

Evidence-Based Practice in an Age of Relativism: Toward a Model for Practice

Ted McNeill

Evidence-based practice (EBP) is considered a hallmark of excellence in clinical practice. However, many social workers are uncertain about how to implement this approach to practice. EBP involves integrating clinical expertise and values with the best available evidence from systematic research while simultaneously considering the client's values and expectations—all within the parameters of the agency mandate and any legislative or environmental considerations. This article explores the feasibility of EBP and attempts to steer a course between those who advocate an EBP model that may appear unachievable to many clinicians and those who dismiss it outright on philosophical grounds. Five areas that affect the feasibility of EBP are explored: misconceptions about EBP, confusion about philosophical issues, questions about the quality of evidence needed to support EBP, substantive knowledge domains required for practice, and issues related to knowledge transfer and translation. An important theme of this analysis is the central role of clinical judgment in all aspects of EBP.

KEY WORDS: *epistemology; evidence-based practice; knowledge translation*

Evidence-based practice (EBP) is considered a hallmark of excellence in clinical practice. However, many social workers are uncertain about how to implement this approach to practice. The challenges can seem overwhelming, and it is not surprising that the idea continues to be controversial in social work. This article explores the feasibility of EBP for social workers by examining key requirements and challenges associated with this approach to practice.

BACKGROUND AND HISTORY OF EBP

EBP developed in the field of medicine where efforts have been underway for many years to implement this approach to care. *Evidence-based practice* has been defined as consisting of an individualized assessment; a search for the best available external evidence related to the client's concerns, including a decision about the extent to which it may apply to a particular individual; and consideration of the values and preferences of individual patients (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996).

In social work, there have been repeated calls to adopt EBP, and the lack of a scientific foundation

for practice has been lamented for a long time (Kirk & Kolevzon, 1978). A shift from a model of "using research evidence" to one that is "grounded in" and reflects a "commitment to" EPB appears to be accelerating (Webb, 2001, p. 59). Compelling ethical arguments that clients have a right to receive services that have been shown to be effective are supported by agency imperatives to make the best use of resources by delivering services that have been shown to be effective.

However, despite this encouragement, social workers have not embraced this approach. It has been shown that social workers do not rely on research-based knowledge as a basis for making clinical decisions (Rosen, Proctor, Morrow-Howell, & Staudt, 1995) despite ample evidence about the effectiveness of social work interventions. Rather, as a profession, we appear to draw on other considerations for clinical decision making, including the use of theory, imperative claims (that is, an obligation to intervene in a particular way, such as in child abuse cases), policy considerations, and client requests for a specific form of assistance. Conceptual rationales (that is, theory) accounted for 75 percent of clinical decision making in this study.

Rationales involving empirical evidence accounted for approximately one percent.

It has also been suggested that *in vivo* analysis of therapeutic opportunities is a key determinant of decision making in clinical situations and not evidence (Webb, 2001). Decision making in practice situations is held to be indeterminate, reflexive, and based on a limited rationality, rather than a data-driven information process. Furthermore, it has been argued that social workers do not use the professional literature in part because of a crisis of relevance (Epstein, 1995). Knowledge produced by researchers—usually university based—is often perceived to be irrelevant for practice. The call for practitioner-driven partnerships with researchers (Hess & Mullen, 1995) to develop knowledge that is relevant to practice, although continuing to hold great promise, does not appear to have been embraced by the field. Earlier strategies of encouraging clinicians to use single-case research designs to create more clinically relevant knowledge are reportedly not working (Howard & Jenson, 1999). Without integrating knowledge and implementing an evidence-based approach to practice to the extent that is feasible, social work is at risk of losing its place of relevance as a helping profession.

MISCONCEPTION ABOUT EBP

Although EBP is referenced frequently as an imperative for clinical practice, its application is not well understood. The image of social workers as “information processors” connotes a mechanistic approach to practice that is untenable for most practitioners. Such an image is highly reductive and reflects an erroneous understanding of EBP. Although clinicians likely realize that such a one-dimensional approach to practice could not work, in the absence of well-defined models, their discomfort with an imagined model may take precedence.

Clinicians who fear that an EBP approach involves a top-down cookbook approach to practice are often surprised to understand that informed advocates of EBP reject such a simplistic approach (Sackett, 1999). However, mechanisms for how EBP might work in social work remain underdeveloped. Gambrill (2001), who has written extensively about EBP, draws on the medical model in outlining a description. It includes the following steps:

- (a) converting information needs into answerable questions (often a difficult step), (b) track-

ing down with maximum efficiency the best evidence with which to answer these questions, (c) critically appraising that evidence for its validity and usefulness, (d) deciding whether research findings (if any) apply to a particular client, (e) involving clients as informed participants and considering their values and expectations, (f) taking action based on the best evidence, and (g) evaluating the outcome (p. 167).

