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ORIGINAL PAPER

Evidence-Based Practice in Social Work: Challenges and Opportunities for Clinicians and Organizations

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Abstract Evidence-based practice (EBP) is increasingly emphasized in social work, yet effective approaches for translating research evidence into social work practice remain elusive. Despite a growing body of evidence describing effective interventions with a variety of populations, social workers continue to encounter substantial challenges with incorporating knowledge gained from these intervention studies into their routine practice with clients. This paper presents the current research outlining the known barriers and promoters to using EBP in social work clinical practice. Because social workers practice within the context of organizations, we consider the barriers that exist at both the individual and organizational levels that affect clinical social work practice. In addition to addressing the various challenges to incorporating research evidence into practice, we will also discuss a variety of emergent opportunities accompanying the move toward EBP that can be leveraged by clinicians in their social work practice with clients.

Keywords Research evidence · EBP · ESI · Clinical social work · Intervention · Mental health

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Introduction

Evidence-based practice (EBP) is increasingly emphasized in social work, yet effective approaches for translating research evidence into social work practice remain elusive. Despite a growing body of evidence describing effective interventions with a variety of populations, social workers continue to encounter substantial challenges with incorporating knowledge gained from these intervention studies into their routine practice with clients (Bellamy et al. 2006; Proctor et al. 2009). A widely used definition of evidence-based practice refers to EBP as a process that incorporates current research evidence with clinical expertise and client expectations and values (Sackett et al. 1996). This definition of EBP as a process instead of a product is distinguished from evidence-supported interventions (ESI) in that ESIs refer to specific interventions or treatments that have evidence demonstrating their effectiveness with certain populations in certain contexts (Chambers 2007). Because the EBP process model assumes that clinicians will be able to identify and implement an intervention with the best available evidence for its efficacy, EBP and ESIs are highly interrelated, although distinct, constructs (Barth et al. 2011; Chambers 2007; Drisko and Grady 2012). As a result, emphasis on EBP in clinical practice may reflect more a focus on implementing ESIs than using the EBP process model (Barth et al. 2011). Growing social service funding mandates and policies requiring agencies to push for greater use of research evidence have especially impacted the work of social work clinicians who provide the majority of frontline mental health services (Bellamy et al. 2006; Edmond et al. 2006; Goode and Piedalue 1999). Continued mandates by funders and policymakers highlight the importance of increasing social work clinicians' understanding of research knowledge, its relationship to evidence-

based practice, how it can be translated into practice, and ultimately, how it affects client outcomes.

In partial response to the greater emphasis on using evidence in practice, schools of social work have begun infusing social work curricula with more content on EBP and ESIs in an effort to bolster social workers' knowledge and skills in applying research to practice (Bledsoe et al. 2007; Grady et al. 2010; Howard et al. 2003). However, in spite of the efforts to increase education and training in EBP and ESIs, social work clinicians continue to experience barriers in the field that negatively impact their ability to use research knowledge in clinical decision-making. As a result, crucial research knowledge generated for the purpose of supporting social work practice with the potential to improve client outcomes has not been used to its full benefit (Proctor et al. 2009).

Studies examining the translation of research evidence to practice show that practitioners experience specific barriers to incorporating research into their decision-making with clients that need to be addressed in order to minimize the research to practice gap (Bellamy et al. 2006; Bledsoe et al. 2013; Proctor et al. 2009). These barriers range from individual perceptions of the usefulness of EBP to clinical practice to problems with implementing ESIs that show effectiveness only under certain circumstances. Studies have also identified specific contextual factors in response to these barriers that may act to promote more effective dissemination of research into practice contexts (Bellamy et al. in progress; Bledsoe et al. 2013; Proctor et al. 2009). As previous articles in this issue have outlined, several practice approaches in addition to EBP and ESI guide the use of research evidence in practice decision-making. The common elements and common factors approaches provide alternative frameworks for addressing many of the barriers that clinicians face in translating research knowledge, specifically ESIs, into practice (Barth et al. 2013; 2011). For example, the common elements approach explicitly addresses the issue of heterogeneity of service populations and fit with specific ESIs for these populations (Barth et al. 2011; Chorpita et al. 2005).

The purpose of this article is to present the current research outlining the known barriers and promoters to using EBP in social work clinical practice. Although we acknowledge that EBP is not the only framework for guiding the incorporation of research evidence in clinical practice, the majority of scholarship conducted on barriers and promoters has stemmed from the EBP movement in social work. As such, it is important to understand the critical aspects of EBP that have influenced clinical social work practice and highlighted the need for alternative approaches to guide research-informed practice. Because social workers practice within the context of organizations, we also consider the barriers to EBP that exist at both the individual and organizational levels that affect clinical social work practice. In addition to addressing the various challenges to incorporating an EBP approach to practice, we will also discuss a variety of emergent opportunities accompanying the move toward EBP that can be leveraged by clinicians in their social work practice with clients.

