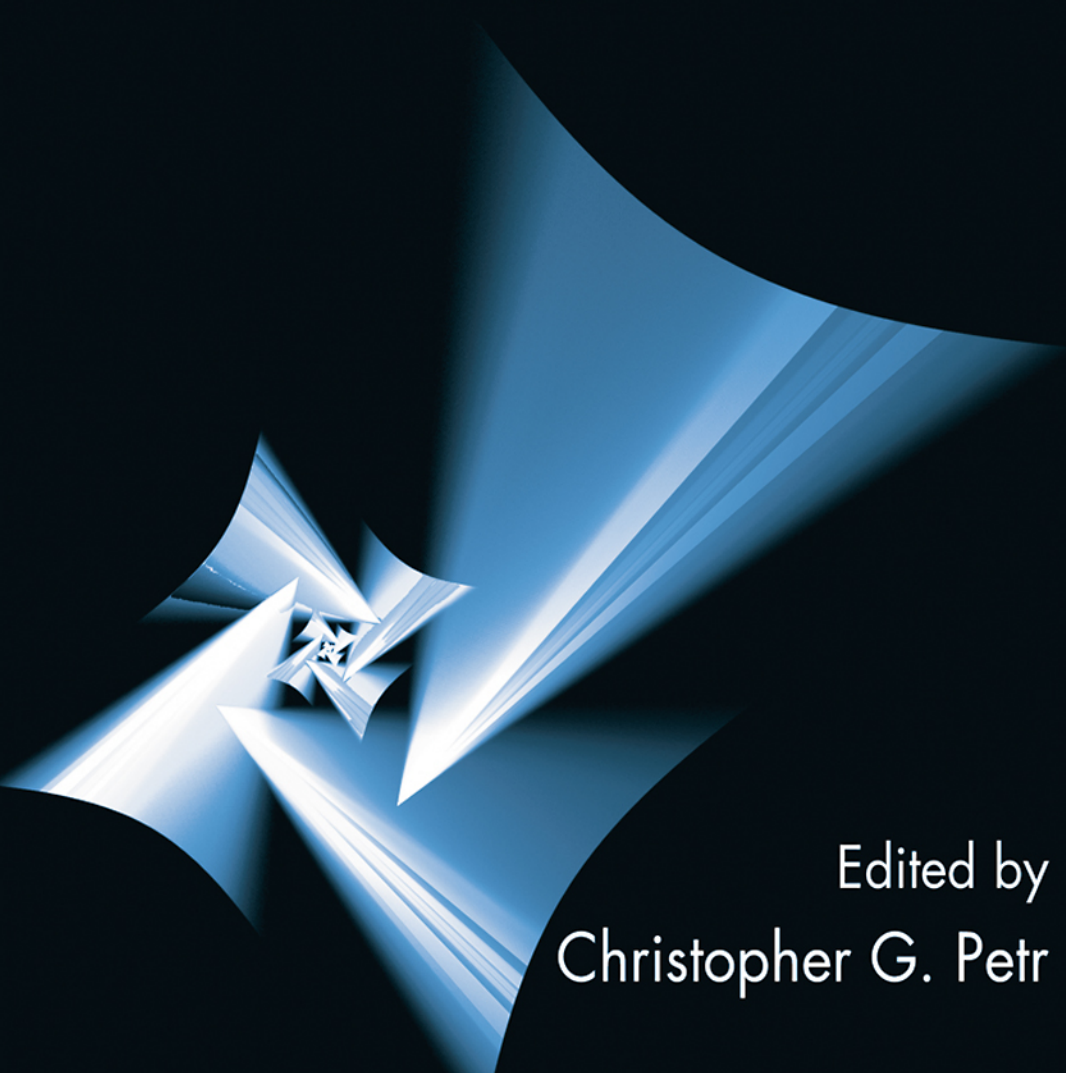


Multidimensional Evidence-Based Practice

Synthesizing Knowledge, Research and Values

An abstract graphic featuring several bright blue, fan-shaped light rays that originate from a central point and radiate outwards. The rays are set against a dark, almost black, background. The rays themselves have a gradient, appearing brighter at the center and fading towards the edges. The overall effect is one of dynamic energy and focus.