Although this list encompasses the essential steps, I suspect many clinicians would find it a daunting task—particularly if they do not have all of the requisite skills such as those needed to gain access to the literature and analyze the quality of existing knowledge. In the fast-paced world of many clinical settings, social workers need feasible strategies that allow them to balance the many competing demands on their time and resources.

POSTMODERNISM AND THE ISSUE OF RELATIVISM

Another factor that complicates the application of an EBP approach in social work relates to the important distinction among the human sciences, the context in which social workers practice, and the medical and natural sciences where EBP has primarily developed. Within the medical sciences, EBP reflects primarily a positivist epistemology, which assumes that clinical practice can be understood objectively through the combined use of rigorous research methods and strenuous efforts to control bias. However, applying this model to human behavior is more complicated because of the way individuals actively make sense of their world, resulting in a much higher level of unpredictability. The interpretivist-constructivist paradigm recognizes that individuals perceive their world in their own unique way and that meaning is “radically plural” and context-dependent. This is the world of relativism. It reflects the postmodern assumption that there is no such thing as objective knowledge about an objective world; rather, all knowledge is situated historically, culturally, and politically and is shaped by the values and experiences of those who create it.

This world of situation-specific meanings is the bedrock for understanding human experience (Wakefield, 1995). This is fundamental to clinical practice. It is delineated by socioeconomic status, cultural background, religious and spiritual beliefs,

sexual preference, gender, age, and ability or disability and includes influences from the broader social and institutional context in which client problems are embedded and services are delivered. This list becomes almost endless as other factors such as physical characteristics, size, attractiveness, intelligence, and social skills exert their influence. Understanding the “reality” of the client is a complex undertaking that involves interpreting the nuances of meaning, behavior, and context. The interpretive paradigm assumes that individuals create and maintain meaningful worlds through dialectical processes by which they interpret their world and act within it (Charmaz, 2000). This world is perceived to be socially constructed as “particular actors, in particular places, at particular times, fashion meaning out of events and phenomena through prolonged, complex processes of social interaction involving history, language, and action” (Schwandt, 1998, p. 222). At the furthest extreme of postmodernism, relativism takes on an anarchical dimension, suggesting that each view of reality is as good as the next, thus leaving the development of knowledge in a conflicted domain where claims of authority are forever suspect.

Any consideration of EBP must reconcile epistemological (that is, how we know what we know) and ontological (that is, the nature of human reality) issues. The fundamental differences between a positivist orientation and the interpretive-constructivist perspective have stood as obstacles to integration for many years. However, many positivists now accept the epistemological criticisms articulated by postmodernists and acknowledge the limitations of objectivity within the human sciences (Gambrell, 1995). Many have adopted a post-positivist position, a reformulated stance that reflects a more relativist version of positivism. Simultaneously, the relevance of the extreme versions of postmodernism in which one expression of reality is considered as valid as the next and where there is no absolute right or wrong is rejected by many social workers. To assume otherwise would be to deny the existence of poverty, child abuse, discrimination, and historical events such as war and the Holocaust. These are more than mere interpretations of events where one view of external reality is as legitimate as another. They reflect a consensus of agreement, often bolstered by physical evidence, that the world is knowable in a particular way. This evolution has resulted in a move

for many clinicians and researchers to a middle ground between positivism and the extremes of postmodernism.

In line with these developments, ontological issues associated with interpreting another person’s reality have been addressed over time as philosophers have attempted to wrestle with this dilemma. Brown (1977) argued that “we shape our percepts out of an already structured but still malleable material. This perceptual material, whatever it may be, will serve to limit the class of possible constructs without dictating a unique percept” (p. 93). Anastas (1995) and Anastas and MacDonald (1994) proposed a “fallibilistic realism,” which takes into account the context of the clinician–researcher and acknowledges multiple internal realities and a “knowable” external world. This is similar to what Wakefield (1995) proposed as a “humble realism.” Although these approaches assume the relativism of multiple realities as each person interprets the social world in her or his own unique way, the social world is still “knowable” even if in incomplete ways. Although knowledge is understood as the product of social interactions because of the interpretive processes associated with understanding the experience of another human being, it nevertheless corresponds to something in the real world (Schwandt, 1998).

From this perspective, although there is not a single, monolithic social reality, there is an external world about which there can be general agreement. Ultimately, this world may be interpreted uniquely by each individual, but it is knowable in the sense that there may be more or less evidence about it and agreement on a collective level. Although truth becomes relative in the sense that there may be more or less agreement about it (Bohan, 1993), it does not reflect the unbridled relativism of the most extreme postmodernist tradition (Denzin & Lincoln, 1994).

