

Evidence-based practice in social work

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Edited by Andy Bilson

Service users and social care practitioners are often marginalised in the production of research, but a system for assessing the quality of social care knowledge will need a more subtle and inclusive approach than a simple hierarchy in which findings from experimental studies take precedence.

Social services are under pressure from Government and the public to demonstrate the effectiveness of what they do. If the search for useable and relevant measures of effectiveness is to succeed, practitioners, managers, and policymakers must have an understanding of the underlying social science concepts such as Evidence-based practice (EBP).

This concept is now promoted as a 'scientific' approach to policy and practice. However, the concept was developed in the field of medicine, and many would ask whether we can safely apply it to the messy process of social problem solving?

The promotion of evidence-based practice also has implications for the content and focus of social work education and training, and for the selection and recruitment of staff and students.

Evidence-based Practice in Social Work provides a comprehensive overview of developments in this field and highlight many important debates and dilemmas.

Writers give clear pointers to the need for a new partnership between research, policy and practice, able to promote effective services. They suggest a more inclusive version of EBP that is better able to respond to the uncertainties of social work practice in the real world.

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Introduction

Andy Bilson

Evidence-based practice in social work is subject of considerable debate relating to a range of issues from the nature of evidence through to the possibility and appropriateness of transferring this idea from health to the 'messier' world of social work practice. This debate is increasingly important as government initiatives in a number of countries attempt to promote a more 'scientific' approach to social work policy and practice. This book contains a range of views which look at this subject from different perspectives. Before discussing these chapters and their place in this debate it is worth examining some of the background.

Evidence-based practice (EBP) as a movement in social work is drawing strength from the developments of evidence-based medicine (EBM) most notably promoted by David Sackett and his colleagues. When putting the articles together for the special edition of the journal *Social Science and Social Work Review* on which most of this book is based I approached David Sackett for a contribution. His reply to this request was relevant to some of the central issues in this book. He gave me advice on others to contact and said 'I am not the person to provide an EBP perspective, since I don't write or lecture about EBM any more' (see Sackett, 2000, for an explanation). Intrigued by this response I looked up the article he cited to find in it a description of why he had 'retired' from the field of EBP. This was not because of any change of heart about the subject but rather that he had taken a position that 'new ideas and new investigators are thwarted by experts, and progress toward the truth is slowed.' He concluded that to avoid this negative effect experts should retire from the field and turn their attention to new problems where, without prestige and commitment to prior pronouncements, they would be able to consider new ideas and evidence and judge these on their merit. In fact this tacit

acknowledgement that science is a human endeavour subject to our peculiar human frailties and strengths is central to the debate about the nature and possibility for evidence based practice in the messy world of social problem solving.

So at the centre of the debate is the nature of evidence-based practice itself. Sackett *et al.* define evidence-based medicine as

the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients, based on skills which allow the doctor to evaluate both personal experience and external evidence in a systematic and objective manner. (Sackett et al., 1997, p.71)

This definition gives a flavour of the issues in developing EBP in practice. The contributors to this book put different stress onto the need to combine evidence and experience and whether personal experience is seen as necessary. There is also the question of whether the approach is as relevant in social work as in medicine and this particularly leads to the issue of how evidence based practice can be promoted within the 'messy' environment of social work. The following chapters deal with these key issues relating to the nature of evidence and how it can be or is being put into practice.

With regard to the issue of evidence, EBM has developed views about the most appropriate research methodologies which can provide the 'external evidence' on which to act. A hierarchy of methods for evaluating treatment effects is proposed (Guyatt *et al.* 1995) with research not directly relating to clinical practice excluded altogether. This hierarchy is topped by systematic reviews and meta-analyses, randomised control trials, through cohort studies down to case reports. It will be evident to anyone with knowledge of research in social work that the forms of research at the top of this hierarchy are almost totally absent (see, for example Maluccio's 1998 review of the research evidence in the USA). Trinder (2000) has argued that this lack of the type of 'evidence' favoured by evidence-based medicine is not simply caused by the lower levels of funding available for social work research but by real methodological and practical problems in the application of RCT's and similar approaches in the messy world of social work. She states that

... social work encounters are not straightforward or linear relationships, but multiple, multilayered, relational and complex, and located in a social and political context. Within this framework of the inherently messy and complex nature of social work and probation, classic formulations of evidence are impoverished and potentially constraining. (Trinder, 2000, p. 149)

The book is organised in three parts. The first part deals with establishing the case for evidence based practice in social work. Part 2 looks at critical reflections on the application of evidence based practice. The final part considers the directions for application. Each part has three chapters dealing with these linked themes.