Barriers to Using EBP in Clinical Social Work Practice

Research examining the practical application of EBP in clinical settings has shown that clinical social workers encounter multiple barriers related to using research evidence in practice. Among these, clinicians often report lacking skills, knowledge and training necessary to effectively apply research knowledge to work with clients. Aspects of EBP that reportedly present the greatest challenges for clinicians are predominantly related to being able to critically appraise research studies and apply research findings to practice (Bellamy et al. 2006; Bledsoe-Mansori et al. 2013; Gray et al. 2013). In a study evaluating a 10-module training program to develop clinician competencies in EBP, clinicians were confident in their ability to find research evidence but struggled to understand the methods and statistics reported in the literature (Bledsoe-Mansori et al. 2013). Differentiating between potentially useful and less useful (and misleading) studies is an important skill for clinicians who are implementing EBP. However, many clinicians lack formal training in research or have not been exposed to research for many years (Gray et al. 2013; Gray et al. in press; Manuel et al. 2009), thus decreasing their ability to determine the appropriateness of a study's findings to their own practice question.

To address the lack of knowledge of EBP, training materials, such as guides and worksheets have been developed to aid clinicians in the quick appraisal of studies. However, clinicians express doubt in their abilities to use these tools independently of researchers (Bledsoe-Mansori et al. 2013). Although training in EBP is a useful first step, training alone is not sufficient to initiate and sustain the use of EBP in everyday agency practice. Training in EBP may be more effective for clinical practice when combined with consultation and supervision beyond the initial implementation period (Fixsen et al. 2005). In addition, clinicians typically have not been trained to deliver many ESIs identified in the EBP process and are therefore, less equipped to deliver them in the practice context. Some ESIs, e.g., motivational interviewing (MI) require specialized training in order to increase intervention fidelity, suggesting the need for complementary training and supervision in their application (Bledsoe et al. 2013).

The nature and relevance of available research also present clinical challenges for clinicians in implementing ESIs. Clinicians often report a lack of fit between the available evidence and their practice contexts, with few studies that inform the practice decisions clinicians are trying to make (Bellamy et al. 2006; Bellamy et al. 2012). Clinicians often express concerns that the standardized approaches encapsulated by EBP and ESI are not appropriate for the given context or cultural concerns of certain clients. Because the culture of the social work profession has not historically supported research evidence as integral to the transmission of social work knowledge, clinicians do not always view research evidence as relevant to their practice (Barratt 2003).

Clinicians also express concern about the differences between the clients they serve and those included in research samples (Osterling and Austin 2008). The lack of assessments and interventions tailored for use with culturally diverse populations continues to be a significant barrier to using EBP in agency practice. Hoagwood et al. (2001) argue that the research community has largely ignored the match between ESIs and the agency settings in which they are delivered. ESIs are typically tested in highly controlled conditions that seek to isolate an intervention's effect by factoring out certain "nuisance variables," such as comorbidity. These "nuisance variables," however, may be important to the success of an intervention in real-world agency practice (Hoagwood et al. 2001). Further, some clinicians believe ESIs are too rigid, thus precluding flexibility and practice wisdom (Chambless and Ollendick 2001). The use of research in practice could be facilitated by more interventions that are flexible and contextually relevant to agency contexts.

Another clinical challenge to implementing EBP is that existing evidence can quickly become irrelevant in practice contexts that are ever-changing in response to new policies, funding constraints, and evolving client populations (Osterling and Austin 2008). The slow production of research, due to limited funding and time-consuming procedures, may not be able to keep up with the ongoing changes in agency practice. For practitioners that do have access to recently published journals, the lag time between generation of research findings and publication results in evidence that is usually several years old and is not useful for current practice (Thyer 2004).

In addition to the above challenges, a variety of attitudes held by clinicians also pose considerable barriers to the adoption of EBP. Some practitioners express suspicion about the use of EBP due to concerns about control, exchanging value for efficiency, decisions motivated by factors outside of the client's best interest, lack of objectivity in research, and the incongruence of researchers' needs and goals with the needs and goals of practitioners (Bellamy et al. 2006). Some feel that advocates of EBP are primarily seeking self-promotion through research and aim to gain notoriety through controversial or trend-setting findings (Gibbs and Gambrill 2002). Among those practitioners who subscribe to the validity and applicability of research evidence to their practice, some may still fail to employ EBP due to lack of resources, including deficits of funding, time, staff, training, and materials (Bellamy et al 2006).

Studies continue to emphasize and explore the complex barriers to implementation of research evidence in clinical practice across disciplines. Surveys of mental health service providers across the spectrum of professional affiliations have generated similar findings to social work practitioners: barriers to EBP occurs on multiple levels, from attitudinal positions of individual practitioners to inhospitable settings or conditions that limit clinicians' ability to access training and information, engage in post-training supervision, and change their practice behaviors. Some clinicians may be overwhelmed by expectations to dramatically change multiple aspects of their practice simultaneously or the difficulty presented by the need to keep up with rapidly evolving research knowledge (Gallo and Barlow 2012). Many doubt the effectiveness of new treatments, believing that their current methods are sufficiently effective and that the strength and nature of the therapeutic relationship between therapist and client is more relevant to treatment outcomes than the use of prescriptive techniques (Gallo and Barlow 2012; Riley et al. 2007; Stewart et al. 2012). Widespread among clinicians is the perceived tension between practice evidence and research evidence; clinicians place higher value on lessons learned from their own clinical experience (Dozois 2013; Pagoto et al. 2007; Stewart and Chambless 2007; Stewart et al. 2012).