Thus, the metaphysical world—that inner world that consists of ideas, interpretations, and subjective meanings that individuals ascribe to the social and psychological world in which they live—is what social workers strive to understand through empathy. On a social level, our collective understanding of this world coalesces around shared interpretations and meanings. This affirms both the existence of “multiple realities” on an individual basis and the possibility of “shared realities” on a collective level where agreement about some of the contours of

the social world may exist. It is in this way that we sort ourselves into various social, cultural, and political groups and define ourselves in ways that are both shared yet ultimately unique.

Complicating this is the fact that many social workers bring a critical perspective to their work and perceive a central role for values when interpreting the social world. Inherent in a critical approach is an assumption that the social world is knowable in a particular way. Although a critical approach has a greater relativist orientation than the positivist tradition (Peile & McCouat, 1997), it holds to an idea that some interpretations of the external world are more compelling than others. Within this tradition, clinical practice is informed not only by values of clients but also by those of antioppression, antiracism, feminism, and other approaches that combine a critical sociology with an orientation to individual subjectivity. This approach emphasizes the local and specific yet aspires to collective political action to promote social justice (Walker, 2001). Meyer (1992) characterized this approach as a humanist version of the environmentalist credo, "Think globally and act locally."

It is in this dynamic context that social workers respond to their clients' needs. Social workers function as "brokers of reality"—this means having the capacity to view the world with different lenses and deciding to accept some versions of reality at the expense of other versions. Social workers operate on the assumption that individual and social problems are knowable. The importance of reflexivity and clinical judgment in defining these realities are central to this process. However, a question central to EBP arises: What is the place of formal knowledge in these complex processes? Furthermore, what constitutes evidence and who determines the quality of that evidence?

QUALITY OF EVIDENCE

A distinction is made in the EBP literature between knowledge claims that are based solely on individual experience or even consensus among clinicians and those that have been subjected to critical tests of their accuracy through research (Gambrell, 1999; Steketee, 1999). Without a foundation in research, knowledge may be based solely on "the opinions of others, pronouncements of 'authorities,' unchecked intuition, anecdotal experience, and popularity" or what Gambrell (1999) referred to as the "authority of the crowd" (p. 348). Consequently,

the use of evidence that is based on research is fundamental to an EBP approach. A key advantage of using scientific methods, as opposed to other ways of knowing, is their skeptical approach to knowledge claims and their ability to show that some findings are false (Barber, 1996). Although a broad range of factors may be theoretically influential in each individual circumstance, only research can identify the factors that apply in the majority of cases. This is clearly beneficial for clinicians who can use such knowledge to guide investigation of "keystone" issues that may be most influential.

Reading between the lines in some of the literature on EBP, there are echoes of the rancorous debate between qualitative and quantitative advocates about the most suitable epistemologies and methods for generating knowledge for social work. However, EBP is not about the truth and nothing but the truth; rather, it is about the best and nothing but the best evidence (Borst-Eilers, 2001). Evidence is much more of a relative concept than proof; it can range from clinical observations to the results of both large-scale epidemiological studies and randomized control trials. The traditional hierarchy of knowledge values randomized control studies, and especially systematic reviews of several randomized studies, because they are considered to be the most powerful for producing credible knowledge (Sackett et al., 1996). But the suggestion that only generalizable knowledge based on quantitative research designs is suitable is both shortsighted and misinformed about the relative strengths and limitations of quantitative and qualitative methods. Without a capacity to examine situations from multiple epistemological perspectives, we would be likely to ask the same types of questions over and over again, systematically biasing the type of knowledge generated. Even knowledge based on qualitative research, social work's equivalent of a microscope, which is more adept at sensitizing clinicians to the rich and nuanced ways that individuals interpret their world, can never completely mirror the individual circumstances and meanings that each person brings to his or her situation. Nevertheless, richness of knowledge is better served by a variety of approaches depending on the specific research question at hand rather than dogmatic reliance on one preferred perspective. In a human sciences discipline like social work, both qualitative and quantitative methods are needed. Wakefield (1995) articulated the relative strengths

and limitations when he said, "We seem forced to trade richness of knowledge for certainty of knowledge. The tension between wanting to *know* the truth (with confidence) and wanting to know the *truth* (in as full-blooded a version as possible) goes back a very, very long way" (p. 11). If the goal is generalizability, quantitative methods are accepted to be superior, but if the goal is a rich understanding of a particular phenomenon, then qualitative methods are indispensable.

In a clinical context, it must be remembered that the findings of any type of research, whether qualitative or quantitative, can only be considered as hypotheses when applied to individual circumstances (Cronbach, 1975). Although both forms of evidence are beneficial, neither is sufficient to dictate the response that a social worker should make. Clinical expertise is indispensable for deciding whether external evidence applies to an individual client and, if so, how it should be integrated into treatment.