Part 1 starts with Brian Sheldon, Rupatharshini Chilvers, Annemarie Ellis, Alice Moseley and Stephanie Tierney's chapter, which puts forward a robust argument for evidence-based practice, and considers the use that social workers make of research. He reports on a major survey of over a thousand social work staff in England. Whilst he finds social work staff have enthusiasm for the idea of evidence-based practice there is also a worrying lack of knowledge of evaluative research. This is not dissimilar to the findings of a smaller survey in the United States (Mullen & Bacon, 1999) and demonstrates the work that needs to be done to increase knowledge of research.

Chapter 2 is by Frank Ainsworth and Patricia Hansen from Australia. They develop an argument for evidence-based practice as a basis for the social work profession's ethics. They stress how research from both the quantitative and qualitative arenas have different and complementary roles in the creation of an evidence base for social work. They see the current education system for social workers as being the key area for reform to promote evidence-based practice and argue for major reforms in areas including the selection and recruitment of both staff and students as well as in the content and focus of the training.

Stephanie Tierney continues this theme in chapter 3 and argues that EBP can have democratising, empowering and protective elements for practitioners and service users.

Part 2 of the book provides critical reflections on the application of EBP in social work.

As a counterpoint to part 1, in chapter 4 Carolyn Taylor and Sue White warn of the danger that evidence-based practice is becoming an orthodoxy without proper critical appraisal of its core ideas. In particular they focus on the hierarchy of evidence and the process by which practice becomes evidence-based. They suggest that, in its current form in social work, EBP is too strongly associated with deductive reasoning and suggest that practice needs both induction and deduction. They argue that EBP forces too much of the attention onto intervention and outcome underestimating the problems of diagnosis, assessment and case formulation. Their call is for a more inclusive version of EBP that is more able to respond to the uncertainties of social work practice in the real world.

In Chapter 5 David Smith takes a critical look at the limits of a positivist approach to EBP. He points out the importance of context and process in making any real sense out of measures of outcomes. Thus the same intervention will have different outcomes if the context or process of its delivery is changed. He considers implications from philosophy and uses examples from his evaluation of social work with offenders to highlight problems in providing evidence. This leads him to suggest that there is a less ambitious but more helpful role for science than providing 'hard' evidence. In social work science needs to provide middle range theories which give indications of helpful approaches and that allow practitioners to develop an integrated approach able to draw flexibly on a range of theories and be responsive in their practice to changes in the social, political and policy environment.

Finally in chapter 6 Nick Frost provides a critique of EBP arguing that it does not take adequate account of the value conflicts that permeate research and practice. He argues for the need to consider research utilisation within a wider framework that recognises the political and economic contexts of social work as well as the values that social workers use to steer their practice.

In Part 3 we start to consider the directions that implementation of EBP can take. This starts with Mike Fisher in chapter 7 who provides a detailed description of the UK Government's initiative to promote evidence-based practice, the Social Care Institute for Excellence (SCIE). SCIE was

established in October 2001 with the aim of improving standards in social work and social care in England and Wales by promoting the better use of research and knowledge. Mike Fisher is SCIE's Director of Research and Reviews. He provides an overview of the current state of research in England and Wales highlighting that service users and social care practitioners are often marginalised in the production of research. In looking at how to categorise research he concludes that 'a system for assessing the quality of social care knowledge will need a more subtle and inclusive approach than a simple hierarchy in which findings from experimental studies take precedence.' He also stresses the need for inclusive approaches to knowledge generation rather than those which favour the academic as the producer of knowledge.

In Chapter 8 Tony Newman and Di McNeish write about their experience of promoting evidence based practice in a major child care charity. They discuss the creation of the 'What Works?' series on child care and some early but encouraging signs of change in practice in their organisation.

