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Article 30

Barriers to Evidence-Based Counseling Practices: A Counselor Educator Training Model

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Abstract

This paper highlights existing barriers to the training and implementation of evidence-based practice (EBP) within the counseling profession. In response to the current need for counselor accountability and adherence to best practices, counselor educators are called to support this agenda. An evidence-based counseling practice (EBCP) training model is presented here to guide this critical process.

Important progress has been made in the merger of science and practice within all branches of the helping professions, thereby serving to bridge the "science-to-service gap" (Fixsen, Blasé, Duda, Naoom, & Van Dyke, 2010, p. 435). Most recently, schools and community agencies have begun to mandate the use of evidence-based interventions supported by school movements such as No Child Left Behind and Response to Intervention. At the same time, the mental health initiative was launched by the President's New Freedom Commission Report (2003) and further supported by the National Institute for Mental Health (NIMH). These actions have begun to bring greater accountability to the counseling profession. The adherence to evidenced-based practice not only supports these initiatives, but also reinforces best practices within the counseling profession, bringing efficiency, transparency, and excellence in counseling outcomes. Yet there are a number of barriers that prevent the universal adoption of evidence-based practice (EBP) and interventions (EBIs) across all areas of the helping professions. Counselor educators need to become aware of these barriers and their impact on counseling student knowledge, attitudes, and subsequent future application of evidence-based practices within the counseling profession.

In this paper we briefly discuss evidence-based practice and why we believe it is here to stay. Next, we discuss the importance of embracing evidence-based practice for the viability of the counseling profession, especially since so many counseling-related disciplines have already begun to lay basic foundation in this area. Building on these points, we discuss barriers to Evidence-Based Counseling Practice (EBCP). In particular, if EBIs have been with us for some time, why are we as counselor educators not universally teaching these methods to both school and clinical mental health counselors? Finally, we introduce a model to guide counselor educators in successfully incorporating EBCP into counselor preparation, including implementation of these concepts into the curriculum and promoting EBCPs within the wider counseling community.

Evidence-Based Treatment and Practice

There is a need for clarification of the terms related to evidence-based research in the literature. The professional research is flooded with terminology to reflect portions of this practice. Many studies reference specific programs, techniques, therapies, theories, and treatments (Jameson, Chambliss, & Blank, 2009; Powers, Bowen, & Bowen, 2010; Southam-Gerow, Hourigan, & Allin, 2009). Other studies examine the adaption of specific techniques or interventions deemed evidence-based or scientifically researched. Yet specific applicability to field-based practice is often left to reader interpretation. In regard to counselor education, a clear definition of practices and clinical effectiveness needs to be established within the literature (Powers et al., 2010). Evidence-based practice is defined by Thomason (2010) as "the integration of research with clinical expertise in the context of the client's characteristics, culture and preferences" p.30. Furthermore, evidence-based practice specifically includes "practices that are informed by research, in which the characteristics and consequences of environmental variables are empirically established and the relationship directly informs what a practitioner can do to produce a desired outcome" (Dunst, Trivette, & Cutspec, 2002, p. 3). Inherent in both of these definitions is the development of competence in the decision making process related to evidence-based practice implementation.

Training students in evidence-based practice as a model for clinical decision making (Addis, 2002; Thomason, 2010) includes a process to help practitioners address issues of treatment selection, ethical practice and application issues with a scientific influence (Gambrill, 2010). Additionally, training future practitioners in EBP includes the consideration of serving the individual counseling needs of those students and clients we work with, as well as multicultural considerations and goal setting as an integral part of treatment selection (Roysircar, 2009). There is a distinct need to bridge the research-practice gap between university research and direct service providers (Abdul-Adil et al., 2010). This would entail the instruction of evidence-based practice as a decision making process of treatment selection and application of EBI within applied settings. Not only would this implementation result in better care for the clients and students that we serve, but it would also help to support the legitimacy of the counseling profession. It is imperative that counselor educators consider the impact of EBP, barriers to our graduate students' future ability to adopt EBP, and subsequently the impact on the gap between research and practice within our profession.

Barriers to Implementation

Utilizing evidence-based practices is not as straightforward as one would imagine. There are many barriers that exist for practitioners including anti-EBP bias and cost of implementation. Counselor educators must be aware of these barriers in order to facilitate the effective utilization of EBP. "Conducting evidence-based practice requires both the existence of feasible, relevant, and effective intervention choices and the availability of detailed information about those choices" (Powers et al., 2010, p. 314).