However, if the use of knowledge is for program planning purposes rather than individual clinical work, then a combination of generalizable and in-depth knowledge likely provides the most comprehensive understanding of the relative merits of various approaches to service (for example, psychoeducation, individual counseling, family treatment, environmental change) and the mechanisms or process by which they work (Padgett, 1998). Multimethod studies incorporating both quantitative and qualitative methods provide the opportunity to draw on the strengths of each approach while balancing their respective limitations.

As discussed earlier, clinical practice is not only about the application of evidence. Critical approaches involve the application of values about the nature of the external world and the implications for the experience of those who live in it. Although critical approaches may rely initially on the discourse of experts for authority, there is every reason that such claims should be tested through research. There is an important place for critical discourses to introduce new perspectives and ideas, and as a way of incorporating an ethical dimension to practice; however, without subjecting these ideas to the kind of scrutiny that scientific methods afford, we are once again left with practice based on opinion. Without rigorous testing, critical approaches to practice are more likely to resemble the world of politics, which is often more about

power than truth. Therefore, we need to ask whether a particular discourse is useful as a frame of reference for understanding certain social or psychological problems.

DOMAINS OF KNOWLEDGE NEEDED TO SUPPORT EBP

A related question pertains to the types of evidence needed to support EBP. Rosen and colleagues (1999) identified three categories of knowledge that are needed: (1) descriptive knowledge to conduct assessments, (2) explanatory knowledge that examines the linkages between client problems and broader social and environmental factors that may contribute to them, and (3) control knowledge that refers to the relative success of various clinical interventions used in practice (Rosen, Proctor, & Staudt, 1999). In an analysis of the current state of supporting knowledge for EBP, Rosen and his colleagues found that 36 percent of all studies contributed descriptive knowledge, 49 percent provided knowledge to assist with the explanation of events, but only 15 percent addressed control functions, that is, interventions. These authors lamented that fewer than one in six research studies was devoted to the central issue they argued was facing the profession, namely, the development of effective interventions for practice. When compared with all articles published (research and nonresearch), only one in 14 articles (7 percent) on average reported research on interventions.

EBP rests on a foundation of clinical skills (for example, assessment, crisis intervention, individual-family-group therapy, psychoeducation, social skills training, case management) and relevant knowledge about the particular population served, including the nature of the clinical issues that need to be addressed. Furthermore, social work treatment is not a discrete, static event but a process that unfolds over time. The reciprocal interplay between the social worker and client transforms the encounter into an iterative process that has been described as "disciplined improvisation" (Pinsof & Wynne, 2000). This idea expands on the importance of reflexivity advocated by Schön (1995) that is essential for integrating numerous considerations (for example, theory, evidence, and experience) in clinical practice. These characterizations of practice are consistent with the notion of treatment as both art and science (Larner, 2004) and highlight the complexity of the process.

An example of this complexity is related to the selection of appropriate targets for intervention. Social workers typically seek to understand client problems in context, which may result in clinicians identifying potential intervention targets at the individual, family, community, and policy levels. The way a problem is formulated has important implications for what outcomes are targeted and what approach may be most effective. The interface among a client's values and needs, the practitioner's values and clinical orientation, and the agency mandate has a direct impact on what is considered a suitable target for intervention and, by extension, what knowledge is needed to inform practice. For example, a single father from a visible ethnic minority culture who is a member of the "working poor" (despite having qualifications from his country of origin) and who is trying to care for a child with a chronic health condition faces many challenges. Assessment might reveal that he is socially isolated and demoralized about what he feels is a profound injustice that he is underemployed and living in relative poverty. It might simultaneously be assessed that he may not be ensuring adequate health follow-up for his child and could likely benefit from parenting classes. On an individual basis, although he may not be asking for this, it might also be felt that he could benefit from counseling related to his demoralized state and possible help to become less socially isolated. This is not an unusually complex situation—social workers are routinely called on to address multiple issues rather than a single problem with someone who may not want all that could be offered at least at the outset of the helping relationship. Hopefully, all of these issues would be addressed either directly or through referral, but the knowledge needed for assessing and managing the relationship over time is substantial. Depending on the agency context (for example, pediatric hospital, welfare office, child protection setting, or counseling agency), there may be more or less of a direct intervention role with each of these issues, but knowledge is nevertheless required to assess each issue.