In chapter 9 John Lawler and I reflect on the earlier chapters and provide some ideas about dealing with the implementation of a more reflective and research aware social work practice in organisations and teams. We provide a 5 part model for interventions to implement better use of research. We argue that there has been a substantial focus on the responsibility of the individual professional for using best evidence to guide their practice and that there is a need balance this by an increased focus on the organisational and team context in which social work takes place. We draw on the literature on organisational change and social work research to develop principles for encouraging greater reflexivity and developing a more open participative approach to the use of evidence to shape new practices in social work at the local level.

The way forward?

In considering what the authors in this book say about the future of evidence-based practice there are two issues which still need to be considered if it is to fulfil its potential to guide and improve practice and policy. The first concerns the nature of EBP and the form it will take and the second is the process of its implementation.

Evidence-based practice is currently in its early stages in social work and there are many avenues still open for its development. In a number of countries its introduction is within a political climate in which social work is coming under increasing attack and where government wants to centralise its control. EBP has the potential to become part of this political process or be the profession's defence against it. A crucial element in determining the part EBP plays is its ability to reflect the complexity of the problems social workers face in their day-to-day work and to challenge overly simplistic and populist policies (for evidence of this look no further than the punitive policies for offenders and the scapegoating of asylum seekers common in many parts of the world). For EBP to take on this role will require it to not only overcome the divide between quantitative and qualitative research and find a synthesis able to use the strengths of all research approaches, but it will also have to include many other forms of knowledge including professional experience, theory, knowledge and experience of service users and so on (see for example le May, 1999). One way to achieve this is for the profession to embrace the concept of EBP and at the same time redefine it as a framework for social work which values the contribution of practitioners and service users; supports professional discretion; and celebrates the complexity of social work practice.

The second issue concerns the process by which EBP is implemented. It is ironic that, in looking at practice, those promoting EBP call on practitioners to have regard to research whilst in their consideration of how EBP is implemented in organisations little regard is given to the substantial literature on such issues as change in organisational culture and professional practice. The naive view that all that is needed is better dissemination and access to research has long been

discredited and more complex multifaceted approaches are needed (for an overview of the effectiveness of different dissemination and implementation interventions in health see NHS Centre for Reviews and Dissemination Bulletin 5 no.1 1999). Some of the drive for evidence-based practice comes from the frustration of researchers who feel their findings have little effect on practice. A danger of this is that as EBP takes hold researchers will become more influential at policy level, forgetting that the strength of their insight into practice is that they have an alternative perspective rather than the whole truth, and they may try to use their new found influence to control practice and force it to improve. This can take the form of developing lengthy and compulsory assessment or recording forms to force social worker's attention onto what researchers see as key issues, or by encouraging government to set targets for practice based on their research interests. Much of the literature on organisational and professional change calls for an inclusive process that engages staff at all levels in a process of ownership of change and in an environment that tolerates and learns from mistakes rather than top down instructions, procedures and target setting. For effective implementation of evidence based approaches this complex process of change needs to be properly planned and resourced if it is to be effective.

Finally the need to base social work practice and policy on sound evidence is rarely denied, but there is a danger in concentrating too much on practice and its limited use of evaluative research. We need to heed Trinder's warning of the need to respond to the social and political context of our actions. For example, the probation service in England and Wales represents the agency which, in its policies, procedures and directives, has been amongst the strongest in promoting evidence-based practice. It is worth noting that this has taken place against a background of national policy that has seen continual condemnations of community based work with offenders and the biggest increase in the prison population, an intervention whose spectacular failure is well documented.

Thus it is clear that there is still a long way to go to help to develop a more reflexive, research aware social work practice. This book provides a comprehensive overview of developments

in evidence-based practice in social work and highlights many important debates and dilemmas. I hope it has shown that these debates are not, as some have suggested, a sterile fight between entrenched camps fighting for empiricism or a postmodern perspective. Rather it addresses fundamental issues about ethics, the nature of social work, research and its applicability and gives clear pointers to the need for a new direction for the partnership between research, policy and practice able to promote better more effective services.