Edited by
Christopher G. Petr

Multidimensional Evidence-Based Practice

Multidimensional Evidence-Based Practice (MEBP) is a new and comprehensive approach to determining best practices in social services.

MEBP improves upon traditional evidence-based approaches by incorporating the views of consumers and professionals, qualitative research, and values. The book begins with a review of the context of best practice enquiry and goes on to present the seven steps of the MEBP model, discussing each step in detail. The model is appraised and explains how questions are formed, how various forms of knowledge and evidence are summarized and evaluated, and how values are used to both critique current best practices and point toward needed improvements. The final seven chapters illustrate the MEBP process at work specific to a range of topics, including best practices in the prevention of child abuse and best practices in restorative justice.

This book will be of interest to social workers and other professionals involved in the delivery of human services. It is also suitable for students and researchers of evidence-based practice.

Christopher G. Petr is Professor of the School of Social Welfare at the University of Kansas, USA. He is also a licensed clinical social worker in Kansas and practiced for a number of years at the local Community Mental Health Center.

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Multidimensional Evidence-Based Practice

Synthesizing Knowledge, Research,
and Values

**Edited by
Christopher G. Petr**

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Foreword

Irwin Epstein

Over the past decade in social work and the other helping professions, academic champions of the *evidence-based practice (EBP) movement* have promoted a narrowly positivist, empirically oriented, contextually stripped and, ultimately, reductionist prescription for choosing practice interventions. Elevating “gold standard” experimental studies and meta-analyses based on these experiments to the highest rung of knowledge generation, some EBP advocates have gone so far as to suggest that social workers who do not follow their prescribed mandates are professionally irresponsible and even guilty of malpractice. To such doctrinaire proponents of EBP any alternative source of professional knowledge and practice wisdom is deemed “authority-based,” devoid of critical thinking.

Not surprisingly, the vast majority of practicing social workers with whom I have spoken about EBP here and in several other countries find this perspective and its accompanying accusations hard to swallow. But practitioners the world over are used to being disparaged by academics. Harder for them to stomach however is the potential loss of professional autonomy associated with the promotion of “manualized” practice guidelines based on reviews of empirical studies conducted and synthesized by non-practitioners.

Worse still is the implicit assumption of a division of labor between academics who create knowledge and practitioners who implement it. In the EBP world, gone is the place for the “reflective practitioner” (Schon, 1983) who generates and shares knowledge from within practice.

At a recent social work conference dominated by academics, where the air was heavy with self-righteous assertions of their EBP superiority, Chris Petr and I found ourselves in need of personal escape. Introduced to each other by a mutual friend, I had recently read Dr. Petr’s co-authored article on teaching doctoral students to extract, critique and distill best practices (Petr & Walter, 2005) and found it to offer a heuristic guide to best practice synthesis that was refreshingly balanced, practical and even-handed. He called it *Multidimensional Evidence-Based Practice (MEBP)*.

Although our work was quite different, at some level Dr. Petr and I were engaged in parallel efforts to integrate social work research and practice. Over the past decade, my approach was to seek ways that practitioners could contribute to their own knowledge of best practices via *practice-based research (PBR)* studies

that they themselves could conduct in their own practice settings but did not require research designs that denied consumers the services they wanted or posed value conflicts for practitioners (see, for example, Epstein, 1995, 1996, 2001; Peake, Epstein & Medeiros, 2005). These studies could be qualitative, quantitative or employ mixed methods. They might rely on available clinical information or on original data collection. Either way, PBR studies were grounded in an authentic agency context rather than an aspiration to a research laboratory. Moreover, they were explicitly intended to promote practice decision-making.

Dr. Petr's strategy for arriving at best practices was to broaden the scope of review and assessment of *existing* literature including but not limited to intervention research studies. Similar to mine, his approach gave comparable credence to qualitative as well as to quantitative research findings rather than locating them on a hierarchy in which the former were treated as methodologically inferior to the latter. He extended his range of inquiry beyond mine by giving attention to the voices of consumers and the values of professionals.

I encouraged him to do a book on the subject, fully illustrating his methodology with exemplars in multiple practice contexts. And he and his doctoral students did it extremely well—providing exemplars in practice contexts as diverse as child abuse and teen pregnancy prevention, increasing access to health care for poor children, increasing parental involvement in child mental health services and therapeutic foster care, improving provider communication with parents whose children are in care, structuring effective restorative justice programs for crime victims and enhancing spirituality among the seriously mentally ill.

