Evidence Based Practice **in Health and Human Services:**
Keys to Critique from a Sociological Perspective

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Beyond Budget Cuts: Managing Human Services in the Neoliberal Era (Session# 121)

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In this presentation I develop key areas of critical inquiry into "evidence based practice"

(EBP), with special attention to the provision of services for older and/or disabled people in home

and community settings. The shift, from institutional to home and community care, is deeply rooted

not only in cultural preferences for autonomy, but also in fiscal pressures and expanded legal rights

for people with disability to be housed in the *least restrictive setting possible, given their health*

status. It is against the backdrop of this systemic change, which is altering the provision of direct

services in virtually all of the clinical fields that serve such clients, that I consider the ascendance of

EBP. In recent years, EBP has become a dominant approach in the design, governance, and

evaluation of policies and programs in health and social services. As Timmermans and Berg show

(2003), there is a much longer history of approaches to standardizing medical care; one was the

rise of "diagnostic related groups" as part of managed care in the 1980s. These rules set limits on

how long patients could remain in the hospital, with public funding, for particular illnesses and

procedures, and were an earlier attempt to impose controls over the costs and discretion within

healthcare. However, the authors argue that evidence-based medicine (EBM) represents a

distinctive shift, in purporting to guide clinical decisions in greater detail.

Though its origins are in clinical medicine, EBP has migrated widely from that field, with

consequences and implications for providers and recipients of health and social services that are, as

yet, little understood. After summarizing the thrust of EBP in medicine, I will sketch key points of

inquiry.

Ostensibly, EBP is technical/rational system for disseminating research, i.e., "evidence," more broadly and systematically, in order that such evidence may inform clinical decisions for the benefit of patients/clients; in turn, this approach promises to enhance the efficacy of treatment and the distribution of resources in an era of intense fiscal pressure. As such, it represents ideals and goals that appear unassailable. Moreover, because it appears to increase professional accountability and reflects positivist claims to scientific objectivity and rigor, EBP avoids any direct association with such politically-contested aspects of neoliberalism as privatization and deregulation. However, in expanding from clinical medicine (with clearer diagnostic categories and goals), to social services, in which multiple, contextual conditions and client autonomy are more complex, EBP poses many important and, for me, troubling questions. Though a broader inquiry would examine the connections between neoliberalism and EBP, my narrower goal here is sketch out key areas of critique of EBP from the standpoint of a critical sociology of aging and disability (one informed as well by the sociology of professional power and status).

In this discussion, I focus on three areas of critique in the implementation of EBP that appear to me most salient from sociological perspective; all reflect tensions regarding the *a-contextual* nature of EBP in providing home and community-based services;

1) Assumptions regarding what counts as evidence (centering on quantification) and how this is reconciled with professional discretion and client autonomy; 2) Implications of EBP for access to and equity of services; and 3) Challenges of implementing EBP across fields of practice, which is especially important in understanding community-based support of older and/or disabled people. Finally, I will argue that a reflective/narrative approach to research, drawing on the pragmatic experience of service providers, is especially needed and relevant to illuminate these issues.

It is essential to realize, along with Gray et al., (2008), that EBP is not merely an attempt to bridge research and practice more effectively, or to strengthen the role of empirical data in evaluating health and social services. The push toward greater "effectiveness" in providing services has been strong for decades. Rather, EBP represents a widespread transformation in what kinds of "evidence" are consulted (for example, research versus professional experience); how and by whom these are counted, in terms of the funding and organization of services; which among the various goals of human services are prioritized; and even in the degree and exercise of professional autonomy across the many clinical fields that are involved in serving older and/or disabled people. The impact of EBP is in human services can be likened to that of *No Child Left Behind* in public education: it has altered the discourse and goals of service provision, imposing new demands on frontline workers and clients, seemingly without allowance for local, contextual resources or inequities that are critical in understanding the realities of service provision.

