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## At the pillar of the proverbial Golden Calf: Sacrificing the Need for 'Responsible Knowing' on the Altar of a Compliance-Based Ethic

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Abstract

Evidence-based practice (EBP) has been promoted and adopted broadly and has led to advances in health and human services. Notwithstanding the underlying rationale of EBP philosophy to diversify the current body of information concerning evidence-based practices, this paper draws attention to critical thinking fallacies that confound non-evidence-based “treatment as usual” practice with actual EBP philosophy. Flawed belief systems about EBP, in tandem with a compliance-based culture, fail to provide structure to the possibility of evidence-based practice philosophy and proper use of EB treatment modalities. Impediments to EBP implementation are created by lack of “responsible knowing” and this results in practitioner complacency toward means of augmenting effective treatment. However, insofar as EBP implementation confronts tension between ‘responsible knowing’ and compliance-based program culture, it gives way to confusion, misdirection, and complacency towards what can be known about EBP and the information gleaned about it. Effectively limiting important aspects of being a responsible knower in terms of the ability to embody accurate knowledge and practice philosophy. Thus, the compliance-based ethic risks incompatibility with the ethical freedom necessary for responsible knowing and is in constant conflict with the proper implementation of EBP.

*Keywords:* compliance-based ethics, evidence-based practice, fallacies, testimonial injustice, critical thinking, human services

At the pillar of the proverbial golden calf: Sacrificing the need for “responsible knowing”  
on the altar of compliance-based ethics

Then the Lord said to Moses, “Tell the Israelites this: ‘You have seen for yourselves that I have spoken to you from heaven: Do not make any gods to be alongside me; do not make for yourselves gods of silver or gods of gold.’” (Exodus 20:22-23 NIV)

In the film, *The Ten Commandments*, Charlton Heston (“Moses”) comes down from the mountain after seeing God and obtaining the Ten Commandments. Upon his descent, he observes that his followers have fashioned the golden calf and are dancing and drinking and reveling—a scene of total debauchery. Moses gets so mad that he throws the tablets down and has to go back to the mountain to request God to carve a new set of tablets. In this paper, the Biblical golden calf illusion is used to indicate the attitudes and beliefs of programs toward evidence-based practice (EBP) philosophy, in the way that Moses’ followers chose to practice idolatry of a false god (Wikipedia, n.d.). The golden calf thus symbolizes unfaithfulness and inconsistency toward “real” EBP. The term “ditheistic” is used to describe this golden calf imagery as representative of the “false god” of EBP, which is taking the place of the “real” god or true EBP.

Evidence-based practice is “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. . . [it]. . . means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Sackett, 1997, p. 3). EBP, then, is an approach to health care in which health care professionals make clinical decisions for their patients based on the best evidence possible (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996); conscientiously building on clinical expertise by drawing on relevant research and patient characteristics and preferences, in full

recognition of the uncertainties of care against a background of evolving circumstances and knowledge (McKibbin, 1998).

EBP is a generalized form of evidence-based medicine, where the latter more strictly pertains to physicians and the former extends the same approach to health domains that predominantly treat so-called mental and behavioral health issues—for example, substance use disorder treatment, which is the focus of this article. EBP is the building block upon which treatment providers take a positive step forward towards enhancing the quality of services they provide (Rousseau & Gunia, 2016).

EBP implementation is currently fashionable as a coherent interpretative model of treatment programs. As a label on a particular offering, it conveys to potential clients that a program is supported by evidence and therefore worthy of endorsement on both practical and moral grounds (Stewart et al., 2016). Added onus is placed on agencies to pay lip service to their status as EB practitioners when auditors, funders, and accreditors insist on seeing an updated set of treatment protocols that are based on research. Failure to do so invites unfavorable performance ratings during program accreditation, or the annual audit review by state authorities and regulatory authorities, which in turn jeopardizes funding (Stewart et al., 2016). Hence, EBP can come to be seen as a fad or even as an ever-changing dimension determined only by what is popular in the field, or by the dictates of regulatory authorities.