Predictably and gratifyingly, since Dr. Petr teaches at the University of Kansas School of Social Welfare, the book is infused with a commitment to consumer empowerment, the strengths perspective and a family focus—values for which his school is widely known and justifiably admired. Thus, the book's contribution goes beyond simply explicating a new methodology for arriving at best practices. Instead it views the synthesis of current best practices as only a first step in a dynamic, thoughtful, and creative process whereby future evaluation studies, values-based criticism and consumer involvement will add to the depth of our understanding and selection of best practices. The MEBP process can be profitably employed by students, practitioners, and academics alike.

For this more intellectually open, value-embracing, and consumer-inclusive model, we owe Dr. Petr and his fellow contributors a considerable debt. In a congratulatory spirit, let's raise a glass.

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Preface

Despite its economic prosperity and high standard of living, the United States is confronted with a myriad number of social problems and issues. Homelessness, child abuse, mental illness, adult and juvenile crime, and substance abuse are just a few of the issues that plague the nation. Millions of citizens experience these problems and their attendant human suffering. Millions, even billions, of dollars are spent on prevention and treatment programs. In this context, it is vital that “best practices” be employed by professionals so that the dollars are well spent and the problems are addressed and resolved.

This book presents a comprehensive (multidimensional, evidence-based, value-critical) approach to determining best practices that was developed in a doctoral-level social work course at a major Midwestern university.¹ Conventional best practices approaches focus on thorough and systematic reviews of quantitative research studies, identifying empirically validated interventions for a given target population and problem. Clearly, this empirical approach to identifying best practices is an important and indispensable component of any best practices inquiry.

The principal contribution of this book centers on broadening and deepening the method and knowledge base of what is considered best practices, providing an expanded and more comprehensive foundation of information to guide professionals, policymakers, and funders. In this multidimensional evidence-based practice (MEBP) approach, it is not enough to report on the empirical research; instead, it is incumbent on the investigator to augment the empirical data with knowledge from consumer and professional sources, to utilize value criteria to identify gaps in current best practices, and to put forward recommendations regarding how to elevate current best practices by addressing those gaps. In addition to quantitative research, the MEBP approach incorporates diverse perspectives on best practices that warrant inclusion: qualitative research, professional practice wisdom, and consumer values and experiences. The MEBP method also includes a blueprint for conducting a value-based critique of the best practices themselves, then utilizing that critique to make recommendations about how best practices in a particular field can be improved.

Chapter 1 presents the intellectual context of best practices inquiry, in all of its considerable complexity. It defines and discusses several key, interrelated, and often confusing concepts: best practices, practice-based research, empirically

based practice, evidence-based practice, and knowledge-based practice. This overview chapter concludes with an outline of the MEBP approach that is the subject of this book.

Chapter 2 presents the specific, seven-step MEBP model for determining current state-of-the-art best practices relative to a particular population and problem. These seven steps are:

- STEP 1: Identify the MEBP question.
- STEPS 2–4: Identify multiple sources of knowledge and evidence pertaining to the MEBP question:
 - STEP 2: Identify sources and summarize consumer perspective.
 - STEP 3: Identify sources and summarize professional perspective.
 - STEP 4: Identify sources and summarize research perspective, including both quantitative and qualitative studies.
- STEP 5: Summarize findings of best practices across three perspectives.
- STEPS 6 and 7: Critique current best practices:
 - STEP 6: Assess the potency of the identified best practices.
 - STEP 7: Use value criteria to critique and improve current best practices.