Rationale for the development of Evidence Based Medicine

According to an Institute of Medicine report (IOM 2008), Evidence-Based Medicine (EBM) arose from awareness of a gap between medical knowledge and research, and the quality of care. This challenge, of *translating* the massive body of published research into practice revealed the limitations of the traditional model of "physician as expert." Other factors behind the EBM movement include more proactive "consumer-driven" approaches to medical care, abetted by online access to medical information, and the expansion of malpractice claims, both of which subject physicians to greater public scrutiny than in the past. Though recognizing the pressures that brought EBM into being, I turn to questions regarding its diffusion into the broader domain of health and social services. I do so without making any claims about whether, on balance, EBP in social services has been beneficial or harmful; instead, I try to advance a research agenda that reflects sociological perspectives.

Defining "evidence" and the limits of quantification

Among the tenets of critical theory has been to reject unthinking acceptance of quantification as a reflection of—or guide to—social experience (e.g., Agger, 1991). In the development of positivist science, a hierarchy of knowledge has enshrined quantification as the supposedly most objective and precise form. In EBM, the "gold standard" by which procedures or drugs are assessed is that of randomized, clinical trials, which offer a "meta-analysis" of many studies and, often, thousands of research subjects. It is notable that, even in drug trials, the efficacy of clinical trials has been questioned; this is true because of the distinctively individual nature of human physiology and responses to drugs, and because of potential differences between trial participants and prospective patients (Leaf, 2013). More to the point, clinical trials, and thus EBM itself, is most relevant to addressing discrete illnesses or conditions with clear biological mechanisms and defined clinical outcomes. Such is clearly not the case in the social services, in which goals—such as returning home after a stay in the hospital or rehab setting—may be contested among clients and providers, and are contingent on blending formal and informal services. In such cases, the local context, financial resources of the client, and eligibility rules and timetables regarding benefits become critical factors to consider. The consequences of such decisions, for individuals and for the healthcare system at large (e.g., in avoiding hospital readmissions) are enormous, and in principle it is difficult to see how any course of action, drawn from data on multiple cases, would be more valuable than the professional discretion of a social worker or discharge planner with intimate knowledge of the client. Theoretically, many forms of research evidence can be brought to bear in EBP; however, the cultural denigration of interpretive knowledge, and practical challenges of utilizing such knowledge in the hectic work flow of human service providers, raise grave concerns about whether in fact multiple forms of knowledge are brought to bear. As critical theorists argue, and institutional ethnographers have shown (e.g., Campbell and Manicom, 1995), categories of

record keeping become self-fulfilling prophesies, reproducing particular definitions of reality, and silencing others.

EBP and Access to and Equity of Services

Concern among advocates for social justice in health care has settled on the funding, adequacy of and access to basic services. For such advocates, as for me, any approach to reorganizing programs and services which fails to acknowledge this larger dynamic is suspect. This concern has been fueled in recent months by the federal budget "sequestration" which led to dramatic cuts in social services nationally. According to news reports, in the single domain of mental health services, 684,000 individuals will lose critical employment and housing assistance, case management services, and school-based supports; and 1.13 million children and adults will be at risk of losing access to any type of public mental health support. Such pressures are exacerbating chronic gaps and inequalities in the social service sector, which also vary widely across states and counties.

As an approach which seeks to disseminate and sanction "best practices," EBP would seem to be mute with respect to structural inequalities in the funding, staffing, and integration of various agencies in the social service realm. Decades of research in sociology and other fields has documented the fragility of funding, inadequate compensation, and career burnout that plague direct service providers. Given these realities, EBP may impose demands upon providers that, even if sound and supported by staff, are unattainable in practical terms. Inasmuch as external funding sources are likely to follow and legitimate the same indices of efficacy defined by EBP guidelines, one would expect differences in resources, across agencies and communities to be compounded in a neo-liberal climate in which there is keen competition for funding. Failure to recognize this, among funders or even professional associations, could lead to penalties for more vulnerable providers or to de-facto rationing of resources, as providers seek to meet external criteria of efficacy. This is

hardly far-fetched, given the experience with testing regimes under NCLB, in which poorer schools have faced sanctions for failing to meet national or state-wide testing standards.

It is crucial to acknowledge that there is an endemic tension, in providing human services, between meeting individual or group needs (say, in the name of *cultural competence*), and serving the greatest number of clients, seen as equal and deserving of uniform treatment. However, as I explore the academic literature on EBP, in social work and other fields, I find little discussion of the micro- or meso-level dilemmas emerging in service provision, or of how these are resolved.