Accrediting bodies and state regulatory authorities may therefore accept agencies' self-described "evidence-based programs"—which are not EBP—without qualification, and without requiring remediation of the gap between such programs and true ethos of evidence-based practice. This translates into agencies acquiring markers of authority when they don't really deserve them. Furthermore, promotion of this received authority, by virtue of advertising,

program reputation, and treatment schedule (all testimonies of a kind), enables more credibility to be gained than would otherwise be the case—a kind of credibility excess. Insofar as such inflated authority leaves other agencies with less credibility, there is a hint here of “testimonial injustice” (Fricker, 2007)—that is, a prejudicial tendency to give less credence to the non-EBP programs and practitioners that virtuously steer clear of a label they do not deserve. Thus, the effect of “honor by association” (Epstein, 2016; Taleff, 2006) endows agencies describing themselves as “evidence-based practices” with a “halo” of evaluative statements (Park, 2002) such as “tried-and-tested”, “gold standard”, and “superior quality care”; distinctions that presuppose whatever facts may be believed about EBP. Thus, by adopting the label, the legitimacy and creditability of EBP becomes part of the identity of the agency, automatically boosting its reputation. Therefore, it comes as no surprise that the trend nowadays is for agencies to describe themselves as evidence-based, whether or not such agencies actually incorporate the philosophy of EBP into the foundational bedrock of their program model.

After all, EBP is a gold standard in health and human services, not simply because it is based on evidence—all health care initiatives take into account evidence—but because it is “a process of lifelong, self-directed, problem-based learning in which caring for one’s own patients creates the need for clinically important information about diagnosis, prognosis, therapy and other clinical and health care issues” (Masic, Miokovic, & Muhamedagic, 2008, p. 219). The clinician in evidence-based practice, therefore, must take the initiative to improve care via self-improvement; availing him or herself of new information from inside and outside the client/clinician relationship. EBP as an agency or program descriptor must then refer to the agency’s commitment to the support structure and clinicians able to provide continuous revision of treatment practices in light of the best evidence suited to individual client needs. However,

digression from this commitment by programs calling themselves practitioners of EBP (often by mere virtue of using some “evidence-based informed” treatment manual, such as Seeking Safety for example) is more often than not the case.

The argument below stresses that EBP is not strictly speaking applicable to substance use disorder treatment agencies and programs; it is a process whereby health professionals and clinicians make clinical decisions. Yet agencies institute rules and monitor outcomes in virtue of which they represent their practice as EBP-compliant, potentially failing to incorporate the crucial components of clinician research, analysis, and revision aimed at more individualized care. This form of agency/program level EBP attribution is nothing less than the proverbial “golden calf”: a false god being worshipped on the altar of a compliance-based ethic to obtain funding. This paper aims to lay bare a systematic mischaracterization of EBP and the fallacies that ultimately undermine its implementation in treatment programs.

### **Why and Whence Evidence-Based Practice?**

And God spoke all these words: “I am the Lord your God, who brought you out of Egypt, out of the land of slavery. You shall have no other gods before me.” (Exodus 20:1-3 NIV)

Epistemic closure is a property of belief systems. It is the principle that if a subject S knows p, and S knows that p entails q, then S can thereby come to know q (Rosenberg, 2002). In other words, a person can come to know the logical implications of his or her beliefs (Stanford Encyclopedia of Philosophy, 2016). What, then, can an agency’s directors know about the agency’s treatment efficacy if they know that its clinicians are properly schooled and engaged in EBP? The answer is a disturbing “not much”. Do things look better from the perspective of the clinician? That is, if a clinician knows the results of every study published on the efficacy of every treatment at her disposal, and all the relevant facts about her client’s characteristics and

preferences, can this improve the clinician's certain knowledge of her client's prognosis for long-term wellness? The answer again is "no", as there is no entailed relation between research plus contextual information and the success of subsequently revised treatment with any particular client (Sheridan, 2016). Why then is EBP the gold standard of substance use disorder treatment? What reasons do agency directors have to institute this approach?

Quite simply, there is no guarantee that any treatment—"tried and true" or otherwise—will work for any given client, but the ethical obligation to nevertheless provide the best treatment possible, is sufficient justification for the use of EBP. EBP is a clinician's best prospect for providing the most effective treatment possible for any given client. Only at the level of the therapeutic alliance, where clinicians seek out the most appropriate research along with contextually relevant information about the client and then apply that knowledge to the case at hand, can agency directors hope to meet the needs of clients time and time again. Evidence of the effectiveness of treatment models is not necessarily good enough. In other words, there needs to be a utilization of factors, like the situation and the characteristics of the client (prognostic indicators), along with research relevant to how those factors relate to the likelihood of getting better (assessment findings), together with a practice of "checking in" with the client regarding the client's perspective on treatment and progress. Such procedure is precisely in line with EBP. Thus, EBPs are important and "good" if followed correctly as a program philosophy, and not just cosmetically indulged as a fad.