Chapters 3–9 are exemplars of the MEBP method, focused on a variety of social issues, and written by former students who attended the doctoral class in which this approach was developed and refined. These chapters fulfill two purposes: they illustrate the process of MEBP, and they contribute content that greatly enriches our understanding of best practices in each topic area. Chapter 3, written by Jacqueline Counts, addresses a major social problem: child abuse. Taking a prevention approach, the author identifies six key best practice components of prevention programs. She concludes that best practices in this area are very well developed and researched, but could be improved by establishing practice/policy feedback loops, strengthening parent leadership, and disseminating the results of research toward wider adoption of best practices. Emily McCave, in Chapter 4, identifies five best practices to prevent teen pregnancy, none of which included abstinence-only programs: sex education, access to contraceptives, youth leadership and development, parent involvement, and community alliances. One recommended improvement is to target research at what works for marginalized youth. In Chapter 5, Karen Stipp addresses the issue of health care access for poor children, identifying best practices as administrative appointment-keeping supports; non-medical supports including referrals, parent education and outreach; provider–parent relationships built upon effective communication; and usual sources of care maintained by continuity of care and a primary provider. To improve best practices, she recommends that providers work more collaboratively to reduce costly emergency visits. Chapter 6, by Tara McLendon, explores the timely issue of parent involvement in mental health services for their children. The two most commonly cited best practices across all three perspectives are

the provision of culturally competent services and showing respect and concern to families. Better incorporation of the strengths perspective during initial contacts is one recommendation for improvement. Uta Walter's review of therapeutic foster care identifies two sets of best practices in Chapter 7. The first set revolves around connecting to, involving, and supporting biological families; the second set focuses on the provider families communicating clearly with agency staff and families, and receiving systematic support and training. She concludes that best practices can be improved by more fully operationalizing the value of family-centered practice. Jung Jin Choi, in Chapter 8, identifies three types of restorative justice programs and the best practices components that they share. Noting that programs are underutilized by persons of color, the gap that he identifies is the lack of attention to cultural competence. In Chapter 9, Vincent Starnino focuses on ways to enhance spirituality among the seriously mentally ill. Although research on this topic is sparse, he identifies eight current best practices, and recommends improvements based on ensuring safety and enhancing practitioner competence and self-awareness.

Note

- 1 Some sections of the Preface and first two chapters are adaptations of previously published work by Petr and Walter (2005).

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1 Best Practices Context

Christopher G. Petr

The context for best practices is fraught with conceptual confusion and controversy. Interrelated and overlapping terms such as “practice-based research,” “empirically based practice,” “evidence-based practice,” and “knowledge-based practice” contribute to the untidiness and disarray. Meanwhile, funding agencies and the general public demand that programs be accountable and produce results. An effective and systematic method for determining best practices is vital to respond to this mandate and to ensure the well being of needy and vulnerable clients. This chapter assesses the intellectual context of best practices inquiry and concludes with a blueprint for conducting of a multidimensional inquiry that integrates various types of knowledge, research, and values.

Social workers, psychologists, and other helping professionals undertake a variety of work roles and responsibilities that require them to maintain high levels of competence in order to ensure the success of their clients and of their service agencies. These roles and responsibilities include providing direct service to clients, program development, administration, scholarship, grant writing, consultation, and research. In order to develop and sustain competence in these activities, helping professionals need to know about current state-of-the-art programs and practices.

For example, a new therapist at a Veteran’s Administration Hospital may want and need to incorporate the most promising approaches for the treatment of adults with Post Traumatic Stress Disorder (PTSD). A foster care administrator, responding to requirements of new federal legislation, may ask staff to research and develop a state-of-the-art program to reunify children with their biological families. At a university, a student may be asked to write a paper on the most effective interventions to combat homelessness. At a family service agency, an administrator may seek the help of a university professor in writing a grant to secure funding for a new initiative to prevent domestic violence. A state legislator, seeking to create legislation to fund the treatment of drug addiction as an alternative to incarceration, may call upon expert professionals to serve as consultants to identify treatment programs that are cost effective.

These are but a few examples. Common to all of the scenarios is a focus on “best practices.” That is, common to the above situations is the desire to ascertain or discover the current best practices in the given arena of concern. Although the term

best practices may mean different things to different people in different contexts, generally speaking, best practices are those behaviors, methods, interventions, attitudes, and knowledge which represent the state of the art in a particular area or field of practice. Not confined to the human services, the term *best practices* is used extensively in business and other fields as well. For example, the British Columbia Ministry of Economic Development has defined best practices as the programs, initiatives, or activities which are considered leading edge, or exceptional models for others to follow (retrieved from www.sbed.gov.bc.ca, April 17, 2007).

