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NASW, RHODE ISLAND CHAPTER
National Association of Social Workers

September 29, 2016

To: Senate Committee on Health & Human Services
From: Rick Harris, LICSW-Executive Director
Re: Mental Health Hearing #2 Evidence-Based Practice

I want to thank this Committee for giving me an opportunity to testify on Evidence-Based Practice relating to mental health and substance abuse/use services in Rhode Island. Even though this is a relatively (30 years or so) new discussion in human services, there is nothing new about the subject matter. It has been around since the beginning of humanity.

I actually know something about Evidenced-Based Practice and there is no way to adequately cover the topic in a 5-7 minute testimony or in this written document. In other words, it complicated. I would be glad to set an appointment with any individual or group of legislators for a three to six hour workshop on the topic, however, I know you probably won't have the time in your very busy schedules.

In my professional career, I have been all over the country providing consultation to hundreds of individuals, agencies, and government entities on this specific subject matter. I also consulted once a week for the Federal Department of Education for an eight year period as a grant reviewer and team leader, which in itself is a form of evaluating evidence-based practice. I have served as an administrator in a large mental health agency; have served on many statewide planning committees; was a Director (principal) of a public alternative school in Massachusetts; have been an advocate and testifier in this fine building since 1983; a provider of clinical mental health services for thousands of hours; am an adjunct professor at two colleges; am a community organizer; a Licensed Independent Clinical Social Worker; and am currently representing the National Association of Social Workers - Rhode Island Chapter (NASW - RI) presenting the following testimony.

The written portion of this testimony will contain two parts:

Part I. This section will contain information related to Evidence-Based Practice which will briefly discuss, from a Social Work perspective, regarding various aspects of Evidence-Based Practice: policy decision making, agency programming, clinical practice and guiding principles regarding ethical and scientific application of practice.

Part II. This section will address, warnings against the exclusive use or mis-use of evidence-based practice. The section will also provide information and thoughts regrading a

number of concerns based on, biases, presumptions, perspectives, ideologies my professional experiences which I believe can impede on effective client services, at times, can be actually be destructive to the client.

Part I: Information Related to Evidence-Based Practice

There are three major areas in which the social work profession is primarily concerned regarding Evidence-Based Practice. **1. Policy Development and Implementation. 2. Mental Health and Substance Abuse/Use Services. 3. Private Practice.** The application of Evidence-Based Practice has some commonality and differences as it applies to the principles of each area. All three areas are subject to bias related to funding, political, professional, geographical and demographic influences.

The social work profession certainly agrees with the basic premise of utilizing principles of Evidence-Based Practice as long as many of the areas of concern that will be covered in Part II are also considered and not allowed to control the process. Following is a short definition of Evidenced -Based Practice from NASW.

NASW Practice Snapshot:
Evidence-Based Practices—For Social Workers
Office of Social Work Specialty Practice

The issue of evidence-based practices (EBPs) is raising questions for social workers about the role of these interventions in providing effective treatment, and their resulting implications for practice. Recent attention by researchers, clinicians, consumers, consumer advocates, and others has brought EBPs to the forefront of the social work field

DEFINITION

Evidence-based practices are broadly defined as interventions for which scientific evidence consistently shows that they improve client outcomes. In *Crossing the Quality Chasm: A New Health System for the 21 st Century* (2001), the Institute of Medicine defines EBPs as including the following factors:

- Best Research Evidence;
- Best Clinical Experience;
- and Consistent with Patient Values.

http://www.socialworkers.org/practice/clinical/csw081605snapshot.asp

The NASW Code of Ethics helps to ensure, within previously stated parameters, the use of Evidence-Based Practice

There are two guiding principles that apply to Evidence-Based Practice: **(Bolded printed areas are from the NASW Code of Ethics)**

1. Social Workers Should Behave in a Trustworthy Manner. This principle helps ensure that social workers utilize evidence-based practice in a way that is as effective as possible, while not letting biases interfere with sound clinical judgement.

2. Social workers should practice within their areas of competence and develop to enhance their professional expertise. This principle requires the social worker to keep up-to-date on the latest practices as scientifically, practically and experientially within their scope of practice.

Several specific ethical standards apply to Evidence-Based Practice as follows:

1.01 Commitment to Clients. Social workers' primary responsibility is to promote the well-being of clients. This standard includes therapeutic services that have been proven within the professional community standards to be effective with clients.

1.03 (a) Social workers should provide services to clients only in the context of professional relationship based on, when appropriate, on valid informed consent. This standard helps guard against bias driven evidence-based practices that potentially could violate the client/helper relationships.

1.04 Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultations received, supervised experience, or other relevant professional experience. Professional social workers will guard against using evidence-based practice that does not seem to meet the specific needs of the client. In reverse, a social worker in accordance to evidence-based indicators, will seek training to gain expertise in a specific skill area to meet client needs.

5.02 Cultural Competence and Social Diversity. Social workers should understand culture and its function in human behavior in society, recognizing the strengths that exists in all cultures. Once again, professional social workers will guard against any evidence-based practices that does not take cross cultural factors into consideration and will emphasize evidence-based practices that do take cross cultural factors into account.

1.06 Conflict of Interest. There are examples or potential scenarios where evidence-based practice standards have been applied by various entities that have created a "conflict of interest" for practioners. I would be glad to provide examples this is has taking place upon request.