If this social worker investigated the literature on the effectiveness of counseling interventions, she or he might find a somewhat confusing picture. In the psychotherapy field where more than 200 models compete for dominance, the number of clinical approaches presents an overwhelming range of choices for clinicians. However, on balance, some

have concluded that there is virtually no difference in effectiveness among various types of therapies (Hubble, Duncan, & Miller, 1999). Consequently, attention has turned to examining the common elements across diverse forms of psychotherapy. Hubble and colleagues identified four common factors that account for positive changes in clients: (1) extratherapeutic factors that account for approximately 40 percent of outcome variance (that is, everything that happens outside the therapeutic relationship); (2) relationship factors that account for approximately 30 percent of outcome variance (that is, caring, warmth, acceptance, affirmation, and encouragement); (3) placebo, hope, and expectancy that contribute approximately 15 percent to the overall outcome (that is, belief between client and clinician in the restorative power of the treatment); and finally (4) model/technique factors that account for the remaining 15 percent (that is, the specific techniques and practices associated with each individual treatment approach).

The social worker might interpret these findings as indicating that there is little need to match the therapeutic approach to the client problem(s); however, this may be premature. Identification of common factors is important, but unlike the psychotherapy findings, several comparisons of social work interventions have showed differential effects (Reid, Davis Kenaley, & Colvin, 2004). These findings are significant because if some interventions are more effective, then evidence-based practitioners need to know which ones may be more effective. Based on these findings, the authors argued for continued efforts to find the preferred intervention and treatment of choice.

Complicating this further, if the family's situation in the example cited was understood as secondary to the corrosive impact of poverty, discrimination, and the general lack of funding for the broad social determinants of health, then the intervention might include advocacy and efforts to make environmental changes. A recent meta-analytic review of the effectiveness of prevalent social work practice models points to the relative success of personal versus generalist, systemic, and radical approaches. Specifically, depending on the target of change—that is, whether the focus was on individual client adaptation or environmental change—the models had differential success. Personal models were more effective in facilitating individual change and generalist, systemic, and

radical approaches were most effective in promoting environmental change (Gorey, Thyer, & Pawluck, 1998). These findings underline the importance of the assessment process and the range of targets for change that may be identified. In turn, the formulation has significant implications for the differential use of self needed to address the situation. Clinical sensitivity and judgment are needed to navigate the relationship when clinical, protection, and advocacy dimensions exist simultaneously. This example points to a range of issues and level of complexity involved in EBP. A significant knowledge base is available to inform practice, and it is essential that we wrestle with ways to support clinicians' access to available knowledge and their ability to use it.

KNOWLEDGE TRANSFER AND TRANSLATION ISSUES

A significant obstacle to implementing any model of EBP involves access to the existing literature. Many clinicians work in settings where they do not have ready access to books and journals. Those who work in close proximity to a university or academic health science center have the best opportunity to read the literature on a consistent basis. Given the vast literature that is available, it is virtually impossible for most clinicians to stay completely informed. Even social workers who specialize in a particular area of practice face a daunting challenge of integrating vast amounts of sometimes conflicting evidence while maintaining a busy practice. This obstacle should not be underestimated. Even those who have the expertise to evaluate evidence find the task time consuming and challenging (Lohr, 2000). Administrators may feel pressure to demand accountability in the form of EBP but are often unable or unwilling to provide the time and resources needed to support this approach to practice. In general, the more that domain-specific knowledge is available to inform practice, the greater the obligation of clinicians to know about and use that knowledge (Gambrill, 1999). A key question for clinicians, researchers, and administrators is how to create a practice environment in which there is support for gaining access to and integrating evidence as part of the dynamic processes during clinical decision making.

Whether it is feasible for busy social workers to consult the literature for every case remains to be seen. The ability to search the literature for each

case would be ideal because it would provide the best match between available evidence and the unique circumstances of each client. However, even selective examination of the literature when a clinician most needs it poses a challenge, because as Mullen and Bacon (2003) suggested, it is beyond the capacity of most social workers as they are currently educated. Therefore, other options are needed to facilitate access to the research literature. To the extent that meta-analyses and systematic reviews of the relevant literature are available, it would reduce some of the challenges associated with compiling and evaluating the evidence, particularly when considerable research is available. Development of practice guidelines also has great potential given their reliance on knowledge generated through research and the use of expert consensus panels representing various perspectives (for example, ethicists, researchers, clinicians, other disciplines, and clients) (Videka, 2003). Many clinicians work on teams, and there has also been a call for interdisciplinary guidelines to facilitate integration across disciplines and reduce narrow duplication (Thyer, 2003). Efforts by teams and agencies, including community-university collaboration as advocated by Hess and Mullen (1995) to partner in the development of resources practice, would be beneficial.