This disconnect extends to perceived discrepancies between the efficacy of treatments delivered in controlled settings and the likelihood of their actual effectiveness in the community (Dozois 2013; Wharton and Bolland 2012). Thus, clinicians continue to believe that research evidence is not generalizable to their practice (Dozois 2013; Wharton and Bolland 2012). Much of this perception can be attributed to the difficulty in distinguishing between implementation effectiveness and treatment effectiveness (Proctor et al. 2011). The effectiveness of many ESIs has been demonstrated through controlled studies conducted under specific circumstances, thus, reducing their generalizability to practice. Proctor et al. (2011) emphasize the importance of conducting implementation research to help clinicians determine if the inability for an ESI to show effectiveness in practice is due to the ineffectiveness of the treatment itself, or from problems with being able to implement the treatment as intended.

Despite increased exposure to and general acceptance of EBP within the profession, some clinicians continue to express negative attitudes about EBP, due to the belief that ESIs acquired through the EBP process require clinicians to disregard clinical experience, empathy, and creativity in order to make practice decisions based exclusively on research evidence which may be irrelevant (Pagoto et al. 2007). Gaudiano et al. (2011) found that psychotherapists who are mostly dependent on an intuitive thinking style demonstrated more negative attitudes toward research and a reduced willingness to use EBP in clinical practice. Recent research has noted clinicians' resistance to using treatment manuals from ESIs identified through the EBP process (Gallo and Barlow 2012). A common criticism to the EBP approach specifically communicated by social workers is that adherence to standardized treatment manuals as part of implementing an ESI is a restrictive, cookie-cutter approach to providing service that is not relevant or useful in the reality of clinical practice with the heterogeneous populations that social workers serve (Gambrill 2003; Garfield 1996). ESIs are also seen to have limited utility for clients who present with more challenging, complex problems and for diverse or special needs populations for whom a specific modality may not have been tested (Southam-Gerow et al. 2012; Wharton and Bolland 2012). Redefining clinicians' understanding of the use of research knowledge in practice as a process, rather than a product, and de-emphasizing the use of treatment manuals may improve therapists' attitudes toward EBP (Borntrager et al. 2009).

In addition to clinicians' attitudes and beliefs, access and resources impact practitioners' ability to effectively learn, adopt, and implement EBP. Many clinicians perceive that lacking the time necessary for learning new techniques is a major barrier for those who wish to incorporate EBP into their practice (Nelson et al. 2006; Stewart et al. 2012; Wharton and Bolland 2012). Likewise, concerns about the cost of training, including the loss of income while participating in training rather than seeing clients, and the materials required to fully implement EBP following initial training have been indicated as perceived barriers (Riley et al. 2007; Southam-Gerow et al. 2012; Stewart et al. 2012). Further, a recent national survey revealed that some schools of social work and social work faculty are still resistant to strong incorporation of EBP into their classrooms, which may produce clinicians who lack EBP experience and knowledge (Bledsoe et al. 2013). Faculty members engaged in EBP-related work with community agencies identified an additional set of barriers to implementation of a variety of aspects of EBP practice within the schools of social work including lack of time, resources, and competing academic pressures (Bellamy et al. in progress).

Organization-Level Challenges

Most social work practitioners work and are nested in human service organizations. EBP can be conceptualized as a form of innovation within human service organizations, i.e., changes in practice aimed at improving organizational performance. Often, as frontline service providers, social work clinicians are called upon to implement organizational innovations, such as EBP. Individual-level determinants for those implementing innovations such as EBP within health care organizations (e.g. clinicians) include tolerance for ambiguity, motivation to change, and the influence of peers within social and professional networks (Greenhalgh et al. 2004). For example, Aarons and Palinkas (2007) found that perceived acceptability of EBP and motivations to use EBP were associated with EBP uptake among child welfare caseworkers. However, an individual clinician's decision to adopt EBP or any other innovation is just one factor affecting adoption within an entire organization (Greenhalgh et al. 2004). Factors such as, organizational culture, leadership behaviors, and human and financial resources may also influence the extent to which clinicians' implement EBP in their professional practice.

Organizational Culture

Organizational culture and climate in human services organizations affect service delivery and outcomes (Glisson and Hemmelgarn 1998; Glisson and James 2002). Constructive organizational cultures marked by norms of achievement and motivation, development of staff abilities, positive interpersonal relationships, and mutual support have been found to be associated with more positive attitudes toward adoption of EBP (Aarons and Sawitzky 2006) in addition to better service delivery outcomes (Glisson et al. 2010, 2012; Glisson and Schoenwald 2005). Likewise, human service agencies with organizational cultures characterized by innovation and learning may be more likely to adopt EBP. Human service organizations that actively engage in evaluation and organizational learning may be more likely to use research evidence to guide interventions (Cherin and Meezan 1998). Among a sample of 19 human service organizations serving persons living with developmental disabilities, Jaskyte and Dressler (2005) found that high levels of consensus concerning the need for stability, security, low conflict, predictability, rule orientation, teamwork and collaboration were associated with a lack of innovation within organizations.

