



Youth care workers' perspectives on and adoption of evidence-based practice



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ABSTRACT

Despite increased emphasis on evidence-based practice (EBP), the limited implementation of EBP is a well-known reality. This research examines youth care practitioners' knowledge of, attitudes toward and adoption of EBP ($N = 74$). Additionally, the difference between EBP and empirically supported treatments (ESTs) is made. Findings show that some practitioner background variables are related to their knowledge of and attitudes toward EBP, but not to ESTs. Findings also provide evidence for current dissemination and implementation models that strongly emphasize the importance of good knowledge of and favorable attitudes toward EBP and EST by practitioners. Expanding the knowledge base of practitioners and positively influencing their attitudes toward EBP are two of the tracks for closing the gap between research and practice.

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1. Introduction

Evidence-based practice (EBP) in psychology and social work has been the topic of an intensive discussion between academics and practitioners for the last decades. Similar to EBP in medicine, EBP in psychology is defined as the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences (APA Presidential Task Force on Evidence-Based Practice, 2006; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). The promotion of EBP aims to enhance psychological practice and public wellbeing by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship and intervention. EBP is a comprehensive concept including, but not restricted to the use of empirically supported treatments (ESTs) (APA Presidential Task Force on Evidence-Based Practice, 2006). Also policy and value directives, practice principles, common factors, common practice elements and specific practice knowledge are considered as parts of EBP (Barth et al., 2011). This latter nuance is important since it identifies one of the most controversial topics in the field, namely, the high-fidelity implementation of empirically supported intervention protocols (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009). According to Sackett et al. (2000) the process of EBP contains five steps: (1) convert a need for information into an answerable question, (2) track down the best evidence to answer that question, (3) critically

appraise that evidence in terms of its validity, clinical significance and usefulness, (4) applying the results of this appraisal to practice, and (5) evaluating effectiveness and efficiency in carrying out the four previous steps and seeking ways to improve them.

1.1. Implementation of EBP in usual care

In most developed countries child welfare policy increasingly emphasizes the pursuit of EBP (Mitchell, 2011). Policy makers, governments and clients are pressuring agencies to demonstrate their adoption of EBP and to indicate how they are moving toward it. Despite this pressure, the limited implementation of EBP within care as usual is a well-known reality. Although almost all agencies are experimenting with new programs and practices, only a minority of these newly adopted programs are empirically supported. Research on the use of ESTs in USA child welfare agencies and children's mental health services showed that only 10 to 25% of the programs are empirically supported (McCue Horwitz et al., 2014; Schoenwald, Chapman et al., 2008). Due to its many different national policies, the situation in Europe is even more complex but comparable, although ESTs may be more widely adopted in the USA than in Europe and Flanders (van Sonsbeek et al., 2015). For instance, in the Netherlands it was estimated that one to 5% of the interventions used in youth care is empirically supported (Veerman, 2012). In Flanders, it was found that in child welfare most often an eclectic approach is practiced including programs, (best) practices and theories comparable to many other countries (Stroobants, Vanderfaeillie, & Andries, 2013).

However, despite the fact that ESTs are not often used, practitioners adopt EBP principles and strategies (Brookman-Frazee, Taylor, &

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Garland, 2010; Thomas, Zimmer-Gembeck, & Chaffin, 2014). Unfortunately these strategies are usually applied with limited intensity and little perseverance, and many well-known strategies are left aside (Brookman-Fraze et al., 2010; Garland et al., 2010; Park, Chorpita, Regan, & Weisz, 2014).

1.2. Conceptualization of EBP implementation

Implementation is defined as “the use of strategies to introduce or change evidence-based health interventions within specific settings” (Novins, Green, Legha, & Aarons, 2013). The aim is to spread knowledge and the associated evidence-based interventions into practice. It is considered as an active, complex and multi-phasic process that involves multiple stakeholders in service systems, organizations and practice (Mitchell, 2011; Novins et al., 2013). Several implementation frameworks for EBP are available and mostly four main phases are distinguished: exploration, preparation, implementation and sustainment (Aarons, Hurlburt, & McCue Horwitz, 2011; Novins et al., 2013).

At the center of EBP implementation stands the clinician, who determines what actually happens (Jensen-Doss, Hawley, Lopez, & Osterberg, 2009). Practitioners have several important roles to play including providing services, training and supervising others, information sharing, serving as administrators and evaluating outcomes (Aarons et al., 2011; Jensen-Doss et al., 2009). Often, as frontline service providers, practitioners are called upon to implement innovations. Individual-level determinants for those implementing innovations such as EBP include tolerance for ambiguity, motivation to change, and the influence of peers within social and professional networks (Wike et al., 2014). It is therefore important to know how these practitioners experience EBP and what factors are related to a successful implementation. Two important predictors of the adoption of EBP are often suggested in the literature: providers' knowledge of and attitudes toward EBP. It is suggested that practitioners should have knowledge of and favorable attitudes toward EBP before they adopt EBP into practice.

However, an individual practitioner's decision to adopt innovation is just one factor affecting adoption within an entire organization and factors such as, organizational culture, leadership behaviors, and human and financial resources also influence the extent to which clinicians' implement EBP in their professional practice (Aarons, 2006b; Wike et al., 2014). The adoption of both EBP and EST is complex and involves coordination and interaction among professionals and levels. There has to be an active and directed incorporation of multifaceted strategies and resources that increases the chances (Moreno & Moriana, 2015; Powell, Proctor, & Glass, 2014).