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Part One

Establishing the case

I

A pre-post empirical study of obstacles to, and opportunities for, evidence-based practice in social care¹

Brian Sheldon, Rupatharshini Chilvers, Annemarie Ellis, Alice Moseley and Stephanie Tierney

Messages from history: The case for evidence-based practice

The concern that measurably effective help should be available to poor, troubled and otherwise needy people is as old as Social Work itself. Joseph Rowntree was much concerned with the issue, and the American pioneer researcher Mary Richmond was writing about the impediments to its realisation on the eve of the Russian revolution, particularly in respect of the need for a common language (which we still do not quite have) in which to discuss questions of evidence:

With other practitioners – with physicians and lawyers, for example – there was also a basis of knowledge held in common. If a neurologist had occasion to confer with a surgeon, each could assume in the other a master of the elements of a whole group of basis sciences and of the formulated and transmitted experience of his own guild besides. But what common knowledge could social workers assume in like case?' (Richmond, 1917, p.5)

Or, consider this politically savvy statement from the President of the American National Association of Social Workers, but then note its date:

I appeal to you, measure, evaluate, estimate, appraise your results in some form, in any terms that rest on anything beyond faith, assertion, and the 'illustrative case'. Let us do this for ourselves before some less knowledgeable and less gentle body takes us by the shoulders and pushes us into the street. (Cabot, 1931, p.6)

Then there is this little poem to the principles of evidence-based service-development contained in the 1968 Seebohm Report:

The personal social services are large-scale experiments in helping those in need. It is both wasteful and irresponsible to set experiments in motion and to omit to record and analyse what happens. It makes no sense in terms of administrative efficiency, and however little intended, indicates a careless attitude towards human welfare. (Seebohm Report 1968, p.142)

Not just another new fad then, and not just another 'initiative' deserving of a 'Good Soldier Schweik' response: enough collaboration not to get into trouble, too little to make it work (see Haslev, 1921).

Yet the Social Work field, particularly in the United States, tried hard to put the question of its usefulness beyond the reach of shifting political ideologies as early as did any of the other helping professions. The first large-scale controlled trials were begun in the 1930s and were reported in the 1940s and 1950s (Lehrman, 1949; Powers & Witmer, 1951; see Sheldon, 1986, for a review of this and later British work). The first medical trials (of streptomycin for pulmonary tuberculosis: see Daniels and Hill, 1952) brought an experimental approach into clinical medicine at about the same time. The agriculturalists beat us all to this, but then, conveniently, their subjects stay put while being observed².

The problem was that the results from the first Social Work experiments were almost wholly nil-nil draws, or worse, (see Mullen & Dumpson, 1972; Fischer, 1976). Indeed these brave, early studies should have taught us long ago something that all the helping professions (including medicine) have only recently begun seriously to acknowledge, namely, that it is perfectly possible for good-hearted, well-meaning, reasonably clever,

appropriately qualified, hard-working staff, employing the most promising contemporary approaches available to them, to make no difference at all to, or even on occasion to worsen, the condition of those whom they seek to assist. It still happens today (see Marshall *et al.*, 2000; Byford *et al.*, 1999; Wessely *et al.*, 2000, Tolley & Rowland, 1995; for a general treatment of these issues, see Hunt, 1997).

Clear negative findings do not, in a strict scientific sense, matter. Lost hopes aside, methodologically kosher but disappointing findings are very precious (see Macdonald, 2004). They tell us, particularly in combination, what *not* to do and, potentially at least, provide arguments for the release of resources for more promising ventures. These large (and for the most part) well-conducted studies did eventually lead to a series of changes in practice favouring more focused and better-organised approaches which later stood up well under test, (see Reid & Hanrahan, 1981; Sheldon, 1986, 1995, 2000; Macdonald & Sheldon, 1992; Thyer, 1995; Macdonald, 2000). However, there are some more detailed points to be made.