Organizations that are larger, well-differentiated and specialized, and contain sufficient surplus of assets (slack resources) are more likely to adopt innovations, such as EBP. Contextual factors such as a culture of learning, risk

taking, idea generation, strong leadership, strategic vision, and good managerial relations also influence an organization's propensity to adopt EBP (Greenhalgh et al. 2004). Research also shows that the innovation (i.e., EBP) must have more support than opposition within the organization, in addition to sufficient time, resources, and leadership perseverance to implement the innovation. For example, some clinicians may experience a lack of support for developing new, evidence-based practice skills in their work environments, receiving clinical supervision that is focused on risk management and administrative issues rather than supporting the institution of innovative practices (Wharton and Bolland 2012). Sufficient ability to collect, interpret, use and codify knowledge supported by effective data systems is also necessary in order for an organization to monitor and evaluate the implementation of the innovation (Greenhalgh et al. 2004).

Leadership

Organizational support and leadership behaviors may also affect EBP uptake. Jaskyte (2011) found that transformational leadership—marked by challenging existing processes and inspiring a shared vision—had a statistically significant association with uptake of programmatic innovations among a sample of 79 education-related nonprofit organizations. Organizational support and leadership have been found in other studies to promote the acceptance and use of EBP (Aarons and Palinkas 2007; Aarons et al. 2009). Support includes offering staff EBP training and other learning opportunities, EBP-specific supervision, use of program evaluation, and financial incentives (Aarons et al. 2009).

Financial

Structural characteristics also affect the likelihood of organizations adopting an innovation (Greenhalgh et al. 2004). Human service organizations need sufficient operating reserves not only to sustain operations, but to invest in new efforts, which may include adopting EBP and/or an ESI. However, many nonprofit human service organizations—especially small to medium sized ones—face a host of financial challenges (Besel et al. 2011; Bielefeld 1994; Boris et al. 2010; Bowman 2011; Carroll and Stater 2009; Chang and Tuckman 1991; Hodge and Piccolo 2005; Weerawardena et al. 2010) that decrease the likelihood that these organizations will adopt EBP and/or affect how well EBP is implemented.

Having a surplus of assets, i.e. slack resources, is associated with increased use of EBP in organizations (Greenhalgh et al. 2004). Lack of slack resources may act as a barrier to EBP adoption among nonprofit human service organizations in both direct and indirect ways. These organizations may lack the financial resources to purchase treatment manuals and pay for clinical staff trainings on using EBP and/or ESIs, while also maintaining current service levels, and to recruit, hire, and retain practitioners with the qualifications to implement EBP. Indirectly, financial instability may be related to leadership and staff turnover, poor morale, and uncertainty, which may decrease the likelihood of EBP adoption and utilization.

Promoters for Using EBP in Clinical Practice

Though the research literature to date invariably focuses on gaps and barriers in dissemination and implementation of research knowledge in practice, key factors have been preliminarily identified that enhance clinicians' attitudes toward and adoption of EBP. Much of this work, however, has focused on the training and supervision concerns of clinicians and the time and resource constraints of clinicians and agencies.

Individual clinician attributes, such as graduate-level training in EBP and fewer years of practice in the field correlate to fewer perceived obstacles to EBP and increased intentions to participate in training related to evidence-supported interventions (Bride et al. 2012; Stewart et al. 2012). In addition, having more time and fewer resource constraints helps to facilitate the process of accessing, consuming, and implementing EBP (Stewart et al. 2012; Wharton and Bolland 2012).

Mental health practitioners overwhelmingly indicate the primacy of peer influence in their exposure to and willingness to adopt new practices; as a result, the use of consultation within peer networks or mentors, peer coaching, collaboration, and providing training models that pair ESI-trained therapists with those unfamiliar with the ESI may be helpful in providing support to practitioners incorporating more research knowledge into their routine practice (Bride et al. 2012; Gallo and Barlow 2012; Southam-Gerow et al. 2012; Wharton and Bolland 2012). Although improved therapist attitudes and knowledge following EBP training alone do not correlate with changed practitioner behaviors, Beidas and Kendall (2010) indicate that ensuring active learning during training does influence both practitioner and client change; thus, accessibility to affordable and relevant training in EBP is essential to effective implementation. In addition, enhancing support for EBP in the workplace environment by providing opportunities to discuss and learn collaboratively (Gallo and Barlow 2012); employing strategies to increase the intuitive appeal of EBP, including pairing research reports with case studies to enhance their relevance for clinicians,

given the likelihood that clinicians base practice decisions on clinical experience (Gallo and Barlow 2012; Gaudiano et al. 2011); and promoting EBP directly to clients in order to increase demand (Gallo and Barlow 2012; Santucci et al. 2012). As external actors increasingly impact individual clinician decisions through policy and funding, some providers are documenting success in rapidly transitioning to EBP and ESIs in community-based agency settings (Williams et al. 2012).

University-agency partnerships may also provide an important avenue for promoting EBP and translating research into clinical practice (Bellamy et al. 2008; Manuel et al. 2009; Bledsoe-Mansori et al. 2013). Partnering with schools of social work can provide agencies with needed resources, consultation, and training to build capacity in implementing EBP, and in turn, agencies provide important practice-related knowledge to inform social work research (Bellamy et al. 2008). Because many agencies are often operating with limited resources, and implementing EBP involves time and costs (i.e., access to research databases, trainings, supervision), university-agency partnerships offer an avenue that addresses many of the organizational barriers to implementing EBP, such as lack of knowledge and training, resources, time, and funding associated with implementing specific ESIs.