A promising strategy for knowledge dissemination involves the use of technology such as computer Web sites and other electronic databases to make relevant information available in a usable format. An example is the Campbell Collaboration (<http://www.campbellcollaboration.org>), which seeks to inform clinicians about effective interventions in the social, behavioral, and educational fields. Through this nonprofit organization, short summaries and reviews of relevant literature are prepared and maintained in an accessible online format for clinicians and others such as policy advocates and educators.

However, as knowledge continues to accumulate and pressure to practice EBP grows, greater efforts are needed to support clinicians in other ways too. The assumption that clinicians access, appraise, and adopt new knowledge as it becomes available is naïve and has largely been discredited. This is not surprising given the traditional emphasis on knowledge creation rather than dissemination. Even when important research-based recommendations are made, knowledge about their availability is rarely, by itself, sufficient to change

practice. For example, a sobering finding from the field of medicine suggests that dissemination of consensus recommendations alone does not lead to action (Lomas, 1991).

Why does relevant information not get to clinicians? Issues related to dissemination and implementation of new knowledge are complex and part of a spectrum of activities that involve raising awareness of research findings and getting them adopted into practice (Rogers, 1995; Sackett, 1999). It has been suggested that the reasons may pertain to the knowledge user (that is, inexperience, lack of motivation, or lack of time), the content of the information (that is, too lengthy, contradictory), and the mode of dissemination (that is, not always accessible) (Barwick, Boydel, & Omrin, 2002).

These challenges suggest that a more systemic and multifactorial model is needed to advance EBP. From the field of knowledge translation and transfer comes a critical recommendation for "knowledge brokers" to help facilitate the exchange, synthesis, and application of information. Such individuals would need to be skilled and respected by their colleagues and have the social capital and communication skills necessary to facilitate the effective use of available knowledge. They would need to have the expertise to synthesize the often-large volume of information and assist in making it accessible to practitioners. Acting as filters and translators, they would serve to help transfer knowledge to practice (Ho, 2003). Knowledge brokers could also provide face-to-face exchanges that are often preferred by clinicians because they allow for discussion about the nuances of application to practice (Barwick et al., 2002).

Recognition that clinicians are potential consumers of information who need to be actively engaged to achieve success is an important consideration for advancing EBP.

It is clear that continued efforts are needed to evaluate the effectiveness of current approaches to facilitating knowledge exchange.

CONCLUSION

In social work the vision for EBP involves integrating clinical expertise and values with the best available evidence from systematic research while simultaneously considering the client's values and expectations—all within the parameters of the agency mandate, legislative requirements, and environmental considerations. To the extent that clini-

cal decisions are made on the basis of a reflexive deliberating process that integrates a range of considerations, including theoretical, situational, ethical, and client variables as well as knowledge based on research (Webb, 2001), social work practice will remain a distinctly human activity, which is likely reassuring to practitioners and clients alike. EBP does not preclude attention to each of the domains cited, and indeed, each is a suitable target for research to enhance understanding. Together, these considerations point to a number of challenges inherent in implementing an EBP approach in social work, and the importance of practitioner creativity, experience, and clinical wisdom to manage each case is central to the process (Rosen & Proctor, 2003). As an evolving approach to practice, EBP is not an all-or-nothing proposition; rather, it is a case of more or less. Perhaps evidence-informed practice is a more apt description of what is feasible at this stage. Nevertheless, imbuing practice with knowledge is an important goal for the profession, and to this end, the following recommendations are made:

1. Increased availability of systematic reviews and meta-analyses of the quantitative literature and meta-syntheses of the qualitative literature—including the development of practice guidelines—are needed to support practice.
2. Continued efforts to map differential effectiveness of interventions and combinations of interventions are indicated.
3. Consolidated efforts by social agencies and universities to marshal resources to create and translate relevant knowledge for practice with specific populations are needed.
4. Greater use of the Internet and other electronic learning technologies are needed to support EBP.
5. More PhD-prepared social workers are required in clinical settings to serve as knowledge brokers in the development and translation of knowledge.
6. Greater integration of EBP in the teaching curricula for social work trainees is needed, including a balanced focus on the strengths, limitations, and potential complementarity of underlying philosophical paradigms.
7. Research is needed to examine more closely clinicians' decision-making processes and the challenges they experience when trying to

implement an EBP approach, to facilitate the development of models for practice that work. **SW**