Several notable problems arise from "evidence-based mandates"—a trend to implement something in substance use disorder treatment on the basis of outcomes evidence.

First, "evidence" for treatment efficacy is often not very convincing. Many of the studies purporting to provide evidence for model or program efficacy use measures that are arbitrary

(reliably measured, scientifically valid, but irrelevant to the real world) (Hoffmann, 2015). A typical such measure is days of use in the past 30 days (as in the Addiction Severity Index or Alcohol Use Disorders Identification Test) (Hoffmann & Schulman, 2005). Days of use do not represent either a real world indication of severity or an appropriate outcome metric (Hoffmann, 2015). For example, an individual who has one glass of wine with dinner each evening would receive a maximum score for alcohol, while the binge drinker sustaining all kinds of problems would score less (Hoffmann, 2015). As an outcome measure, days of use is also inadequate and inappropriate; it fails to establish whether or not substance use disorder remission has been achieved (Hoffmann, n.d.b). Remission is now clearly defined by the DSM-5 as not manifesting any diagnostic criteria other than craving in a designated timeframe (3 months for initial remission and 12 contiguous months for sustained remission) (American Psychiatric Association, 2013). The other criticism of the research is using days of use in the past 30 days as both a severity and an outcome criterion—a combined measure (Hoffmann, 2015). The DSM-5 defines “severity” as the number of positive diagnostic criteria and remission (initial and sustained) (American Psychiatric Association, 2013), all of which are clearly defined and clinically relevant. There is no doubt that measuring use is easier than determining remission. Similarly, studying anyone with an indication of a substance use disorder is easier than actually documenting the level of severity as defined by the DSM-5 (American Psychiatric Association, 2013). The problem is that measuring the easy way obscures reality (Park, 2008) rather than illuminating knowledge of treatment success (Hoffmann, 2015).

The second problem with evidence-based mandates, is that the evidence for “successful” program models is normed on select subgroups that have met strict inclusion criteria. Of course, these clinical trial groups, which have passed a plethora of exclusion criteria, are not the only

ones to which the data (supporting the program model) are supposed to apply (Feinstein & Horwitz, 1997). In some actual practices, the treatment population may be a particular ethnic/racial group not represented in the studies from which the evidence mandates are derived (Humphreys and Weisner, 2000). So, given that the randomized controlled clinical trials relied upon most for evidence involve discrete subgroups, the source of evidence and numbers in support of the model or treatment manual is not always applicable or resonant with the wide diversity of subgroups in the patient population (Lowman and Le Fauve, 2003). Moreover, the patient mix in actual practice might disrupt the delivery of services (in contrast to picking and choosing inclusion and exclusion criteria as in research protocols). Thus, treatment models touted as evidence-based are suspect: they have limited population application given their artificiality with respect to the real world of program practice, as programs do not always have the luxury of individually selecting their patients (Bellg et al., 2004; Carroll et al., 2007; Hoffmann, 2015).

The third issue is the question of practicality in the real world. Even if the problems of evidence criteria irrelevance and the non-randomness of trials is overcome, some experimental models are shown to be much too expensive to be delivered with the present reimbursement schedules in place—they are too intensive, involve services well beyond what most programs can provide, require levels of expertise that are unrealistic, are too long, etcetera. (Aarons, Hurlburt, & Horwitz, 2011; Hoffmann, 2015). For example, a five-year continuum of care extension “post-treatment” “completion” based on health professional recovery programs treating physicians with substance use disorders (DuPont, McLellan, Carr, Gendel, & Skipper, 2009). Replicating the principles and standards of the physician substance use disorder treatment model as a set (“gold”) standard of addiction treatment would raise the bar and improve treatment outcomes (DuPont, McLellan, White, Merlo, & Gold, 2009). However, such a program

is not necessary, practical, or likely for the general patient population given the type of contact and oversight needed for a diversity of clients/patients with the resources provided by either private or public funding (Hoffmann, 2015).