In a recent national study examining partnerships between community agencies and schools of social work, 81 % of respondents endorsed increased opportunities for training in EBP and ESIs for faculty and staff, as a promoter for greater use of EBP (Bledsoe-Mansori et al. 2013). In this same study, 83 % of respondents indicated that more agency requests for assistance in implementing EBP would result in better collaborations around the uptake of EBP. In addition, agency participants in an EBP training program indicated that additional resources, i.e., access to research articles, training, supervision, and time to find and evaluate articles would promote the implementation and dissemination of EBP in practice (Manuel et al. 2009). This study also found that agency and administrator "buy-in" is necessary to support clinicians' utilization of EBP as well as to enhance sustainability of any EBP innovations that are implemented within an agency (Manuel et al. 2009).

Emergent Opportunities

Scholars continue to grapple with the challenges experienced by social work clinicians in using research evidence to guide practice decision-making. Although understanding the barriers and promoters to using EBP is instrumental in formulating our way forward as a discipline, the current landscape holds some important opportunities for advancing EBP within social work clinical practice. A few of these opportunities include: reducing the confusion about the difference between EBP and ESIs among researchers, practitioners, funders, and policymakers; adapting existing evidence-supported interventions for a variety of service populations; and increasing social work's role in interdisciplinary research and practice.

Inconsistencies in the definition of EBP has created confusion among researchers, practitioners, funders, and policymakers about whether evidence-based practice refers to using research evidence to complement or replace practice evidence and clinician expertise (Rubin and Parrish 2007). Thus, agreement on the use of the term evidence-based practice presents an opportunity to alleviate many concerns that clinicians express about using EBP and ESI in practice. For example, referring to EBP as the process of applying a variety of evidence, including clinician expertise and client values to practice decisions versus a product that restricts practice provides clinicians a wider range of evidence from which to draw; meaning that applying research evidence and drawing upon clinical expertise are not mutually exclusive endeavors.

Given the increase in mandates from funders and policymakers for greater application of empirical research evidence in clinical practice, agencies often confuse EBP with ESI, resulting in the uptake of interventions that may have a strong empirical evidence base but are not the right fit for the agency, the clinician, the client, the cultural context, and/or the problem. This often takes the form of funders requiring the use of EBP, or a specific ESI for working with clients in order to receive initial and/or continued funding. Though clinicians have indicated that this kind of mandate serves as a barrier due to its "cookie-cutter" approach and failure to consider the client's unique needs along with the clinician's expertise, a true EBP approach integrates all forms of evidence in treatment decision-making, including existing research evidence, clinician expertise, and client values and needs (Bledsoe-Mansori and Killian-Farrell in press). Thus, this challenge presents an opportunity for differentiating between an EBP process approach and the implementation of a specific ESI when EBP emphasis is required. In addition, a clinician's ability to distinguish between EBP and ESI can inform agency administrators' development of future grant proposals that can better reflect the service needs of clients as well as help administrators meet important funding needs. By understanding the appropriateness of a specific ESI or the need to engage in the EBP process, clinicians can influence the type of treatment that clients receive up front rather than simply being the implementers of a funder mandate. Clinicians' input on EBP-related requirements by funders also can contribute necessary expertise about the fit of certain ESIs to specific client populations with unique problems, needs, and desires for clinical intervention. In addition, distinguishing EBP as a process and not a product

allows social work practitioners to demonstrate to funders, policymakers, and administrators that implementing EBP necessarily includes consideration of clinician expertise and client input in addition to available research evidence.

Adapting interventions for real world practice presents another potential opportunity. A challenge to implementing ESIs for many social work practitioners is that not all ESIs have been tested with every population, and therefore, clinicians do not have a base of research evidence from which to draw when making practice decisions with certain clients. The ability to adapt interventions is especially important given that most social work clinicians do not provide mental health services to one homogeneous population, but to racially, ethnically, and culturally heterogeneous populations presenting with a variety of complex problems. Also, because of the unique nature of client needs especially regarding mental health services, it would be impossible to develop and evaluate interventions for every client population. This presents an opportunity for using clinical skill and expertise to adapt existing interventions to address the heterogeneity of populations that social work clinicians serve. Bledsoe-Mansori and Killian-Farrell (in press) note that to date, most of the work on adaptation of interventions has focused on cultural adaptation (i.e. race/ethnicity or country of origin) rather than complex client presentations often represented in mental health practice. They suggest expanding on emerging work that focuses on adapting interventions for clients based on their multiple problems and complex service needs (i.e. the common elements approach) in order to maximize the effectiveness of existing interventions rather than attempting to design interventions for every potential population (Bledsoe-Mansori and Killian-Farrell in press).

Another notable opportunity is the expansion of interdisciplinary research and practice. As the medical and mental health fields become more holistic and begin to incorporate more environmental and social factors, many areas of social work practice will necessarily involve exposure to evidence-based practice in other disciplines. This provides a unique opportunity, not only to learn from new evidence bases, but to serve as experts in our own areas and contribute our own knowledge to the creation of a more integrated evidence base. In addition, the challenge of rapidly advancing technology in the realm of mental health presents an opportunity for social work clinicians, as part of multidisciplinary teams, to leverage those advances and translate them into effective interventions that reflect the expertise, values, and perspectives of clinical social work.