Interest in best practices spans the globe. In the United States, the National Governor's Association for Best Practices (www.nga.org) produces reports for governors and their staff in five categories: education; health; homeland security and technology; environment, energy, and natural resources; and social, economic, and workforce programs. In the latter category alone, 68 publications were produced between January 2004 and June 2007, on topics such as prisoner re-entry, transition from foster care, and senior involvement in volunteerism. At www.bestpractices.org, the United Nations Habitat organization co-sponsors an international database of best practices programs that improve life in cities and communities worldwide. Countries may submit model programs for a three-stage assessment and review process, potentially resulting in a \$30,000 cash prize. Over 2,000 practices from 137 countries are contained in the database, including topics such as housing, poverty reduction, and empowerment of women.

As mentioned above, a uniform definition of best practices remains elusive: there are many assorted ways to define and determine what best practices are including practice wisdom, use of expert advice, professional standards and guidelines, and evidence-based practice (Kessler, Gira, & Poertner, 2005). There is wider consensus about what is meant by *practices*, which are the direct service, program level, professional actions that are undertaken to ameliorate or prevent problems and symptoms among a target population of clients, or consumers. Practices are distinguished from policies, which are the broader guidelines that are embedded in legislation and organizations, that spawn and guide programs and practices at the direct service level.

More problematic is the term *best*. What makes a practice best? Who decides? What criteria are employed? Are the best practices those endorsed by expert professionals? By clients, the users of services? Are best practices those that have been proven by science to work? Are they the practices determined in a local setting to meet the needs of local clients? What levels of empirical support and general consensus is necessary to be a *best practice*?

In determining what practices are best, Multidimensional Evidence Based Practice (MEBP) is one method among many. Depending on one's point of view, best practices can also be conceptualized as *practice-based research*, *empirically based practice*, *evidence-based practice*, or *knowledge-based practice*. Yet, there are no firm and distinct boundaries around these categories, as will be discussed in the following sections.

Practice-Based Research

Practice-based research asserts that, in order to improve local performance and enhance accountability, it is important for practitioners and agencies to study their own practices and clients (Epstein & Blumenfield, 2001). This view of best practices posits that practitioners must continually monitor and reflect on their own practice approaches as part of a continuous quality improvement effort. In practice-based research, practitioners define the issues and practices that they want to improve upon, and may or may not seek help from researchers to help with study design and data analysis. One form of practice-based research is clinical data mining (Epstein & Bloomenfield, 2001). Typically, because of limited time and budgets, the practitioners retrospectively analyze data that are readily available and routinely collected in the agency, such as case records. This retrospective analysis of data and case records can help providers understand service trends and make better decisions regarding staff assignments and changes in service delivery.

For example, Nilsson (2001) reported on a practice-based study in a children's hospital aimed at identifying psychosocial factors common to frequently readmitted pediatric diabetes patients. These frequent readmissions were frustrating to medical personnel and required the expenditure of considerable resources. The study hoped to gain insight into how to serve the population better. A social worker analyzed the case records, including medical histories, social work records, and mental health files of those 18 patients most frequently readmitted. Content analysis of these records identified psychosocial issues that were common to the group. Recommendations from the study included focusing parent and family work on gender issues because results indicated a preponderance of teenage females in the sample, who were affected more by parenting problems of over-involvement than boys, who were more affected more by under-involvement. Other recommendations included early screening for psychiatric symptoms and the initiation of a new family therapy program to respond to the predominance of family-related psychosocial factors.

A recent iteration of practice-based research has been advanced by Scott Miller and colleagues (www.talkingcure.com). This group of mental health clinicians and researchers have developed two simple measurement scales that service providers can use to assess, from the client perspective, both client outcomes (Miller, Duncan, Brown, Sparks, & Claud, 2003) and the therapeutic alliance between the worker and the client (Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003). Irrespective of theoretical orientation or technique, these tools provide immediate practice-level data to keep the work focused on achieving individual client-directed goals while monitoring the quality of the helping relationship.