The fourth reservation is that even if the model is practically realistic, there is the question of fidelity and whether this can be maintained within the reality of a program's shortcomings such as in human capital, resources, and staff turnover (Bellg et al., 2004; Carroll et al., 2007). For example, turnover of staff may have less effect on short-term treatment, as the quality of therapist performance may matter less, but the overall quality of the therapist will have greater importance for more complex case presentations (e.g., borderline personality disorder) with poorer prognosis that require a longer duration of treatment (Goldberg, Hoyt, Nissen-Lie, Nielsen, & Wampold, 2016). Here, compared to a poorer performing therapist of low quality, a more effective therapist stands to deliver greater accruals in patient retention time and therapeutic benefits (Goldberg et al., 2016). More broadly, how do we know that the model continues to work if it was originally designed and normed on a specific substance use disorder, such as alcohol, but is then applied to severe stimulant and opiate use disorders or habituated injection of substances? Thus, given the realities of staff and management changes, variation in the population seeking services, and shifts in attitudes about what constitutes a good outcome, questions arise about how a chosen program avoids potential model drift, that is, changes over time in how services are delivered (Waller & Turner, 2016). Perhaps it is also important to ask if model drift is a bad thing after all.

All of this points to a conclusion that instituting evidence-based models is not always the best way to improve substance use disorder treatment, because when agencies call themselves

and their offerings “evidence-based” it means they have chosen curriculum, models, and practices supported by evidence in precisely a way that is problematic.

### **The Evidence-Based Bandwagon: The Sin of Misdirection**

Then the Lord said to Moses, “Go down, because your people, whom you brought up out of Egypt, have become corrupt. They have been quick to turn away from what I commanded them and have made themselves an idol cast in the shape of a calf.” (Exodus 32:7-8 NIV)

An evidence-based model is not an evidence-based practice. Effective clinicians must be “responsible knowers”—capable of calling upon a well of evidential support for treatment options that reflect client differences. Clinicians must be free, within their respective programs, to make real-time adjustments to treatment on the basis of what they learn from progress monitoring during treatment (Sheridan, 2016). These are the hallmarks of EBP.

Responsible knowing applies to agency heads as well as clinicians. If an agency adopts the EBP approach, it should know its requirements and limitations, and be prepared to live by them, which means on the one hand putting in place the structural possibility of EBP and on the other getting out of the way of clinicians’ decisions made on its basis (Sheridan, 2016). On both these fronts things are not as they should be. In fact, agencies may have two major impediments to EBP implementation. One is that they mistake EBP with rules and policies that promise better outcomes—in effect, instituting evidence-based models or programs or shifting from one evidence-based model to another—a mistake that is bolstered by the second impediment, a compliance-based ethic. With regard to the first impediment, a genuine desire for improved treatment efficacy can even lead agencies down the path of fallacious justification and gross misrepresentation (Sheridan, 2016).

The need to know well—what is here referred to as “responsible knowing”—is an ethical imperative understood in the real world of substance use disorder treatment as the practical need

to develop and expand one's knowledge base in theory and empirical application in the aim of effective treatment. In the spirit of this directive, agency directors strive to implement, within their means, the most effective treatment programs possible. This substantiates the appeal of EBP. But the notion that EBP is the gold standard in treatment quality and practice, without a firm understanding of and commitment to its structural requirements, can lead to the erroneous assumption that EBP automatically translates into better performance outcomes, thereby promoting poor practice of EBP (Lee & Hunsley, 2015). Problems likely compound when expectations and assumptions about EBP are not properly tempered (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). Without prudence and due diligence, a directive for responsible knowing, can most likely actually thwart responsible knowing.

In view of EBP appearing to add legitimacy to programs claiming its application it may in fact be used to compensate for systemic issues inherent in the agency's service delivery model. Some agencies create the veneer of EBP by way of what Fearnside and Holther (1959) called "word magic" (p. 68). For example, statements such as (1) "We have implemented an evidence-based practice curriculum" or (2) "We are an evidence-based treatment program," may be stand-in proclamations for (3) "We are up to date in our offering of services" and/or (4) "The services that we offer are proven to work and are of top-notch quality." But (1) and (4) assert at best that the agency offers evidence-based models—not EBP—and by substituting that fact with the intimation of EBP, the agency is either disingenuous or assumes that EBP can exist without the supporting structural changes to their own program necessary to foster treatment flexibility. Since EBP implementation depends on these structural changes, claiming application of EBP, as illustrated also in (2) and (3), is a hollow declaration.