Barriers for Practitioners

Practitioner barriers to Evidence-Based Practice in the community are many and include lack of training, limited access to treatment manuals, inadequate research evaluation skills, and limited professional supervision (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009; Chambless, 1999; Chan et al., 2010; Karekla, Lundgren, & Forsyth, 2004). One of the primary factors associated with lack of utilization among current practitioners is insufficient graduate training in basic concepts of research, evidence-based methods, knowledge, and utilization (Chan et al., 2010). Practitioners, especially those in supervisory or administrative positions, need to be armed with basic concepts related to evidence-based practice, such as those described by the Council for Training in Evidence-Based Behavioral Practice (2008). The Council describes five steps for carrying out the Evidence-Based Practice process: 1) asking, 2) acquire, 3) appraise, 4) apply, and 5) analyze. Once established in the profession, practitioners report insufficient time for training in the utilization of evidence-based interventions in the field and difficulty in receiving training through continuing education (Chambless, 1999; Chan et al., 2010).

Even if practitioners feel adequately trained, a sample of seasoned professionals report barriers and exhibit resistance to adherence. Explanations might include the fact that treatments are reported as not easily adapted to the multifaceted needs of the applied setting (Southam-Gerow et al., 2009) and treatment manuals are not easily accessible or are costly. When they are accessible, many practitioners report that treatments are not

always described in sufficient detail to implement the treatment (Rathvon, 2008). Oftentimes, true implementation of an EBP requires resources beyond an agency or institution's ability to provide. For example, EBPs may require consulting teams, extended training, live supervision, or other fidelity-ensuring mechanisms that may be seen as interfering with the agency's fiscal productivity.

In addition, the appropriateness of the treatment within a particular setting comes into question. Within a clinical mental health setting, length and frequency of treatments may not coincide with third party payment issues (Addis, 2002). For example, evidence-based intensive in-home family counseling approaches that divert children from inpatient or residential treatment are frequently not reimbursed by managed care companies. Even though they may be far more effective in the long-term, the short-term investment is viewed as cost-prohibitive. Within schools, many evidence-based treatments are viewed as impractical (Rathvon, 2008) and not easily adaptable to an education setting. When an EBI is deemed acceptable, the school personnel may lack the necessary supports to guide and sustain proper application (Becker & Domitrovich, 2011). Moreover, theory based agencies may reject particular treatments perceived as conflicting with the orientation of choice. Those strongly committed to behavioral interventions will be reticent to incorporate modern psychodynamic methods within an existing practice, despite scientific evidence of success. In both school and agency settings, practitioners may be resistant, feeling that manuals detract from the authenticity of the therapeutic interaction (Addis, 2002, Karekla et al., 2004) or that they fail to appreciate unique aspects of the individual (i.e., cultural diversity, client treatment preferences; Bernal & Scharron-Del-Rio, 2001).

Organizational issues such as level of supervision and adequate funding often limit the viability of adherence to EBP. Poor leadership and lack of supervision contribute as barriers to EBP (Chambless, 1999; Rapp et al., 2010; Swain, Whitley, McHugo, & Drake, 2010). Supervisors may be less likely to make EBP a priority due to increased attention, costly training, and the need for extra personnel (Powers et al., 2010; Swain et al., 2010). Without these aforementioned supports, practitioners would need to independently research interventions, a practice for which they often don't have time (Rathvon, 2008).

Barriers for Counselor Educators

Further, the literature suggests that practitioners are aware of the importance of treatment effectiveness but feel they lack the training and resources to effectively perform these interventions (Karekla et al., 2004). The barriers to utilization of EBPs across the professional counseling field threatens to further impede future practice and derail accountability. Unfortunately, barriers also exist at the training level for many helping professions. Therefore, it is imperative that counselor educator programs adequately provide students with the knowledge and skills needed to deliver counseling services within an EBP framework. Current research suggests that this is not consistently happening (Karekla et al., 2004; McHugh & Barlow, 2010). Various mental health disciplines, including social work and psychology, have called for increased attention on the pedagogy of EBP (American Psychological Association Presidential Task Force on

Evidence-Based Practice, 2006; Forman, Fagley, Stenier, & Schneider, 2009; Rubin, 2007).