Conclusion

In the last decade, the profession of social work has moved to the forefront of the EBP movement. As a result, social work research and scholarship focused on greater integration of research evidence into clinical decision-making has increased our understanding of important clinical and organizational barriers, promoters and strategies to using research in practice. Although the merits/value of EBP is subject to ongoing debate, recent studies have shown that social work clinicians and other mental health service providers are supportive of using research in practice when they have the necessary training, resources, and organizational supports required to implement EBP effectively (e.g., Gray et al. in press).

Social work clinicians unmistakably play an important role in the translation of research to practice. However, utilizing evidence in practice with the ultimate goal of improving outcomes for clients is not solely the responsibility of social work clinicians and human service organizations. Future efforts to effectively implement and disseminate EBP should involve many perspectives, including leaders of social work organizations, clinicians, clients, researchers, and policymakers. Multiple voices that can articulate continuing challenges and illuminate important practice questions are necessary to ensure that the translation of research knowledge into practice remains relevant to clinicians and ultimately, improves the lives of their clients. Although social work is just beginning to address the various challenges that have accompanied the move toward EBP, leveraging the opportunities that exist within those challenges is critical to the successful implementation and sustainability of EBP in future social work practice.

Conflict of interest The authors declare that they have no conflicts of interest.

References

Aarons, G. A., Fettes, D. L., Sommerfeld, D. H., & Palinkas, L. A. (2012). Mixed methods for implementation research: Application to evidence-based practice implementation and staff turnover in community-based organizations providing child welfare services. *Child Maltreatment, 17*(1), 67–79. doi:10.1177/1077559511426908.

Aarons, G., & Palinkas, L. (2007). Implementation of evidence-based practice in child welfare: Service provider perspectives. *Administration and Policy in Mental Health and Mental Health Services Research, 34*(4), 411–419. doi:10.1007/s10488-007-0121-3.

Aarons, G. A., & Sawitzky, A. C. (2006). Organizational culture and climate and mental health provider attitudes toward evidence-based practice. *Psychological Services, 3*(1), 61–72. doi:10.1037/1541-1559.3.1.61.

Aarons, G. A., Sommerfeld, D. H., & Walrath-Greene, C. (2009). Evidence-based practice implementation: The impact of public versus private sector organization type on organizational support, provider attitudes, and adoption of evidence-based practice. *Implementation Science, 4*, 83. doi:10.1186/1748-5908-4-83.

Barratt, M. (2003). Organizational support for evidence-based practice within child and family social work: A collaborative study. *Child and Family Social Work, 8*, 143–150.

Barth, R. P., Kolivoski, K. M., Lindsey, M. A., Lee, B. R., & Collins, K. (2013). Translating the common elements approach: Social work's experiences in education, practice, and research. *Journal of Clinical Child and Adolescent Psychology, 43*, 301–311. doi:10.1080/15374416.2013.848771.

Barth, R. P., Lee, B. R., Lindsey, M. A., Collins, K. S., Streider, F., Chorpita, B. F., et al. (2011). Evidence-based practice at a crossroads: The timely emergence of common elements and common factors. *Research on Social Work Practice, 22*, 108–119. doi:10.1177/1049731511408440.

Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology Science and Practice, 17*(1), 1–30. doi:10.1111/j.1468-2850.2009.01187.x.

Bellamy, J. L., Bledsoe, S. E., Manuel, J., Fang, L., & Mullen, E. J. (2012). Addressing the barriers to EBP implementation in social work: Reflections from the BEST Project. In T. Rzepnicki, S. McCracken, H. Briggs (Eds.), *From task-centered social work to evidence-based and integrative practice: Reflections on history and implementation*. Chicago: Lyceum Books.

Bellamy, J. L., Bledsoe, S. E., Mullen, E. J., Fang, L., & Manuel, J. (2008). Agency-university partnerships for evidence-based practice in social work. *Journal of Social Work Education, 44,* 55–75.

Bellamy, J. L., Bledsoe, S. E., & Traube, D. E. (2006). The current state of evidence-based practice in social work. *Journal of Evidence-Based Social Work*, *3*(1), 23–48.

Bellamy, J. L., Bledsoe-Mansori, S. E., Dinata, E., Wike, T. L., Grady, M., Killian-Farrell, C., & Doernberg, A. (in progress). Implementing agency-university partnerships for evidence-based practice in social work: Models based on findings from the agency-university partnership study.

Besel, K., Williams, C. L., & Klak, J. (2011). Nonprofit sustainability during times of uncertainty. *Nonprofit Management and Leadership, 22*(1), 53–65. doi:10.1002/nml.20040.

Bielefeld, W. (1994). What affects nonprofit survival? *Nonprofit Management and Leadership, 5*(1), 19–36. doi:10.1002/nml.4130050104.

Bledsoe, S. E., Bellamy, J. L., Wike, T. L., Grady, M. D., Dinata, E., Killian, C., & Rosenberg, K. (2013). Agency-university partnerships for evidence-based practice: A national survey of schools of social work. *Social Work Research, 37*(3), 179–193.

Bledsoe, S. E., Weissman, M. M., Mullen, E. J., Betts, K., Gameroff, M. J., Verdeli, H., et al. (2007). Evidence-based psychotherapy in social work training programs: Does the definition of evidence matter? *Research on Social Work Practice, 17,* 449–455.

Bledsoe-Mansori, S. E., & Killian-Farrell, C. (in press). Challenges for evidence-based social work practice: A response to McKay and colleagues. *Research on Social Work Practice*.