Summary of Part I

There is a great need for Evidence-Based Practice. Our whole Western world thinking is primally based on the scientific /problem solving method. Without it we would be in the dark ages still. **There is no basic reason not to utilize Evidence-Based Practice in mental health and substance abuse/use services as long as we take certain precautions to not over utilize the concept and let it totally drive our services and service development without reason and fairness to the client and helper. That we cannot do.**

Part II. Warnings Regarding the Exclusive Use or in my Opinion, Mis-Use of Evidence-based Practice.

In the opinion of this author, there is no such thing as a non-bias report, policy analysis, testimony or research product. I constantly read GAO reports prepared for Congress and find bias, although not necessarily on purpose. The fact is: It is impossible to include all information, to have all the facts, or to analyze everything necessary to write a completely non-bias document of any kind. Information we must leave out or can not obtain alone guarantees bias. Who orders, who pays for, or who request the document influences the outcome of any research project. Once completed, the many users and the various interpreters at all levels, influences the outcome.

Just last week in the sports section of the ProJo a sub headline read; **"Dodgers Score Two Late to Defeat Yanks"**. This is a simple example of how this headline can be interpreted differnently in different situations. A sighted person will interpret this headline correctly. Dodgers win. A visually impaired person being read to hears: **"The Dodgers Lose"**. An English as a second English language person may be totally confused by the use of the word two. For we also use **"too, two, to"**. A person with a cognitive language or process communication disability may be totally confused by the headline, altogether. When I read this headline to my highly educated social work class, they naturally assumed that the Dodgers had lost the game, just like the visually impaired person would. **This is a very simple example demonstrating how easy it is to misperceive what others may think is a straightforward easy to interpret message. Think how many ways we can misinterpret evidenced-based findings and then implement the findings wrongly if not careful.**

Another example, if we apply evidence-based practice to a simple medical procedure as follows: I am using a cutting tool to trim my bushes in my backyard. I slip and end up with a three-inch gash

in my wrist requiring stitches. I then go to the friendly medical walk-in center. The doctor does the following procedures.

1. Inspect the wound.

2.. Clean the wound.

2. Put some antibiotic on the wound.

3. Stitches the wound.

4. Bandages the wound.

5. I pay the bill.

6. I get better.

7. All goes well and I have a minimal scar.

I should be able to go to any qualified medical center and, based on evidence-based practice procedures, the results should be the same. Easy as apple pie. The same just isn't true for the subject matter of the hearing this afternoon.

In mental health and substance abuse/use services, we are adding a number of infinite variables, including the few listed below:

1. A lot of different methods to provide services.

2. Different environments/settings in which the services can be and should be provided.

3. Funding or lack of funding available.

4. Duration and frequency of available/allowed services.

5. Cultural competence/language availability of services provided.

6. Competence of the provider.

7. Biases of the professional provider.

8. Match between the provider and the client.

9. Independent variables of that particular day, hour, minute of service gernated by the clinet and the provider.

10. Cognitive/intellectual and/or ability/capacity of both the client and the provider

11. Scope of practice of the provider

12. Financial ability to pay/insurance capacity of the client.

13. Social supports available to the client.

14. The client's ability to control the identified issues that are so impacting their lives within and without client's system(s).

15. Social policies which had great impact on the ability of the client's ability to get along in the world.

16. Experiences the client had which impacted on the client's life such as lack of a good public education, poverty, physical abuse, sexual abuse, criminal record, unfair social policies and host of other conditions of that were no fault of his/her own.

17. And so many more variables that we don't know about and cannot be accounted for by any model of research controlled or not.

(Please keep in mind that humans are very complicated. The human brain is a fantastic computer which we have very little understanding of how it works and have no way of knowing the interactions of environmental factors which are constantly changing in nano seconds, none of which are duplicated ever in the history of the world or universe.)

Thoughts Concerning "Models" & Evidence-Based Practice (Not necessarily the opinion of NASW- RI)

Throughout my career I and teams that have worked with me, have developed a number of extremely successful programs within agencies. These programs have had great outcomes. Many of these programs were federally funded demonstration projects. In fact, they were so successful, I was invited several times to present nationally in Washington, DC for various programs. I presented these programs under the condition that they never would be referred to as a **"Models"**. The problem with models, in my opinion, is that they actually cannot be duplicated anywhere. **Concepts, on the other hand within models, should be and can be duplicated and utilized most places.** Concepts are

universal because the human condition is universal, for the most part.

I freely gave all ideas and program information to whoever wants them without charge because clients deserved that information. The conceptual frameworks contained in the services we developed worked wonderfully in most environments, but needed to be modified to meet the specific needs of the clients, neighborhoods and communities. **This is the way I look at evidence-based practice also**. **See below for the template I recommend:**

1. Look at the Evidence-Base Practice you would like to use.

2. Modify the practice to meet the needs of the clients served locally.

3. Take into consideration all the local laws, agency protocols and other regulations.

4 Modify to account for the staff skill base of the agency and/or the practitioner.

5. Apply the service.

6. Make sure to remove all biases to the extent possible.

My Final Recommendation (This is not necessarily the opinion NASW - RI)

Please don't take the shortcut like the Sailors of Greek Mythology who found themselfs cast upon the rocks. Don't be seduced by the Sirens of some funding sources and some entity's who use "trendy flowery shortcut language" related to Evidence-Based Practice and use the "quick fix" programs that are sometimes advertised under the: very expensive; sometimes very cheap; or sometimes highly idealized; "Evidence-Based Program Pre-Packed One Size Fits All Model". Please heed the "Warnings" contained in this testimony.

If you would like more information please feel free to call me 401-274-4940 or e-mail at rhodeislandnasw@gmial.com

I truly appreciate the time you have taken to read this document.
Respectfully submitted,

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Executive Director