1. The early negative findings came as a great surprise to everyone, both to those closely involved in the research, and later readers of it. When consulted at intermediate stages in the conduct of studies staff were always sanguine about the undoubted gains being made (see Jones & Borgatta, 1972). However, these alleged improvements disappeared when the control data were added to the equation – as is common today (see Macdonald, 2004).
2. The publication of scattered single studies with clear negative findings did little to alter professional attitudes, and where they were known about at all, they were seen as flukes. It was reviews, that is, collections of experimental material, that urged the conclusion upon us that just because particular approaches or patterns of service-provision were routine, congenial and familiar, this nevertheless told us little at a scientific level about their effectiveness.
3. Standards regarding acceptable levels of evidence vary greatly across disciplines and circumstances. At a multi-disciplinary mental health conference two years ago, the

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following quotation from a systematic review of approaches to relapse prevention in cases of schizophrenia was read out, but amended, so that wherever the phrase 'case-management' occurred, the name of a mythical neuroleptic medication, *Lususproxine* was substituted (*lusus* is Latin for playfulness):

Case management increased the numbers remaining in contact with services. Case management approximately doubled the numbers admitted to psychiatric hospital. Except for a positive finding on compliance from one study, case management showed no significant advantages over standard care on any psychiatric or social variable. Cost data did not favour case management but insufficient information was available to permit definitive conclusions. (Marshall et al., 2000, p.34)

The audience was then asked what they thought should happen regarding this treatment, and overwhelmingly suggested that it should no longer be used. However, when they were let in on the little thought experiment, a substantial number, though sympathetic to the *principle*, thought that little could be done about social care interventions since they were embedded in national and local policies, and that different rules applied. A 'Mexican Wave' shrug rippled through the audience to accompany these comments. *Should different rules apply though, is the question, since both constitute interventions?* Our tendency to fall in love with favourite theories, methods or concepts, and to question the motives of any critics; our tendency to follow, rather slavishly, the routine but often uninformed prescriptions of government are not always cost-free to our clients.

The position in the early 1990s was that both reviews and single studies were showing clearly positive results (e.g. in 78% of the 94 screened outcome studies reviewed by Macdonald and Sheldon, 1992) but that staff, inhabiting a workplace culture favouring action over reflection, and much pre-occupied with the new commercial principles which accompanied community care reforms (see Griffiths, 1988) appeared rarely to have heard of these more promising findings (see Sheldon, 1987a). However, as a result of the work of a few irritatingly

A pre-post empirical study of evidence-based practice in social care

persistent Social Work academics, and under the influence of developments in the Health field, particularly those brought about by the Cochrane Collaboration (see Cochrane, 1973; Maynard & Chalmers, 1997) new impetus was given to research programmes which had service development objectives as their *raison d'être*. Most notably in our own field was the funding (£5 million to date) of the Centre for Evidence-Based Social Services (CEBSS) at the University of Exeter³ - a partnership project originally involving the Department of Health and (to date) 20 social services departments, and charged since 1997 with the following aims:

1. to translate the results of existing research into service and practice development;
2. to ensure research findings are available to social services departments when reviewing and changing service delivery, and are fed into the review process;
3. to collaborate with providers of DipSW and post-qualification courses to ensure that education and training in Social Work incorporates the knowledge available from research;
4. to improve the general dissemination of research findings to local policy makers, managers, practitioners, carers and service users;
5. to commission new research where significant gaps in knowledge are identified.

With such promising contemporary developments in hand, why dwell on historical matters at all? Well, there are three good reasons:

1. One of the more sensible views of Karl Marx (paraphrasing Hegel) was that 'those who know no history are often condemned to relive it'. If there is any field in which this is true it is Social Work, wherein old ideas (whether plausible or whacky) frequently just acquire new names and are recycled.
2. Our common experience in the social services is that new initiatives which ignore their historical roots wither quickly when the limited supplies of political fertilizer dry up (just

think back five to 10 years).

3. Large enterprises, when they seek to change behaviour within organisations rather than merely the terms of discourse, depend upon a widespread discussion of aims, purposes, and desired results if they are to secure 'informed consent' from staff regarding the extra work to be done.

In other words, regarding this promising idea of evidence-based practice, current enthusiasm should be tempered by remembering that the sieve of history has large holes.

The concept of evidence-based social care and its implications.

Having had a look at the origins of the idea, we must now consider what it implies. Here is a short definition containing the principal features (freely adapted from the work of Sackett *et al.*, 1996 in evidence-based medicine):

Evidence-based social care is the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare of those in need.