1.2.1. Knowledge of EBP

One logic condition of EBP implementation is that practitioners have knowledge of it. Many authors have emphasized the importance of bridging the gap between research and practice by enhancing the knowledge base of practitioners (Kazdin, 2008; Newnham & Page, 2010). Some evidence supports this assumption. Most of the research has focused on the positive association between training and supervision and the adoption of ESTs (Jensen-Doss et al., 2009; McCue Horwitz et al., 2014; Scudder & Herschell, 2015). Some authors also report a direct positive association between knowledge (of the EST and of core therapy principles) and the adoption of ESTs (Sanders, Prinz, & Shapiro, 2009; Turner, Nicholson, & Sanders, 2011). On the other hand, some authors did not find an association between knowledge of EBP and the adoption of it (Higa-McMillan, Nakamura, Morris, Jackson, & Slavin, 2015).

However, an important question remains unanswered: to the best of our knowledge it is still unknown if youth care practitioners' knowledge of the process of EBP are also associated with more adoption of EBP and/or with more use of ESTs? As previously mentioned, this is important because EBP is more than the implementation of ESTs. The process of EBP includes tracking down evidence, applying the evidence to practice, and evaluating outcomes. It sounds reasonable that when practitioners

have knowledge of the process of EBP and understand the rationale behind intervention methods, this could have a positive impact on the implementation of EBPs (Bearman, Wadkins, Bailin, & Doctoroff, 2015; Lilienfeld, Ritschel, Lynn, Cautin, & Lutzman, 2013). This might also result in a higher usage of ESTs since ESTs are considered as a component of EBP (Drisko, 2014). However, it is also possible that the relation between knowledge of EBP, including knowledge of ESTs, and the use of EST is nonexistent or negative since a high-fidelity use of manualized interventions could raise more resistance to the providers (Borntrager et al., 2009). Also, previous authors (e.g. Lilienfeld et al., 2013) have suggested that a strong emphasis on EBP stimulates providers to ask questions, search for information and evaluate their outcomes while an emphasis on ESTs might almost suppress such activities.

To our knowledge little research has focused on which provider factors are associated with more knowledge of EBP. A few studies showed a positive correlation between a higher educational degree, clinical setting, theoretical orientation, lower clinical experience and being clinically active, and EBP knowledge was found (Berke, Rozell, Hogan, Norcross, & Karpiak, 2011; Nakamura, Higa-McMillan, Okamura, & Shimabukuro, 2011; Thomas et al., 2014). However, this positive association was not always found. Moreover, many other factors such as age, years of training, typical number of active treatment cases, professional specialty, and location were not related to EBP knowledge (Nakamura et al., 2011). Due to the absence of direct comparisons between practitioners' knowledge in Flanders, Europe or USA it is difficult to state whether their knowledge of EBP is comparable. However, the broad literature on EBP is expanding in Europe as well as in the USA, although the debate has probably started later in most European countries. Thus, it may be that exposure to the concept and meaning of EBP is more common across different professional disciplines in the USA, and this has been developing for a longer period of time than in Europe and Flanders (van Sonsbeek et al., 2015).

1.2.2. Attitudes toward EBP

Despite knowledge of EBPs, practitioners are sometimes reluctant to adopt them and give more face value to clinical experience (Newnham & Page, 2010). For instance, Pignotti and Thyer (2012) found that although most practitioners stated to have used an EST during the past year, they also frequently provided unsupported treatments. Moreover, positive clinical experiences, theoretical preferences, personality, and emotional compatibilities of practitioners were more influential in their choice of interventions than favorable research reports in peer reviewed journals (Pignotti & Thyer, 2012). However, practitioners with particular preferences including the theoretical orientation, are more likely to be motivated to learn the subtleties and nuances of specific interventions, which could facilitate learning and translate into the competent delivery of prescribed therapeutic techniques (McLeod, 2009; Wolk et al., 2016). Such an allegiance to interventions influences clinical outcomes via the quality of treatment delivery (McLeod, 2009; Southam-Gerow et al., 2010).

Both positive and negative attitudes toward EBP are respectively positively and negatively related to self-reported adoption of EBP (Nelson & Steele, 2007). Many practitioners express concerns regarding the research supporting ESTs (e.g. lack of generalizability, high focus on outcome instead of process, and clinical relevance of significant statistic differences) and the applicability of EST in practice (e.g. a desire for a greater emphasis on the therapeutic relationship, and the need for flexibility within treatment protocols) (Kazdin, 2008; Nelson, Steele, & Mize, 2006). It is often concluded that most practitioners perceive research as relevant to their clinical work, but generally less relevant than other sources of information such as own past clinical experiences, theoretical orientation and colleagues' advice (Lilienfeld et al., 2013; McCue Horwitz et al., 2014; Thomas et al., 2014). There is also some evidence that practitioners are less reticent to the concept of EBP than to manualized ESTs (Borntrager et al., 2009; Jensen-Doss et al., 2009).

To date, some research has focused on the provider characteristics associated with the practitioners' attitudes toward EBP and ESTs. Yet, since

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