In light of university academic requirements, accreditation and licensure guidelines, not surprisingly, counselor educators experience a lack of time in the curriculum to dedicate to empirically validated methods (Council for Accreditation of Counseling and Related Educational Programs [CACREP]). There is also evidence of resistance among training professionals who hold a bias towards authority-based decision making, based on consensus, anecdotal experience, or tradition (Gambrill, 2006). Counselor educators may feel pressure to choose one school of thought in regards to student training needs. In turn, some prefer training students in theoretical orientation and view the emphasis on scientific evidence as inconsistent with this view.

Regardless, educators may be required to incorporate content in response to best practices, state and local mandates, and patterns of need within the profession. Clinical mental health counseling programs that fail to adequately prepare students to understand, value, and choose EBPs may inadvertently be setting students up for professional failure by limiting future job skills and marketability. For licensed professional counselors and helping professionals who depend on third party payment, the literature suggests a trend toward insurance reimbursement for EBI, mandatory adherence of EBP in order to qualify for liability insurance, and mandatory use of brief interventions to treat clients (Thomason, 2010). Herein is an ethical responsibility for all counselor educators.

Ethical Issues and Obligations for Counselor Educators

Counselor educators are ethically obligated to train future practitioners to appropriately evaluate and utilize EBP (Gambrill, 2006) and recognize barriers to this practice (Addis, 2002) in both school and community settings. School and community settings require counselor accountability, including the use of evidence-based techniques, impact on student/client growth, and data to support this impact. Furthermore, providing best practices in the counseling profession is an ethical obligation to our graduate students, their students/clients, and the profession at large. In fact, it is a social justice imperative. Counselors, including students in field work, could easily be overwhelmed by the limited resources and daunting responsibilities inherent in community mental health practice (Paris & Hoge, 2009). Students who work in areas of poverty, diversity, or high need require training in best practices to enable them to even the playing field for those who do not have as much in terms of resources. Counselor educators have an ethical responsibility to provide the necessary mindset, skills, and training to prepare future counselors to implement effective interventions.

As well, counselor educators can impact the culture of responsible, ethical treatment planning by emphasizing the importance of supporting EBP through on-site provision of resources, time for training and on-going supervision. Literature suggests that lack of adherence is in part due to lack of agency organizational support (Rapp et al., 2010; Swain et al., 2010), poor leadership, and guidance that ensures practitioners follow guidelines (Rapp et al., 2010; Swain et al., 2010).

Resource Availability

Implementation of evidence-based counseling in community agencies or schools requires an intense investment in training, money, and other resources. Practitioners must

be provided with workshop training, manual(s), and clinical consultation/supervision (Sholomskas et al., 2005). This is similarly true for supporting EBC in counselor education. Even if counselor educators and students are highly motivated, good pedagogical practices in EBC require exposure to a variety of evidence-based models and their materials, including treatment manuals. Students should then have opportunity to apply this clinical knowledge at a minimum in role-play or most ideally with actual client populations in lab or fieldwork settings. There are some significant problems with these training needs.

First, treatment manuals and other program-fidelity supportive materials are expensive. Frontline practitioners have been found to harbor concerns about program costs (Rapp et al., 2010) and to skeptically view new evidence-based approaches as propaganda, pseudoscience, or fads (Gambrill, 2006). Given the costs, it may be difficult to convince university colleagues to view evidence-based materials as necessary. Evidence-based approaches may not be appreciated by counselors who have been working longer who are perhaps more entrenched in a particular theoretical orientation, or who feel that manuals detract from authenticity of therapeutic interaction (Addis, 2002; Karekla et al., 2004) or the art of psychotherapy (Thomason, 2010). In addition, university administrators may fail to understand how critical it is to support the purchase of comprehensive treatment materials, including manuals and other supportive literature.

Counselor educators must be adequately trained in the general evidence-based philosophy as well as at least one to two evidence-based approaches. This kind of training is by nature, extensive. Indeed, brief workshops and the like appear to be ineffective in helping clinicians implement EBCs in practice (Beidas, Edmunds, Marcus, & Kendall, 2012). We could thus draw similar conclusions about counselor educators attempting to teach these approaches and concepts; a workshop or didactic training program is no replacement for supervised clinical practice. However, in spite of the need for counselor educators to have some real-world experience with an evidence-based approach, the academy including counselor education may not recognize or reward clinical training as it does publications and other scholarly artifacts (Orr, 2005). Further, the rigors of committee work and other university and community service coupled with an increasing teaching burden may make it impossible for tenure-track faculty to engage in applied practice in either schools or community settings.