Conscientiousness

How do the key words in this quotation translate to the Social Work field? *Conscientious* surely reminds us of our ethical obligations to clients, not least among which is to try to keep up to date on research which (a) helps us understand the nature and development of personal and social problems, and (b) requires that we keep abreast of studies on the effectiveness of particular interventions which might ameliorate these. This is, after all, what we as, generally speaking, rather less up-against-it consumers expect of the services that we use - from medical and nursing staff to gas fitters (plumbers are, of course, a different matter entirely). Surely social workers, concerned with the well-being of the most vulnerable in society cannot be

exempt from a similar obligation?

Hippocrates (400BC) counselled his student physicians on the moral imperatives of intervention thus: 'First, do your patient no harm'. Can it be said that the social services do no harm? Just to mention the events on the Orkney Islands (see Dalrymple, 1994; Sheldon, 1995⁴) or at Cleveland (Butler Sloss, 1988) sadly puts this matter beyond doubt. Then there are sins of omission rather than of commission to consider, as in the many reports of the deaths of children in our care (see Howitt, 1992; Sheldon, 1987b; Laming, 2003). The problem is that 'hard cases make bad laws'. Child death from abuse is statistically rare, but below this visible iceberg tip is a much larger mass of children suffering non-fatal, but serious physical (and sometimes more cruel) emotional injuries. True conscientiousness would imply much greater attention to these, whose cases do not make the Daily Mail leader page (see Macdonald & Macdonald, 2000). All of the above points apply equally well to the fields of mental health, and the care of frail, elderly people (see Sheldon, 1994; Trappes-Lomax *et al.*, 2002).

Explicitness

Explicitness, that is, the recommendation that we work in as open and contractual way as possible with clients, has emerged as a key ingredient in effective helping over the last three decades (see Reid & Shyne, 1968; Stein & Gambrill, 1977; Sheldon, 1980, 1986; Macdonald & Sheldon, 1992). It causes some problems though, and has done for some time, as this quotation (from two pioneer experimentalists addressing the issue of what exactly is the distinctive contribution of Social Work) shows - and frustratingly, continues to show:

These qualities cannot reside in the mind of someone in the agency who knows what they think is important but cannot express it because it is too subtle to be communicated or because it is a relationship so fragile that any attempt to measure it would destroy it. (Jones & Borgatta, 1972, p. 112)

The idea that basic scientific procedure is much too blunt an

instrument with which to poke about in the inevitably mysterious dynamics of what passes between would-be helper and might-be helped was once the major obstacle to the goal of explicitness in our dealings with clients. Indeed, the idea is still in circulation (see Webb, 2001; Sheldon 2001). However, a new version of this problem has now arisen. Its origins lie in the community care reforms of the 1990s (a great, but politically compromised cause which nevertheless quietly achieved most of what was intended) wherein initially heart-warming phrases about 'needs led' services were later nullified by decisions that 'needs' for which there were no budgets, no facilities, or no conveniently available expertise, did not (in true Orwellian fashion) really count as needs. Transparency of decision-making and honesty about what existing funding can and cannot provide should surely be our aim in these matters. All the rest must be passed on fearlessly to democratically elected politicians – whether they like it or not.

Then there is the curse of Carl Rogers to contend with (some good ideas, but nothing to justify his Guru status on Social Work courses). Why is it that 'I can feel your anger' is seen as a much cleverer statement than, 'have you ever thought of ...?' Imagine meeting Carl Rogers on campus and asking the way to the library and getting back, 'I sense you feel lost'. Respondents in client-opinion studies have been telling us for forty years that they value explicit advice (which of course they are entitled either to take or ignore) but that this approach was/is seen as low trade by social workers. In any case, in-depth relationships instead of help with utility arrears has gone out of fashion as a problem and has been replaced by a 'B & Q' approach to welfare: 'if we have it, it will be on the shelf', and 'no, we only do the one size'. A rather injudicious development this, since research favours tailor-made solutions.