Yet the façade of EBP implementation enables programs a reprieve from accountability and their responsibility to improve the effectiveness of services. From this standpoint, there is a possibility that some agencies, with inherent flaws and deficits, feel reassured that by wrapping themselves in the cloak of EBP they have taken all necessary steps to overcome their limitations. There are several problems with this thinking, not the least of which is that the façade of EBP is not actually EBP. Mistaking evidence-based programs or models for EBP can induce a closed feedback loop in which the “evidence” supporting perpetuation of the “evidence-based curriculum” consistently informs program staff that the curriculum is best for their clients. In other words, any treatment yielding outcomes evidence is extrapolated as being an evidence-based treatment. If that is all there is to being EBP-compliant, then such treatment is the most effective possible.

Misunderstandings about EBP might also foster the belief that EBP can substitute for outcomes monitoring, which attempts to track effective services and document those that are ineffective. Monitoring is crucial to EBP when it reflects features of outcomes that are clinically relevant. Similarly, providers mindful of their “evidence-based” status may grossly overestimate the effects of their treatment and unjustifiably feel that it generates better client outcomes and improves treatment trajectories simply because such statements are regarded by providers as true of EBP (Sheridan, 2016). For instance, when compared, it appears that there are minimal differences in outcomes between mainstream specific “models” of therapy or treatment modalities (Miller & Moyers, 2015; Tucker & Roth, 2006). Project MATCH (Project MATCH Research Group, 1998) is one example in which millions of dollars were spent to determine that CBT (cognitive behavior therapy), MI (motivational interviewing), and 12-Step facilitation produced nearly identical overall results (Hoffmann, 2015).

Thus without the availability of data and evidence, staking a claim to a well-known or popular name-brand treatment or therapy this is a fallacious “appeal to authority” (Gula, 2002, p. 45). The tendency to think that newer EB treatment modalities should supersede older treatment approaches is at best a fallacious appeal to novelty not supported by reality (Taleff, 2010). For example, Cognitive Behavioral Therapy (CBT) and Rational Emotive Therapy (RET) were used routinely as part of 12-Step programs for more than 35 years (i.e., the Minnesota Model) (Anderson, McGovern, & DuPont, 1999). Further, evaluations of quality programs from the 1980s show that results were as good as many of the so-called evidence-based randomized trials with all their exclusion criteria (Hoffmann, 2015).

So far, the assumption has been that agencies intending to incorporate EBP implement something far weaker, if anything at all. Even on the assumption that the agency is taking measures to implement EBP, the idea that either a program is EBP and thus good, or not EBP and thus flawed, is a false dichotomy (Gula, 2002). Moreover, while the research is not conclusive that provider service drift is a big problem or that fidelity to a model creates significant effects in outcomes (Hawkins, 2016), there is an expectation that EBP will drive greater variations in clinical outcomes, especially if there are clinicians engaged in evidence-based practice within a more traditional model without treatment fidelity procedures (Prowse, Nagel, Meadows, & Enticott, 2015). The magnitude of real effect, however, may have more to do with differences in staff engagement with deliberate practice (Laska & Nordberg, 2016)—such as the deliberate, purposeful seeking out of challenges that enhance particular clinical skillsets in order to deliver a better quality of service product to clients than fidelity or drift, or even EBP (Rousmaniere, 2016).

The reality is that EBP is itself just a label for an approach to substance use disorder treatment; one that is easily confused with other approaches also based on evidence. Clearing away the confusion is only part of the solution—agencies must also structure their organizations around an ethic that fosters clinician responsibility and initiative and grows skills and knowledge in an environment of deliberate practice (Goldberg et al., 2016). But the current culture of care—the compliance-based ethic of EBP—is perhaps the greatest impediment to instituting EBP.