Bledsoe-Mansori, S. E., Manuel, J. I., Bellamy, J. L., Fang, L., Dinata, E., & Mullen E. J. (2013). Implementing evidence-based practice: Practitioner assessment of an agency-based training program. *Journal of Evidence-Based Social Work, 10,* 73–90.

Boris, E. T., de Leon E., Roeger, K. L., & Nikolova, M. (2010). Human service nonprofits and government collaboration: Findings from the 2010 national survey of nonprofit government contracting and grants (Center on Nonprofits and Philanthropy Report). http://www.urban.org/UploadedPDF/412228-Nonprofit-Government-Contracting.pdf.

Borntrager, C. F., Chorpita, B. F., Higa-McMillan, C., & Weisz, J. R. (2009). Provider attitudes toward evidence-based practices: Are the concerns with the evidence or with the manuals? *Psychiatric Services, 60*(5), 677–681.

Bowman, W. (2011). Financial capacity and sustainability of ordinary nonprofits. *Nonprofit Leadership and Management, 22*(1), 37–51. doi:10.1002/nml.20039.

Bride, B. E., Kintzle, S., Abraham, A. J., & Roman, P. M. (2012). Counselor attitudes toward and use of evidence-based practices in private substance use disorder treatment centers: A comparison of social workers and non-social workers. *Health and Social Work, 37*(3), 135–145. doi:10.1093/hsw/hls022.

Carroll, D. A., & Stater, K. J. (2009). Revenue diversification in nonprofit organizations: Does it lead to financial stability? *Journal of Public Administration Research and Theory, 19*(4), 947–966. doi:10.1093/jopart/mun025.

Chambers, D. (2007). Defining research informed practices: Partnerships to integrate evidence based mental health practices into social work education and research. *Proceedings of the Institute for the Advancement of Social Work Research*. Bethesda, MD.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685–716.

Chang, C. F., & Tuckman, H. P. (1991). Financial vulnerability and attrition as measures of nonprofit performance. *Annals of Public and Cooperative Economics, 62*(4), 655.

Cherin, D., & Meezan, W. (1998). Evaluation as a means of organizational learning. *Administration in Social Work, 22*(2), 1–21. doi:10.1300/J147v22n02_01.

Chorpita, B. F., Daleiden, E., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research, 7*, 5–20.

Dearing, J. W. (2009). Applying diffusion of innovation theory to intervention development. *Research on Social Work Practice, 19*(5), 503–518. doi:10.1177/1049731509335569.

Dozois, D. J. A. (2013). Psychological treatments: Putting evidence into practice and practice into evidence. *Canadian Psychology, 54*(1), 1–11. doi:10.1037/a0031125.

Drisko, J., & Grady, M. (2012). *Evidence-based practice in clinical social work*. New York: Springer.

Edmond, T., Megivern, D., Williams, C., Rochman, E., & Howard, M. (2006). Integrating evidence-based practice and social work field instruction. *Journal of Social Work Education, 42*, 377–396. doi:10.1080/10437797.2013.755099.

Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature (FMHI Publication #231).* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Gallo, K. P., & Barlow, D. H. (2012). Factors involved in clinician adoption and nonadoption of evidence-based interventions in mental health. *Clinical Psychology Science and Practice, 19*(1), 93–106. doi:10.1111/j.1468-2850.2012.01276.x.

Gambrill, E. D. (2003). Evidence-based practice: Sea change or the emperor's new clothes? *Journal of Social Work Education, 39*, 3–23.

Garfield, S. L. (1996). Some problems associated with "validated" forms of psychotherapy. *Clinical Psychology Science and Practice., 3*(3), 218–229.

Gaudiano, B. A., Brown, L. A., & Miller, I. W. (2011). Let your intuition be your guide? Individual differences in the evidence-based practice attitudes of psychotherapists. *Journal of Evaluation in Clinical Practice, 17*(4), 628–634. doi:10.1111/j.1365-2753.2010.01508.x.

Gibbs, L. E., & Gambrill, E. (2002). Evidence-based practice: Counterarguments to objections. *Research on Social Work Practice, 12*, 452–476.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and

outcomes of children's service systems. *Child Abuse and Neglect, 22*(5), 401–421.

Glisson, C., Hemmelgarn, A., Green, P., Dukes, D., Atkinson, S., & Williams, N. J. (2012). Randomized trial of the availability, responsiveness, and continuity (ARC) organizational intervention with community-based mental health programs and clinicians serving youth. *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(8), 780–787. doi:10.1016/j.jaac.2012.05.010.

Glisson, C., & James, L. R. (2002). The cross-level effects of culture and climate in human service teams. *Journal of Organizational Behavior, 23*(6), 767–794.

Glisson, C., & Schoenwald, S. K. (2005). The ARC organizational and community intervention strategy for implementing evidence-based children's mental health treatments. *Mental Health Services Research, 7*(4), 243–259.

Glisson, C., Schoenwald, S. K., Hemmelgarn, A., Green, P., Dukes, D., Armstrong, K. S., et al. (2010). Randomized trial of MST and ARC in a two-level evidence-based treatment implementation strategy. *Journal of Consulting and Clinical Psychology, 78*(4), 537–550. doi:10.1037/a0019160.

Goode, C. J., & Piedalue, F. (1999). Evidence-based clinical practice. *Journal of Nursing Administration, 29*, 15–21.