REFERENCES

- Anastas, J. (1995). *Fallibilistic realism: An epistemological framework for social work research*. Paper presented at the annual meeting of the Society for Social Work and Research, Washington, DC.
- Anastas, J. W., & MacDonald, M. (1994). *Research design for social work and the human services*. New York: Lexington Books.
- Barber, J. G. (1996). Science and social work: Are they compatible? *Research on Social Work Practice, 6*, 379–388.
- Barwick, M., Boydell, K., & Omrin, C. (2002). *A knowledge transfer infrastructure for children's mental health in Ontario: Building capacity for research and practice*. Toronto: Hospital for Sick Children.
- Bohan, J. S. (1993). Regarding gender: Essentialism, constructionism, and feminist psychology. *Psychology of Women Quarterly, 17*, 5–21.
- Borst-Eilers, E. (2001, October 10). *Medicine and politics: The many shades of evidence*. Paper presented at the 9th Cochrane Colloquium, Lyon, France.
- Brown, H. (1977). *Perception, theory, and commitment: The new philosophy of science*. Chicago: University of Chicago Press.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509–535). Thousand Oaks, CA: Sage Publications.
- Cronbach, L. J. (1975). Beyond the two disciplines of scientific psychology. *American Psychologist, 30*, 116–127.
- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications.
- Epstein, I. (1995). Promoting reflective social work practice: Research strategies and principles. In P. M. Hess & E. J. Mullen (Eds.), *Practitioner–researcher partnerships: Building knowledge from, in, and for practice* (pp. 83–102). Washington, DC: NASW Press.
- Gambrill, E. (1995). Less marketing and more scholarship. *Social Work Research, 19*, 38–47.
- Gambrill, E. D. (1999). Evidence-based practice: An alternative to authority-based practice. *Families in Society, 80*, 341–350.
- Gambrill, E. (2001). Social work: An authority-based profession. *Research on Social Work Practice, 11*, 166–175.
- Gorey, K. M., Thyer, B. A., & Pawluck, D. E. (1998). Differential effectiveness of prevalent social work practice models: A meta-analysis. *Social Work, 43*, 269–278.
- Hess, P. M., & Mullen, E. J. (1995). *Practitioner–researcher partnerships: Building knowledge from, in, and for practice*. Washington, DC: NASW Press.
- Ho, K. (2003). *Knowledge translation and learning technologies: Perspectives, considerations, and essential approaches*. Vancouver: University of British Columbia.
- Howard, M. O., & Jenson, J. M. (1999). Clinical practice guidelines: Should social work develop them? *Research on Social Work Practice, 9*, 283–301.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association.
- Kirk, S., & Kolevzon, M. S. (1978). Teaching research methodology from Z to A. *Journal of Education for Social Work, 14*(1), 66–72.
- Larner, G. (2004). Family therapy and the politics of evidence. *Journal of Family Therapy, 26*, 17–39.
- Lohr, K. N. (2000). *Assessing "best evidence": Grading the quality of articles and rating the strength of evidence*. Retrieved December 23, 2005, from http://www.rti.org/epc/grading_article.html
- Lomas, J. (1991). Words without action? The production, dissemination, and impact of consensus recommendations. *Annual Review of Public Health, 1*(12), 41–65.
- Meyer, C. H. (1992). Social work assessment: Is there an empirical base? *Research on Social Work Practice, 2*, 297–305.
- Mullen, E. J., & Bacon, W. F. (2003). Practitioner adoption and implementation of practice guidelines and issues of quality control. In A. Rosen & E. K. Proctor (Eds.), *Developing practice guidelines for social work intervention* (pp. 223–235). New York: Columbia University Press.
- Padgett, D. K. (1998). *Qualitative methods in social work research: Challenges and rewards*. Thousand Oaks, CA: Sage Publications.
- Peile, C., & McCouat, M. (1997). The rise of relativism: The future of theory and knowledge development in social work. *British Journal of Social Work, 27*, 343–360.
- Pinsof, W. J., & Wynne, L. C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy, 26*, 1–8.
- Reid, W. J., Davis Kenaley, B. D., & Colvin, J. (2004). Do some interventions work better than others? A review of comparative social work experiments. *Social Work Research, 28*, 71–81.
- Rogers, E. (1995). *Diffusion of innovations* (4th ed.). New York: Free Press.
- Rosen, A., & Proctor, E. K. (2003). Practice guidelines and the challenge of effective practice. In A. Rosen & E. K. Proctor (Eds.), *Developing practice guidelines for social work intervention: Issues, methods, and research agenda* (pp. 1–16). New York: Columbia University Press.
- Rosen, A., Proctor, E. K., Morrow-Howell, N., & Staudt, M. (1995). Rationales for practice decisions: Variations in knowledge use by decision task and social work service. *Research on Social Work Practice, 5*, 501–523.
- Rosen, A., Proctor, E. K., & Staudt, M. (1999). Social work research and the quest for effective practice. *Social Work Research, 23*, 4–14.
- Sackett, D. L. (1999). Getting evidence into practice. *Effective Health Care, 5*(1), 2–16.
- Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal, 312*(13), 71–72.
- Schön, D. A. (1995). Reflective inquiry in social work practice. In P. Hess & E. J. Mullen (Eds.), *Practitioner–researcher partnerships* (pp. 31–55). Washington, DC: NASW Press.
- Schwandt, T. A. (1998). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (pp. 221–259). Thousand Oaks, CA: Sage Publications.
- Steketee, G. (1999). Yes, but cautiously. *Research on Social Work Practice, 9*, 343–346.
- Thyer, B. A. (2003). Social work should help develop interdisciplinary evidence-based practice guidelines, not discipline-specific ones. In A. Rosen & E. K. Proctor (Eds.), *Developing practice guidelines for social work intervention* (pp. 128–139). New York: Columbia University Press.