Judiciousness

This next word in our definition concerns the exercise of sound, prudent, sensible, judgement. Our stock is not high in this regard, and considered pragmatism has been out of fashion for two decades at least. We seem instead, lacking a healthy

professional immune system, to be prone to infection by fads and fashions: some, on the face of it plausible, some less so (see Sheldon, 1978; Sheldon & Macdonald, 1999). Incidentally, Tallyrand, Napoleon's foreign minister, gave the following advice to passing-out graduates of the elite *corps diplomatique*... 'but above all, gentlemen, please, no zeal'. Neglected advice, perhaps.

The case here is that not all that could be done should be done; and that not all things that staff like the idea of are reasonable; but that equally, some things that appear demanding or expensive in the short run turn out to be a bargain in the longer run. Potential risks arising from some, or no intervention, either in cases or in policies, should of course be thoroughly assessed and evaluated, but in the sure and certain knowledge that not all eventualities can be predicted (see Macdonald & Macdonald, 2000). All else is dangerous pretence and comes back to haunt us. So much so that social services staff now spend only 13-16% of their working week in face-to-face contact with clients, the rest of the time is spent on 'virtual reality Social Work', i.e., preparing a case for a possible Inquiry – statistically unlikely, but then (to invert the National Lottery slogan) 'someone has to loose' and it could be you.

Organisational obstacles to evidence-based service provision

If evidence-based social service provision were to become a reality, as opposed to just a laudable aspiration, then we would expect to see the following changes in the way the Social Work profession organises itself.

- There would be in place a well-qualified workforce within which knowledge and experience are regularly up-dated by training courses which make regular reference to research firstly on the nature and development of social problems and secondly on what is known at an empirical level about the effectiveness of different approaches designed to address them.
- There would be qualifying courses, which, as a matter of

priority, would address and review the literature on the effectiveness of services and equip students critically to appraise the results reported therein rather than relying upon comfortable notions of 'eclecticism' (see Sheldon, 1978).

- The profession would nurture a system of staff supervision which regularly draws upon research to inform decisions made about cases and projects, and wherein questions such as 'why are we proceeding in this way?' and, 'on what evidence?' would be seen as routine professional enquiries, not as personally threatening questions (see Macdonald & Sheldon, 1998).
- Departmental meetings would regularly include references to research on what has been tried elsewhere, regionally, nationally and internationally, when services are being monitored or reviewed, or where departmental restructuring is in the offing, which ubiquitously it is, but often without benefit of supportive evidence for the changes envisaged and the value versus the costs involved. Those who doubt whether scientific principles can properly be applied to human behaviour should consider Sheldon's three laws of reorganization, which have proved to have Newtonian, solar eclipse- prediction precision: i) If your director of social services leaves and is replaced you will be reorganized; ii) This will happen however recently you have been reorganized; iii) This will happen no matter what the size of the budget deficit regarding front-line care services (Q.E.D.). A single contravening example would of course refute these laws (see Popper, 1963), however none is evident to date. The American biologist Paul Ehrlich offered some good advice when he wrote that 'the first rule of intelligent tinkering is to save all the parts until you understand what they do'.
- There would be a range of support facilities available to assist staff in their efforts to keep abreast of research relevant to their field, e.g., departmental library and information services capable of efficiently delivering books and journal articles to enquirers and able to distribute summaries of available evidence, with those in charge of

them able to show that such services are regularly used. There would be subscriptions to research databases⁵ so that staff can search the literature in their field; and subscription to key journals containing empirical research.

- There would be better and more Internet access (see Moseley, 2004) so that systematic reviews and studies of good quality, both on problems and plausible solutions could be readily accessed (for example, www.cochrane.org; www.campbellcollaboration.org; www.ex.ac.uk/cebss; www.be-evidence-based.com; www.york.ac.uk/inst/crd/). There are some remaining chaff/wheat ratio problems with some of the research reported on websites, but with a little trained-in discrimination (see the CEBSS critical appraisal skill courses documentation on www.ex.ac.uk/cebss/casptraining.html) these should recede. All this will happen, but is presently happening much too slowly in the Cinderella services and we should probably jump up and down about the fact more. The remnants of commercially-minded service managers, who made their names with 'spreadsheet accountability' and top-down 'workforce compliance strategies' in the 1980s should have thought more about the fate of British Leyland perhaps.
- At an attitudinal level, there would be a workforce which takes some personal responsibility for acquainting itself with the empirical evidence on service-effectiveness (this is beginning to happen, see below), with a reasonably well-founded expectation of practical support from management for this necessary task.
- There would exist a range of collaborative arrangements between social services departments and local and regional universities and research institutes, so that each tangibly influences the work of the other, and within which each group of staff might unexceptionally be encountered on the corridors of the other pursuing common purposes. In other words, Social Work academics and social services managers should get out more.