Grady, M. D., Werkmeister Rozas, D., & Bledsoe, S. E. (2010). Are curriculum decisions based on the evidence? How social work faculty members make choices in curriculum decisions. *Journal of Evidence-based Social Work, 7,* 466–480.

Gray, M., Joy, E., Plath, D., & Webb, S. A. (2013). What supports and impedes evidence-based practice implementation? A survey of Australian social workers. *Research on Social Work Practice, 23*, 157–166.

Gray, M., Joy, E., Plath, D., & Webb, S. A. (in press). What supports and impedes evidence-based practice implementation? *A survey of Australian social workers. British Journal of Social Work.*

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly*, *82*(4), 581–629. http://www.jstor.org/stable/4149085.

Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52*, 1179–1189.

Hodge, M. M., & Piccolo, R. F. (2005). Funding source, board involvement techniques, and financial vulnerability in nonprofit organizations: A test of resource dependence. *Nonprofit Management and Leadership, 16*(2), 171–190. doi:10.1002/nml.99.

Howard, M. O., McMillen, C. J., & Pollio, D. E. (2003). Teaching evidence-based practice: Toward a new paradigm for social work education. *Research on Social Work Practice, 13*, 234–259.

Jaskyte, K. (2011). Predictors of administrative and technological innovations in nonprofit organizations. *Public Administration Review, 71*(1), 77–86. doi:10.1111/j.1540-6210.2010.02308.x.

Jaskyte, K., & Dressler, W. W. (2005). Organizational culture and innovation in nonprofit human service organizations. *Administration in Social Work, 29*(2), 23–41. doi:10.1300/J147v29n02_03.

Manuel, J., Mullen, E. J., Fang, L., Bellamy, J., & Bledsoe, S. E. (2009). Preparing social work practitioners to use evidence-based practice: A comparison of experiences from an implementation project. *Research on Social Work Practice, 19,* 613–627.

Mullen, E. J., & Bacon, W. (2004). A survey of practitioner adoption and implementation of practice guidelines and evidence-based treatments. In A. R. Roberts & K. Yeager (Eds.), *Evidence-based practice manual: research and outcome measures in health and human services*. New York, NY: Oxford University Press.

Nelson, T. D., Steele, R. G., & Mize, J. A. (2006). Practitioner attitudes toward evidence-based practice: Themes and challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(3), 398–409.

Osterling, K. L., & Austin, M. J. (2008). The dissemination and utilization of research for promoting evidence-based practice. *Journal of Evidence-Based Practice, 5*, 295–319.

Pagoto, S. L., Spring, B., Coups, E. J., Mulvaney, S., Coutu, M., & Ozakinci, G. (2007). Barriers and facilitators of evidence-based practice perceived by behavioral science health professionals. *Journal of Clinical Psychology, 63*(7), 695–705.

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health, 36*, 24–34. doi:10.1007/s10488-008-0197-4.

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., et al. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health, 38*, 65–76. doi:10.1007/s10488-010-0319-7.

Riley, W. T., Schumann, M. F., Forman-Hoffman, V. L., Mihm, P., Applegate, B. W., & Asif, O. (2007). Responses of practicing psychologists to a web site developed to promote empirically supported treatments. *Professional Psychology Research and Practice, 38*(1), 44–53.

Rogers, E. M. (1995). *Diffusion of innovations*. New York: Free Press.

Rubin, A., & Parrish, D. (2007). Challenges to the future of evidence-based practice in social work education. *Journal of Social Work Education, 43*, 405–428.

Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal, 312*(7023), 71–72.

Santucci, L. C., McHugh, R. K., & Barlow, D. H. (2012). Direct-to-consumer marketing of evidence-based psychological interventions: Introduction. *Behavior Therapy, 43*(2), 231–235. doi:10.1016/j.beth.2011.07.003.

Southam-Gerow, M., Rodríguez, A., Chorpita, B. F., & Daleiden, E. L. (2012). Dissemination and implementation of evidence based treatments for youth: Challenges and recommendations. *Professional Psychology Research and Practice, 43*(5), 527–534. doi:10.1037/a0029101.

Stewart, R. E., & Chambless, D. L. (2007). Does psychotherapy research inform treatment decisions in private practice? *Journal of Clinical Psychology, 63*(3), 267–281.

Stewart, R. E., Chambless, D. L., & Baron, J. (2012). Theoretical and practical barriers to practitioners' willingness to seek training in empirically supported treatments. *Journal of Clinical Psychology, 68*(1), 8–23. doi:10.1002/jclp.20832.

Thyer, B. A. (2004). What is evidence based practice? *Brief Treatment and Crisis Intervention, 4*, 167–176.

Weerawardena, J., McDonald, R. E., & Mort, G. S. (2010). Sustainability of nonprofit organizations: An empirical investigation. *Journal of World Business, 45*(4), 346–356. doi:10.1016/j.jwb.2009.08.004.

Wharton, T. C., & Bolland, K. A. (2012). Practitioner perspectives of evidence-based practice. *Families in Society, 93*(3), 157–164.

Williams, M. E., Rogers, K. C., Carson, M. C., Sherer, S., & Hudson, B. O. (2012). Opportunities arising from transformation from treatment as usual to evidence-based practice. *Professional Psychology Research and Practice, 43*(1), 9–16. doi:10.1037/a0025003.

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