Empirically Based Practice

In contrast to practice-based research in which the practitioner focuses on local, internally generated data to improve service, another view of best practices holds

that the role and responsibility of the practitioner is to behave in accordance with *externally* generated and validated interventions and methods. In this way of thinking, the practitioner imports best practices that have been endorsed by experts and/or validated by rigorous research. This broad, external locus of best practices encompasses the remaining categories of best practices for discussion in this chapter, including MEBP. It is important to note that practice-based research, with its internal locus of emphasis, is not antithetical to these external views; that is, best practices can be generated both from within and from without a particular practice setting. Practice-based research is a means to verify the applicability of externally generated practices to individual situations.

To many, best practices are those that have been proven to work. That is, best practices are those treatments or interventions that have been shown to be effective through rigorous scientific research. This approach to best practices is termed *empirically based practice*. Calls for empirically based practice have been issued from policymakers and other authorities, who stress the need for performance-based accountability in social programs. Years ago, Lisbeth Schorr, in the highly influential book *Within Our Reach: Breaking the Cycle of Disadvantage* (1988), stated that “reliable evidence about interventions that work has become more important than ever” (p. 268).

Since then, a plethora of professional organizations and government agencies have endorsed and promoted an empirically based approach to best practices. The American Psychological Association (APA), Division of Clinical Psychology commissioned reviews of the literature to ascertain the scientific evidence for the efficacy of various treatments, resulting in *A Guide to Treatments that Work* (Nathan & Gorman, 1998). The President’s New Freedom Commission on Mental Health (2003) identified the need for more research-based interventions, and recommended strategies to bridge the gap between science and service.

Government-sponsored initiatives and private institutions support a variety of online clearinghouses and collaborations that conduct and disseminate systematic reviews of empirical studies for various fields of practice. These include the Campbell Collaboration (www.campbellcollaboration.org) focusing on education and social welfare; Cochrane Collaboration (www.cochrane.org) for health care issues, the “What Works Clearinghouse” (www.whatworks.ed.gov) established in 2002 by the U.S. Department of Education, and National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov) sponsored by the U.S. government’s Substance Abuse and Mental Health Services Administration (SAMHSA). Other international centers of this type include the Nordic Campbell Center in Denmark, the Institute for Evidence-Based Social Work Practice in Sweden, the Australian Centre for Evidence-Based Clinical Practice (Morego, 2006), and the Belgian Center for Evidence-Based Medicine (Hannes & Laurence, 2007).

Empirically based practice in social work is exemplified by *The Handbook of Empirical Social Work Practice Volume 1: Mental Disorders* (Thyer & Wodarski, 1998), and *Volume 2: Social Problems and Practice Issues* (Wodarski & Thyer, 1998). In these volumes, the editors have organized materials by chapters which

summarize research articles on various diagnoses and topics, and provide guidelines for effective practice based on that research. For example, for Post Traumatic Stress Disorder (PTSD), the conclusions are that “effective treatments of PTSD maintain a focus on the trauma and related memories, thoughts, and feelings; avoid blaming or stigmatizing the victim; provide information about responses to trauma; attempt to strengthen client’s internal resources, such as work, family, and social support; and instill hope about the chances for improvement” (Vonk & Yegeddis, 1998, p. 371). For effective psychosocial treatments of Attention Deficit Hyperactivity Disorder (ADHD), conclusions indicated that short-term behavioral interventions were effective with children who are unmotivated and lack insight, while long-term cognitive treatments were recommended for insightful adults and adolescents (Markward, 1998).

The empirical approach to best practices inquiry is driven not only by concerns about performance and accountability, but also by ethical considerations. The statement of *Ethical Principles of Psychologists and Code of Conduct* of the American Psychological Association (2002) states that “Psychologists’ work is based upon established scientific and professional knowledge of the discipline” (2.04). The *Code of Ethics* of the National Association of Social Workers (1996) states that “Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice” (5.02 (c)). This guideline also pertains to the ethical mandate of informed consent, because professionals need to know the evidentiary basis for alternative practices and policies in order to fully honor the informed consent principle (Gambrill, 2003).

Clearly, there is a strong rationale to support the idea of empirically based practice. Basing practice decisions on empirical evidence is an attempt to assure quality of services and accountability. It also honors the ethical mandate of informed consent and protects professionals from liability for using untested procedures. Ideally, basing decisions on established evidence is more effective and efficient in achieving outcomes, because time, energy, and dollars are not wasted on ineffective attempts to remedy the problems. Finally, empirically based practice may be more objective and scientific, forcing professionals to tether their own more subjective and emotional responses.