### **The Compliance-Based Ethic: The Sin of Complacency**

[Moses] said to Aaron, “What did these people do to you, that you led them into such great sin?” “Do not be angry, my lord,” Aaron answered. “You know how prone these people are to evil... They gave me the gold, and I threw it into the fire, and out came this calf!” (Exodus 32:21-24 NIV)

When ethical and moral reasoning is steeped in rules, laws, and policy equated with “doing the right thing”, a compliance-based ethic (CBE) is most likely in effect. The “raison d’être” of CBE is risk management. Its ultimate purpose is to ensure avoidance of undesirable consequences that could follow from decisions of inexperience and misguided beneficence, but in practice it can lead to the percolation and flourishing of false risk management strategies (Knapp, Handelsman, Gottlieb, & VandeCreek, 2013). When agencies institute EBP as a tactical maneuver to appease funders and maintain standing with state accreditors and regulatory authorities, it is indicative of a compliance-based ethic. To avoid suggestion here of a motive fallacy (Shaw, 2004), it is important to note that motivation for instituting EBP is relevant here to the extent that it *perhaps* indicates an agency operating within a compliance-based culture. The “right” motivation alone doesn’t necessarily ensure that an agency will achieve the objectives of EBP, nor does the “wrong” motive mean that it will inexorably engage in poor quality EBP. But

an agency rooted in compliance-based ethical thinking is most probably highly vulnerable to precarious investment in EBP.

In line with a compliance-based ethic, integrity is generally promoted and gauged by how well the agency and its members conform to rules set by regulatory authorities and thus play by the “political rules of the game”. The quality, fidelity, and coherence of EBP implementation are different matters, largely because the freedom needed by an evidence-based practitioner is inconsistent, or in tension with, the compliance-based ethic. It is also more difficult to gauge the degree to which an agency “conforms” to EBP (since it cannot be measured by outcomes evidence) other than noting the rules and policies it puts into place that, at most, spell out the motions of applying EBP.

So, in this odd space of regulating a loosening of regulations, well-meaning agency heads flounder. Rather than offering valid reasons for EBP and presenting supportive arguments for its adoption, leaders may employ a battery of authoritarian techniques to empathetically assert, for example, that they fully understand the value of EBP and that it clearly works for agency and clients. Similar emotive language laces program pamphlets and websites, seemingly to convince regulatory bodies and the general public of the validity of what they say about how they use and benefit from EBP. Correlative pronouncements on practice (e.g., “we are an evidence-based program”) and use (e.g., a treatment schedule listing EBP modality) of EBP are in this case a “smokescreen” (Warburton, 2007). These are politically correct statements in a healthcare culture that respects and encourages rules and compliance; but without real application they resemble a public relations exercise that uses EBP as a marketing ploy (Stewart et al., 2016).

This trend is disingenuous. EBP is the antithesis of a compliance-based ethic. It expressly shifts the practical and ethical responsibility of patient/client care to the practitioner. EBP is

much more demanding than simple compliance to rules and policies—clinicians are asked to be responsible knowers, to upend protocols that might be outdated and/or ill-fitting with a particular client’s needs. Any suggestion by an agency promoting substance use disorder treatment services that its clinicians are responsible knowers is weakened to the degree it is not grounded in a culture and ethic compatible with the appropriate power and proper intent behind EBP. The highest level of competency is not easily attained, but as McInerney (2004) states, it is a basic principle of logic that “if we are going to make deliberate statements about important matters in a serious context, we are under obligation to make sure our statements square with what is actually the case” (p. 29).

In short, a compliance-based ethic is a likely cultural barrier in substance use disorder treatment agencies. It encourages compliance to rules rather than the promotion of individual responsibility. It thwarts the initiative and work necessary to revise practices in real time on the basis of evidence and instead fosters an environment of ethical complacency.