Challenges of Implementing EBP across Clinical Fields

A final line of critique of EBP reflects the importance, in supporting people who are older and/or disabled, of inter-professional collaboration. The viability of evidence-based *medicine* is partly a reflection of the clear, hierarchical organization of authority and responsibility in provide acute care (epitomized by the hospital). However, the reality among older, and many disabled, people is of multiple chronic conditions, which must be managed in the community with considerable personal autonomy. Supporting that autonomy is, of course, central to the ethical mandate of social work and other clinical fields. Whether couched in terms of limiting professional control, or of client empowerment, this value is clearly stated, as in the NASW Code of Ethics, which states in part, *"Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs."*

Upholding that value is all the more challenging, when there are multiple providers and fields involved in meeting the needs of particular clients. Still, the need for collaboration has been established in the areas of elder services, as well as others such as mental and developmental

disability and addiction. One model, from the state of Oregon, is the Coordinated Care Organization,

(CCO), which is

> "...a network of all types of health care providers (physical health care, addictions and
> mental health care and sometimes dental care providers) who have agreed to work together
> in their local communities to serve people who receive health care coverage under the
> Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage
> chronic conditions, like diabetes. This helps reduce unnecessary emergency room visits and
> gives people support to be healthy. (Oregon Health Policy Board, 2013).

The same team-orientated approach to providing services is well-established in other

domains of the health and human services sector, such as hospice care and domestic violence

intervention. How, we ask, are these disparate groups to find consensus on what counts as strong

evidence; how it should be weighed against others' in inter-professional teams; or on what is

defined as clinical the primary clinical goal? Presumably, in the era of EBP, each member of the

team will be accountable to distinctive discourses and standards of practice; the question of how

these are reconciled or made commensurable can be framed in formal terms, based on clinical

guidelines within various fields, or (more sociologically) in informal, pragmatic terms, reflecting the

daily accommodations that workers, and clients, are obliged to make. This, too, echoes a rich

tradition in sociology, represented by such analyses as that by Michael Lipsky, whose *Street-Level*

Bureaucracy (1980) was published over thirty years ago.

Conclusion: The Value of Reflection by Practitioners

I conclude the discussion by calling for more reflective, narrative study of the impacts—

positive, negative, unintended—of EBP in the domain of human services. My effort has been to

show that a sociological perspective on these questions is not only provocative for those in the

social sciences, but also of vital relevance for practitioners, administrators, and clients of such

services. Though many of the issues raised above are quite current, they can nonetheless be

illuminated by methods and approaches that have proved to be powerful in understanding other professional groups and worlds. From one standpoint, the central problem is that of understanding how formal bodies of knowledge are integrated and translated, via clinical experience and contextual knowledge, into benefits for clients or patients. This is hardly a new problem, and I see great promise in applying interpretive/phenomenological approaches, such as that which Patricia Benner (2001 [1984]) employed to study the development of clinical excellence in nursing. In *From Novice to Expert,* Benner sought to uncover the *embedded knowledge* in which nurses glean and apply their science-based training to the contextual demands of particular patients and circumstances. Through intensive, semi-structured interviews, often focusing on *Critical Incidents* in which nurses believed their intervention to have been especially consequential for patient outcomes, Benner documents the development of expertise over time. She sees expertise as holistic, in the sense that,

> the expert….no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action…With an enormous background of experience, (s/he) now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem, without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions (2001 [1984], 31-32)

Achieving a level of excellence is a central goal in professional training and socialization. Advocates for evidence based practice argue that the collective body of evidence can now serve clinicians in avoiding "wasteful consideration" of ineffective approaches to decisions. Those same advocates promote EBP as a resource, rather than a barrier or constraint, for practitioners, and further claim that such guidelines are in keeping with "person-centered" care or counseling, since the provider is better able to discuss options and risks, in a spirit of informed consent. These are exciting claims, and their acceptance in the professional and policy world, in past decade or so, is

dramatic indeed. However, I have developed on a set of questions and concerns regarding the implementation of EBP, in the domain of services for older and/or disabled people, which will be of central importance in the years to come, both in policy and in human terms.

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