However, criticisms of empirically based practice are also widespread, calling attention to important issues (Beutler, 2000; Denzin & Lincoln, 2005; Ferguson, 2003; Friedman, 2003; Gould, 2006; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Hurlburt & Knapp, 2003; Krill, 1990; Schön, 1983, 1987; Webb, 2001; Witkin, 1998, 2001). Objections to the traditional empirically based practice approach center on difficulties and costs in applying research results to real-world routine practice situations, the subversion of clinical judgment and individualized care, disagreements about what constitutes evidence, and the exclusive use of quantitative approaches.

The scientific process of developing rigorous, valid empirical support for a particular model of intervention is a laborious, complex, costly, and time-consuming process in the real world. Then, after the development and validation phases,

dissemination and adoption of the empirically based models are hindered by cost and resistance from providers (Beutler, 2000; Schoenwald & Hoagwood, 2001). The typical stages of the validation process are to first establish *efficacy* through strict research protocols and randomized trials, next establish the *effectiveness* of the model in real-world situations, then *disseminate* and *transport* the model to a wide, often skeptical professional audience. Concerned about the principle of individualized care, many professionals note that even the best randomized controlled studies only establish differences between groups of clients, and that many individual clients are not helped by the so-called proven methodology.

A principal criticism of empirically based practice centers on the issue of what constitutes evidence. Within the empirical camp itself, evidence generally means quantitative data, but even here, there is disagreement about what level of research quality is required to certify that an intervention is in fact empirically based. Researchers can agree that best practice is what has been proven to work, but what level of scientific “proof” is required to certify that a certain set of practices actually works? For example, the Promising Practices Network (www.promisingpractices.net), an influential consortium of private and government organizations including the RAND Corporation and the New York State Office of Children and Families, lists a variety of programs that have been categorized as “proven” or “promising.” To be listed as “proven,” the program needs to document only one experimental or quasi-experimental study with a sample of at least 30 in both the treatment and the comparison groups, demonstrating that at least one outcome is changed by 20%. These criteria are much less rigorous than those of the U.S. Office of Management and Budget (OMB) (www.whitehouse.gov/omb/part/2004_program_eval.pdf), which emphasizes that strong evidence of program impact requires more than one randomized controlled trial, preferably conducted by an independent party, in typical real-world settings.

Even when experts agree on the standards, deciding whether or not those research standards have been met can spur heated, even acrimonious, debate about the quality of evidence produced by empirical studies. This situation was extant in the recent published controversy over the effectiveness of Multisystemic Therapy (MST). For years, MST has been widely recognized as an empirically based practice for youth with severe behavior problems, with apparently strong evidence of effectiveness derived from several randomized, controlled studies. Yet, a thorough systematic review of the scientific evidence originally conducted for the Cochrane Collaboration (Littell, Pops, & Forsythe, 2005), and later summarized in *Children and Youth Services Review*, (Littell, 2005) concluded that the evidence indicated that MST was not consistently more effective than other alternatives for youth with social, emotional, or behavioral problems.

Scott Henggeler, the principal founder of MST, and his colleagues responded with an emotionally charged defense of MST and intense criticism of Littell’s methods, conclusions, and motives (Henggeler, Schoenwald, Bourdin, & Swenson, 2006). Their defense encompassed not only methodological issues, but also attacked Littell’s motivations, suggesting that she was defending the status quo because of some unspecified self-interest. In the same issue, Littell responded

to those comments (Littell, 2006). Littell reiterated and defended her critique, including among other things, the flawed method of random assignment in MST studies, the questionable validity of fidelity measures, the inconsistent reporting of sample sizes, and the paucity of independent trials of the MST model. She particularly noted the potential conflict of interest inherent when the developers of models evaluate, promote, and financially benefit from the success of their models. Even though government and professional organizations endorse a model's empirical foundation, Littell cautioned that these endorsements can be influenced by political necessity. Promoting programs with some evidence of effectiveness, she asserted, is different from waiting to disseminate and transport programs until they have been subjected to rigorous independent evaluations of their effectiveness.