To help support counselor educators in their efforts at teaching evidence-based approaches, consultants or external speakers should be invited to share practical expertise in the classroom. Coordinating such visits takes time and energy on both the part of the counselor educator and the community practitioner. Moreover, the state of our mental health system requires that practitioners increasingly limit their duties to revenue-generating activities.

Perhaps the most arduous challenge is that a model-adherent evidence-based approach that actively monitors program fidelity often requires full-time practice alongside intensive supervisory/consultant oversight. As in many situations, the best learning is by doing. Therefore, a small amount of training such as a one-day workshop becomes significant if it is accompanied by subsequent supervisory or consultation support. Indeed, active monitoring of program fidelity by way of expert consultation is found to correlate significantly with higher clinical skill levels and is viewed as a critical

component of any evidence-based treatment (Beidas et al., 2012). This is true of counselor educator training as well as student counselor training.

The Training Model

Commitment to EBP begins with the planning and intentional application of the EBCP Model. Based on EBP literature and barriers to implementation, this model must include curriculum changes, including increased focus on instructional strategies, research appraisal and program evaluation, clear knowledge of treatment applicability in applied settings, focused, ongoing supervision strategies as well as appraisal and data collection skills.

The first course of action would include adjustments to the program philosophy and core curriculum, including the addition of competencies and learning outcomes reflecting the faculty commitment to training students in EBCP. Course syllabi and textbooks will support the necessary training in EBP philosophy, knowledge, and skill acquisition. Vivian et al. (2012) suggested the inclusion of various classes including research in emotion, behavioral learning, interpersonal relationships, cognitive research on biased processing, neurological basis of behavior, research methods, life span development, empirically supported relationships and principles of change as well as knowledge of potentially harmful practices. In a recent study investigating therapist adoption of EBP (Beidas, et al., 2010), contextual variables including therapist variables, organizational support, quality of training and client variables were explored among several EBP studies. Quality of training was found to be an important contributor to therapist adherence and competence with EBP, specifically effective methods of education included "active learning" and behavioral rehearsal of skills (Beidas & Kendall, 2010, p. 2). Therefore it is imperative when training in EBP that educators utilize experiential methods and encourage the practice of EBP decision making skills.

As noted earlier, there is a growing need to conduct and evaluate research done in schools and community mental health agencies to establish and support the evidence base for our counseling practices. While many non-university based practitioners may not have the time or the desire to engage in research, they do have an obligation to stay current with, and keenly appraise, the research conducted by others that will inform our field-based practices. The American Counseling Association (ACA), the American Psychological Association (APA), and the National Association of School Psychologists (NASP) all contain specific standards within their ethical codes/guidelines that define ethical professional conduct to include the use of practices that are grounded in research (e.g., ethical principle C.6.e in ACA (ACA, 2005), ethical principle 2.04 in APA (APA, 2010), and ethical principle II.1.4 in NASP (NASP, 2010)). Thus, a counselor's ability to evaluate research is of the utmost importance in carrying out our commitment to the beneficence of our clients.

Unfortunately, practitioners leaving university-training programs to enter the community agency and school settings are often under-prepared to expertly appraise the research base of the EBCP they employ. Chan et al. (2010) and Heppner and Anderson (1985) posited that graduates of university training programs often have insufficient training in basic concepts of research, methods, knowledge, and utilization. Typically, university training programs require students to take one course related to research, and at

times, this course also attempts to incorporate basic tenets of program evaluation, or the research component is secondary to practicums and theories (Lundervold & Belwood, 2000; Sexton, 2000). Clearly, this is an ambitious undertaking; one that seems to result in graduates receiving inadequate exposure to the broad range of skills and knowledge needed to effectively evaluate research in the field. Additionally, research methodology and procedures of statistical analysis of data are advancing such that a basic understanding of probability, t-tests, and basic research design may be insufficient for field-based practitioners to assess of-the-moment disseminated study findings (Lundervold & Belwood, 2000; Okech, Astramovich, Johnson, Hoskins, & Rubel, 2006). Universities that prepare practitioners (as opposed to doctoral-level academics) often do not expose students to the statistical and methodological concepts (such as regression analysis, hierarchical linear modeling, etc.) needed to understand research that accounts for greater variability in the data through increasingly complex research designs and analyses.