### **Conclusion**

And the Lord struck the people with a plague because of what they did with the calf Aaron had made. (Exodus 32:35 NIV)

The “ditheistic” normative standard in addiction treatment in the context of this discussion means that the shortfalls of EBP implementation are not widely known because there is an unrecognized tension between the “god” of responsible knowing and the “god” of a compliance-based ethic. EBP is the substance use disorder treatment industry’s best way of manifesting responsible knowing, whereas its compliance-based ethic is its antiquated way of managing risk. The foregoing argument makes the case that the compliance ethic seems to undercut sincere appreciation and genuine implementation of EBP. Misunderstandings and misconceptions about EBP can therefore abound, rooted in fallacious reasoning or assumptions

about EBP. These are compounded by a feedback loop that makes any evidence for effective treatment look like proof of evidence-based practice that is beneficial for clients. For example, program agencies crediting themselves for the newfound success experienced by a former program client, will use this as a reference that enables staff to favorably gauge the quality and worth of their program. However, clients deemed a program failure—and poor outcomes in general—are more likely to be conveniently forgotten or dismissed as not bearing any evidence relevant to the quality and worth of the program. In turn, this can lead to overlooking deficiencies in program infrastructure and shortcomings in staff qualifications, competency, training, credentials, including self-reflective practices enhancing professionalism (for discussion see Knapp, Gottlieb, & Handelsman, 2017), as well as possible iatrogenic conditions of program practices and policies, all of which contribute to diminished service delivery quality and poorer outcomes. Evidence-based practice philosophy stresses focus on how delivery of care failed to optimally suit the client or at least how care could have better served client needs. The consequence of the compliance ethic, therefore, is that competency of service delivery remains stagnant with providers and staff members falsely believing they are responsible knowers who are practicing EBP.

In strong contrast, EBP is the approach of truly responsible knowers, ethically grounded in respect for the client against a landscape of uncertainties and evolving knowledge, and committed to expanding this knowledge to understand both the strengths and limitations of a treatment model relative to the circumstances of the individual client. Agencies in turn must be committed to embracing adjustments that allow improvements to the standard of care along these lines, and reject compliance as a compelling standard for risk management.

Finally, the efficacy of a therapy or medication usually varies by site (program) and also by the providers within substance use disorder treatment programs. Responsible knowing means understanding there are large differences in the strength of evidence for the efficacy, or otherwise, of different treatment modalities in the substance use disorder treatment field (Miller & Wilbourne, 2002). At the same time, it also appears that providers exert a large effect within whatever treatment modality is being provided (Miller & Moyers, 2015). Responsible knowing about evidence-based practice indicates that the way to verify that programs are achieving the desired goals of this approach is to ensure routine monitoring and research is focused on individual differences in response to different treatment strategies. This means shifting from a programmatic approach in which every client essentially gets the same “treatment”, to an individualized approach where the needs and characteristics of the individual client inform priorities and strategies (Hoffmann, n.d.a). So, it matters what programs do and how they do it. While there are different evidence-based treatment modalities to choose from (e.g., couples therapy, trauma-informed care, cognitive behavioral therapy including “relapse prevention”, contingency management, motivational interviewing, etc.) (Manuel, Hagedorn, & Finney, 2011), these may be implemented merely in compliance to mandates by state agencies or introduced as a fad without being followed correctly. Therefore, the first major step to imbuing the philosophy of EBP is the imperative that programs should endorse individualized client feedback. This is because the chief obsession of the compliance-based cultural ethic that permeates program practice is consequentialist thinking and the need to meet minimum standards set by state regulatory agencies and accreditation authorities. This conformist culture is very likely to neglect the individuality of clients/patients and their overall holistic needs.

As has been stated, the essence of EBP philosophy is individualized care based on best practice standards, however, setting aside prejudices, to avoid introducing a flawed belief system that thwarts EBP philosophy requires checks and balances. Thus, the most pragmatic and realistic approach for such programs to begin in simplest form is client-directed, outcome-informed (Miller, Duncan, & Hubble, 2005) and feedback-informed treatment (Miller, Hubble, Chow, & Seidel, 2015). This way, program service delivery gradually shifts from compliance-based thinking that fosters and reinforces critical thinking errors (Taleff, 2006) to getting accurate client feedback concerning productivity of sessions, the therapeutic alliance, agreed treatment goals, and other program characteristics, that is, a well-supported EBP (Miller, Sorensen, Selzer, & Brigham, 2006). This feedback can also improve provider empathy by identifying individual client differences and expectations, and it can have a significant effect on treatment outcomes through enhancement of the therapeutic alliance (Miller, Forcehimes, & Zweben, 2011; Moyers & Miller, 2013; Miller & Rose, 2009;). Application of EBP philosophy with true intent is the most optimistic path to betterment of the client/patient, both in the specific realm of substance use disorder treatment and in the broader field of health care and human services delivery.

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