- Videka, L. (2003). Accounting for variability in client, population, and setting characteristics: Moderators of intervention effectiveness. In A. Rosen & E. K. Proctor (Eds.), *Developing practice guidelines for social work intervention* (pp. 169–192). New York: Columbia University Press.
- Wakefield, J. C. (1995). When an irresistible epistemology meets an immovable ontology. *Social Work Research*, 19, 9–17.
- Walker, S. (2001). Tracing the contours of postmodern social work. *British Journal of Social Work*, 31, 29–39.
- Webb, S. A. (2001). Some consideration on the validity of evidence-based practice in social work. *British Journal of Social Work*, 31, 57–79.

Ted McNeill, PhD, RSW, is director of social work, Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, Canada M5G 1X8; e-mail: ted.mcneill@sickkids.ca.

Original manuscript received September 13, 2004
Final manuscript received May 25, 2005
Accepted August 15, 2005

TEP

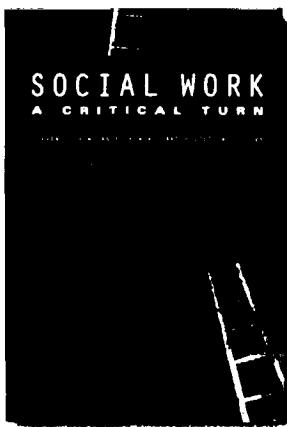
THOMPSON EDUCATIONAL PUBLISHING

www.thompsonbooks.com

**SOCIAL WORK
A CRITICAL
TURN**

Editors:

Steven Hick, Canada
Jan Fook, Australia
Richard Pozzuto, USA



ISBN 1-55077-147-7
236 pages / Paper
Price: \$32.95 US

Social Work: A Critical Turn is both an introduction to critical social work and an examination of current theory and practice. This volume features contributions from an international group of scholars who define the main theoretical underpinnings of a critical approach to social work and examine innovative practice methods using this approach.

This book situates critical social work within a theoretical context, comparing it with postmodernist, radical, feminist, anti-racist and structural approaches. It also reviews key issues that require further development in critical social work theory, practice and research.

Contents

Introduction: Towards "Becoming" a Critical Social Worker / Steven Hick and Richard Pozzuto

Part 1: Critical Perspectives on Social Work: An Overview

1. Current Understandings of Critical Social Work / Jim Iffe, Karen Healy, Trevor Spratt and Brenda Solomon, with summaries by the editors
2. Therapeutic Critique: Traditional versus Critical Perspectives / Richard Pozzuto, G. Brent Angell and Paul K. Dezendorf
3. Reconceptualizing Critical Social Work / Steven Hick

Part 2: The Practice of Critical Social Work

4. Human Rights and Critical Social Work / Jim Iffe
5. Empowerment: A Contextual Perspective / Jan Fook and Christine Morley
6. Critical Anti-Racism Praxis: The Concept of Whiteness Implicated / June Ying Yee
7. Radical Drama with Children: Working with Children Using Critical Social Work Methods / Trevor Spratt

Part 3: Theories and Critical Perspectives on Social Work

8. A Reflexive Materialist Alternative / Gerald de Montigny
9. Unfinished Fictions: Becoming and Unbecoming Feminist Community Organizers / Sarah Todd
10. Analysis of Social Location and Change: Practice Implications / Ben Carniol
11. Post-Critical Social Work Analytics / Graham McBeath and Stephen Webb

Part 4: The Future of Critical Social Work

12. Where in the World Are We? Notes on the Need for a Social Work Response to Global Power / Amy Rossiter
13. Feminist Social Work: Past, Present and Future / Brid Featherstone
14. Under Reconstruction: Renewing Critical Social Work Practices / Karen Healy
15. Challenges and Directions for Critical Social Work / Jan Fook

Orders in the USA

Toll-free Tel: 1-800-565-9523
Toll-free Fax: 1-800-221-9985

By Mail: University of Toronto Press

Distribution Division
2250 Military Road, Tonawanda, NY 14150

By E-mail:

utpbooks@utpress.utoronto.ca