To address these knowledge gaps university training programs need to ensure they educate their undergraduate and graduate students more broadly in research skills. University students need to know how a research base is established and the evolving methodological and statistical concepts that follow. Relatedly, they need to understand the importance, and the limitations, of early clinical research (Southam-Gerow et al., 2009). That is, they must appreciate that new lines of research are typically established through single-case and open trial studies to establish not only the preliminary benefits to the subject of study (treatment, approach, intervention, etc.), but also the safety of such treatment within the population studied. Furthermore, university students need to be able to distinguish between studies designed to establish the efficacy of a treatment versus the effectiveness of a treatment (Southam-Gerow et al., 2009). When establishing efficacy, researchers strive to establish that a particular treatment demonstrates the ability to produce desired results in a population that is studied in a controlled setting (e.g., university clinic or laboratory with a control comparison group). Once efficacy is established, researchers then strive to demonstrate that the treatment is better than or comparable to other active treatments (the results of the treatment under study produce comparable or better results than current treatments). Finally, researchers then attempt to show that their treatment is also effective. In these types of studies, the treatment is used in less-controlled community and/or school-based settings to establish that desired results can be obtained in natural settings (Southam-Gerow et al., 2009). At this stage in the development of new treatments, practitioners have the information they need to make informed decisions about the applicability of new treatments to their specific setting. Furthermore, treatments that are tested within a university research setting may not be easily adapted to the multifaceted needs of the applied setting (Southam-Gerow et al., 2009). Without an understanding of this process by which EBCPs are established, field-based practitioners may be misled or become misinformed as to the true or potential field-based applications of treatments that they are investigating for use with their population of clients.

Research Methodology

The need for improved training in research methodology for field-based practitioners within their university training programs is clear. Regardless, there exists

the very real and challenging obstacle of enfolding needed content into already demanding courses and course sequences. Many would contend that adding this level of instruction may be outside the realm of established university research courses, and alternatively, adding an additional class to address such content is not a viable option for many training programs (Okech et al., 2006). To address this research gap, it has been suggested that research-specific mentoring, presenting research findings at conferences, and submitting research-based manuscripts for publication could be useful activities to increase experience and competency in this area (Lambie & Vaccaro, 2011; Okech et al., 2006).

Alternatively, Kratochwill (2007) proposed that web-based learning is an effective vehicle for disseminating this important information. By requiring students to participate in web-based inquiry (through webinars, online learning courses, etc.), existing research courses will not become overburdened with content. Additionally, such web-based learning would avoid the need to add courses to already demanding university training course sequences for field-based practitioners. In developing such web-based learning experiences, content developers would need to ensure that the previously mentioned competencies were directly taught and measured. That is, such learning experiences would need to include understanding of the continuum of clinical research (from single-case studies to effectiveness studies), the transportability of interventions from the clinic to the field, and development of a critical eye for evaluating research that is disseminated to the public (Southam-Gerow et al., 2009). Gambrill (2006) suggested that field-based practitioners could be instructed in the use of databases such as that developed by Cochrane and Campbell (Higgins & Greene, 2005) to effectively review disseminated research. Practitioners would be aware of control for bias and overestimation of positive effects. Clearly, undertaking these steps and creating more rigorous exposure to and understanding of research methodology within university training programs is essential to ensuring that we are enacting ethical, professional, and beneficial treatments for the students and clients whom we serve.

Setting and Treatment Applicability

A common criticism of evidence-based approaches is that such interventions may be impractical for real life practice in schools (Rathvon, 2008) or in community agencies. Evidence-based approaches, when implemented correctly, require consistency and firm commitment to protocol. For example, Multisystemic Therapy (MST) is a strongly supported and widely accepted evidence-based treatment aimed at decreasing acting out behaviors, most frequently among court-involved youth. MST requires home-based treatment delivery for approximately four months, with a team of clinicians available 24-hours a day (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). The extreme length of many of the home-based sessions and the high frequency of treatments would clearly be prohibitive for some counselors (Addis, 2002). This treatment approach would not be an option for a private practitioner, nor would it be a counselor education-friendly approach for teaching students about evidence-based approaches. Although schools are ideal natural environments in which to address children's mental health needs, EBPs are not ideally tailored for this setting and issues of transportability make real world applications difficult (Masia-Warner, Nagle, & Hansen, 2006).