Perhaps the overarching lesson in this controversy is that there are always limitations and methodological flaws in the conduct of scientific research investigating the effectiveness of complex intervention strategies in the complex world of health and social systems. That is, to some extent, empirical findings of the effectiveness of human services programs are always suspect. Thus, it behooves us not to rely exclusively on empirical data to uncover best practices, but to incorporate other, also admittedly less than perfect, sources of evidence or knowledge, such as professional experience and consumer wisdom (Ferguson, 2003).

What is "best" should not be defined simply as "what works" in a narrow, quantitative way, but should be established via a range of sources and opinions, including qualitative research, which can be particularly useful in systematically documenting consumer and professional experiences. Because it disparages the basic assumptions of empirically based practice, a particularly damaging criticism is that leveled by qualitative researchers (Denzin & Lincoln, 2005). According to these authors, knowledge to guide practice should not be limited to that knowledge derived from a positivist, conservative paradigm that values quantitative methods of inquiry. In contrast to quantitative research which seeks, through the scientific method, to quantify data and analyze causal relationships between variables, qualitative research seeks to find individual meaning, focusing on the processes of social experience. Thus, knowledge is defined more broadly by qualitative researchers, to include voices of those otherwise not heard in the traditional, quantitative approach. Despite its long history and recent resurgence in many academic disciplines, qualitative research is marginalized in the world of empirically based practice. The resulting narrow view of science and evidence is seen to serve the interests of a conservative political agenda by maintaining the status and power of a Eurocentric, patriarchal world view (Lincoln, 2005).

Evidence-Based Practice

In recent years in the United States and much of Europe, the discourse about best practices has been dominated by evidence-based practice (EBP). EBP is an outgrowth of evidence-based medicine, which is defined as the use of current best

evidence in making decisions about individuals (Sackett, Strauss, & Richardson, 1997).

In considering the intellectual context of best practices, one of the most confusing semantic issues is the close affiliation of the terms *empirically based practice* and *evidence-based practice*. Although these two terms are sometimes used interchangeably, recent proponents (Cournoyer, 2004; Gambrill, 2003) of evidence-based practice (EBP) assert a clear distinction. These authorities frame evidence-based practice as an outgrowth and improvement on empirically based practice. For our purposes it will remain fruitful to distinguish between empirically based practice and EBP, but the reader is forewarned that this distinction is not always made in other texts and sources.

Departing from a strict and narrow focus on empirical studies, evidence-based practice is a broader term than empirically based practice in that it considers three important factors: external research findings in the context of the appropriateness of their application to an individual situation; ethical issues such as informed consent; and client values and expectations (Gambrill, 2003). Franklin (2001) states “the basic principle for evidence-based practice is to choose interventions based on the best empirical evidence that are also appropriate for the client and situation” (p. 131). The experts in deciding whether and how to apply an empirically based practice guideline to a given client situation are the clients and providers themselves. Thus, evidence-based practice is viewed by its proponents as extending and enriching empirically based practice toward integrating practice and research. The broader definition acknowledges that empirical data should not dictate action, but should be considered in context.

Gilgun (2005), after reviewing evidence-based medicine, evidence-based nursing, and evidence-based social work, concluded that there are four “cornerstones” of EBP in social work. These are 1) what we know from research and theory; 2) professional wisdom and professional values; 3) what we have learned from personal experience; and 4) what clients bring to practice situations. Social workers should not blindly apply or impose research findings to every individual client, but instead use their own experience as well as the client’s preferences to honor client self-determination.

Still, despite the acknowledgment of factors other than research findings, it is the empirical evidence that is central to evidence-based practice, as its name denotes (MacDonald, 2000; McNeill, 2006). Perhaps because of this, the broad definition of evidence-based practice cited above is not universally endorsed. Gilgun’s review (2005) of evidence-based social work in the United Kingdom, for example, noted the lack of recognition of clinical expertise and client’s perspectives at the point of application of evidence. *Evidence-based Practice Manual: Research and Outcome Measures in Health and Human Services* (Roberts & Yeager, 2004a) is a 1,050 page, 104 chapter book with wide interdisciplinary scope published by Oxford University Press. It is perhaps the most comprehensive and thorough examination of evidence-based practice to date. In the introductory chapter (Roberts & Yeager, 2004b), the editors define evidence-based practice as “the conscientious, explicit, and judicious use of the best available scientific