Next Steps

We do wish to acknowledge one particular setting in which the value-laden EBP decision-making process proposed here may be problematic. Little has been written about the challenges inherent in the provision of EBP-driven services within the context of a faith-based social service agency. Recognizing this gap in the literature, we urge those in the faith-based arena to research their specific interventions in order to develop empirical support for them. We have ethical concerns about knowingly providing non-empirically supported treatment interventions without being clear with our clients that that's what we're doing. However, many faith-based agencies do not yet have established literature to validate their services. Developing this research base will result in huge strides forward to legitimize the powerful work being done in faith-based organizations, while also serving as a challenge to those service providers who may be utilizing interventions with no empirical support. Inherent in this call for further research are two potentially controversial obstacles. First, we must be ready to address what faith-based practitioners are to do when the EBP process yields an intervention their agency cannot implement within the context of their mission. Second, we must begin to consider whether or not there are interventions that should be established within the literature as effective for a client who identifies as atheist and other interventions deemed effective for highly-spiritual clients. These are large research tasks to undertake; yet we feel compelled to make the case for their relevance in applying our value-laden EBP decision-making process to a broad audience.

By adding self-awareness and transparency to the EBP decision-making model, practitioners and clients alike may feel more secure that clinical decisions are more scientifically rigorous and bias-free. Practitioners are *not* "values-neutral" in our work with clients, especially when faced with particularly diverse populations and behaviors that carry with them an element of spiritual, moral, or other personal bias. Helping professions of all kinds, including social work and medicine, have an ethical responsibility to engage in a truly transparent EBP process – one in which we present *all* treatment options found in the literature, regardless of practitioner or client values and preferences. By engaging in an ongoing process of self-awareness, we can begin to work toward "tempering" our own values. We can never truly shelve our personal values, morals, and beliefs, but we can account for them by following the value-laden EBP decision-making process suggested here.

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