Thus the critical training bridge that Kazdin described (2009), which helps move our knowledge from scientific theory to practice, is hampered with this particular and many other evidence-based approaches. Indeed, many of the evidence-based practices are highly specific in regard to setting, population, or modality and may therefore be less relevant to many counselor educators and their students. On the other hand, many of the evidence-based approaches share concepts or practices that one might carry out of the specific, model-adherent practice setting and into other client or student situations**.** In a school setting, align your methods with the school improvement plan and use progress monitoring to assure appropriateness and measure effectiveness.

Supervision Strategies

One of the greatest benefits of working within an evidence-based approach is the intensive training and support, elements necessary in maintaining high quality and program fidelity. This means that the supervisors and administrators hold a great deal of responsibility for nurturing clinicians and promoting practices that will yield the best results (Rapp et al., 2010) and in helping clinicians view such support as a great advantage rather than as a burden (Asgary-Eden & Lee, 2011). In some evidence-based approaches, it is not uncommon for clinicians to meet with team members, a clinical supervisor, and a professional consultant all within the timespan of a week (Henggeler & Schaeffer, 2010). While some practitioners might find this level of oversight oppressive or intimidating, it appears that after a period of adjustment, most clinicians find great benefit from the layers of quality control. Indeed, a study by Aarons, Sommerfeld, Hecht, Silovsky, and Chaffin (2009) found that staff turnover was lower within a highly structured evidence-based in-home treatment program. Fidelity monitoring was found to be particularly helpful. As it was hypothesized, the supportive coaching model of consultation was encouraging rather than punitive.

It is well established that effective supervision involves the provision of ongoing objective feedback to evaluate treatment effectiveness (Addis, 2002). Research in evidence-based approaches has demonstrated benefits related to the use of audio recordings (Sheidow, Donohue, Hill, Henggeler, & Ford, 2008) and other methods for close monitoring of in-vivo intervention skills (Fixsen et al., 2010; Rapp et al., 2010). Other factors that appear to impact supervision include the actual or perceived skills of the supervisor in a particular evidence-based practice (Carlson, Rapp, & Eichler, 2012; Rapp et al., 2010). Other supervisory skills, such as ineffective group supervision leadership, have been shown to discourage practitioners from embracing particular approaches (Rapp et al., 2010). The use of counseling practice-based networks has also been promoted to assist independent practitioners or smaller agencies to provide enhanced evidence-based programs, even if such programs cannot meet 100% fidelity (Kosciulek, 2010). In general, the intensity of the evidence-based approach to supervision communicates the need for increased adequate supervision (Chambless, 1999).

Appraisal and Data Collection

In order to support the long-term viability of EBP in applied settings, Abdul-Adil et al. (2010) suggested utilizing a model of collaboration based on multiple levels, affording a flexible framework for implementing and sustaining EBP. This working alliance is meant to assist both the applied practitioner and placement with the structural

supports of training, assessment, consultation, research and supervision (Abdul-Adil et. al, 2010). Beidas et al. (2012), in a implementation study, found that in addition to brief training, ongoing consultation was a critical element in increasing effectiveness, "likely providing the therapist with a venue for clarification, and practice of concepts, learning concepts and practicing over time, case consultation, and using problem solving to overcome implementation barriers" (p. 661). These methods improved therapist fidelity to evidence-based treatment.

Several studies recommend the use of a partnership research model to bridge the gap between research and practice (Abdul-Adil et al., 2010; Chamberlain et al., 2012; Riemer, Kelley, Casey, & Haynes, 2012). These relationships can inform implementation, sustainability, and evaluation of EBP in applied settings, community or school. These partnerships will ensure that current students have fieldwork placements with a philosophy that is in alignment with your counselor education program. Most importantly, students need the knowledge and skills necessary to collect data and appraise EBP. One way students can support this critical step is to seek out partnerships once established in professions. University partnerships will not only support students while in training but can forge relationships with these new professionals in the field.

Conclusion

This article provides a model that guides the instruction on evidence-based counseling practice. Counselor educators have an ethical responsibility to encourage the training and implementation of EBP across all counseling settings. We not only have an obligation to our students to prepare them to compete among many helping professionals but to provide the most effective services to their clientele. The barriers are many, including insufficient training, misleading research, practitioner resistance and bias, and inadequate supervision and leadership. Counselor educators must instill in students a strong underlying philosophy and the skills necessary to pursue future utilization of EBP for the better of the counseling profession and for our clients.

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