Wishful thinking? We think not given the new resources now available, but whether or not this wish list is ever granted

will depend upon those at the sharp end backing the *idea* with more than concerned, Rogerian nods and sighs. 'Cognitive-behavioural therapy', rather than insight-giving is, at an organisational level, closer to what we need.

There was great pressure at the inception of the CEBSS project to 'hit the ground running', just as there are pressures in day to day practice to do 'something' - whatever it is - quickly. Our approach in CEBSS was to argue that we could not live up to our name, if we did not have an evidence-base of our own. Therefore, (military analogies still in place note) we agreed to take some 'aerial photographs' of 'the ground' first. This exercise took the form of a large-scale questionnaire exercise, the results of which are summarized below. The purpose of the questionnaire was to establish the level of support amongst staff for the idea of evidence-based social care and to gauge the prospects and problems for the development of an evidence-based culture within departments. As will be evident in the graphs and tables which follow, this questionnaire exercise was then repeated, to see whether, or to what extent, attitudes and knowledge had changed over four years.

Design and content of the questionnaire⁶

The sample was drawn from information supplied by (though, 'midwifed out of' might be a more accurate phrase) social services departments participating in the CEBSS project. At the time of data collection, all of these departments but one were in the South West of England. It consisted of social workers, team leaders, care or case managers, heads and deputies of residential facilities, occupational therapists, and a small number of nurses and teachers (all employed in social services departments). A proportionate stratified random sample of 2285 professional grade, frontline social services staff were contacted in 1998 (time 1) to participate in the study, from a population of 6994. In 2002 (time 2), 2272 questionnaires were sent out to a sample calculated in exactly the same way (it was impractical to try and target the very same people who had been included at time 1 since the questionnaire returns were anonymous).

Stratification took place as to whether staff were field workers, residential and day care staff, occupational therapists, or other, in order to ensure representation for each category. Calculations to obtain a representative sample size were made separately for each participating department with four separate considerations (see Monette *et al.*, 1989; Oppenheim, 1992) namely: number of variables being investigated; level of population homogeneity present; precision level required (95% confidence level); and an appropriate sampling fraction to avoid overestimation.

A 42-item questionnaire (see Table 1 overleaf) was sent to participants with a guarantee of confidentiality based on code numbers⁸, and a brief description of the purpose of the study. A maximum of three mail outs took place to ensure a good return rate, but no arm-twisting by Directors was involved (honest).

Analysis

For the purposes of analysis by occupational status, qualifications and job titles were used to categorise participants as social workers (holding a DipSW, CQSW, or CSS), occupational therapists (holding a Diploma or BSc in Occupational Therapy) and 'other social care professionals' (mainly care or case managers who may or may not hold these qualifications, or who may have relevant but different ones).

Responses to the closed questions were coded and then entered into the statistical package SPSS, version 10. Data from the open-ended questions were coded and analysed thematically. Answers to open-ended questions were analysed independently by two researchers and a (more than satisfactory) inter-rater reliability level of 85% was obtained. Chi-square tests were used to determine associations between categorical variables, and independent t-tests were used to assess differences on interval data. Both chi-square and t-tests were used to assess differences in responses from time one to time two.

Table 1

Topics covered in the questionnaire.

| Topic | Information included: |
|--|--|
| Demographic information | Age, gender, length of employment, post title, type and level of qualification, and the client group with which respondents mainly worked. |
| Departmental influences on the availability and use of research findings | Extent to which research findings were discussed in supervision and departmental meetings, availability of and satisfaction with facilities such as library, summaries, etc., perceived support for evidence-based practice within the department. |
| Existing reading habits and preferences | Identification of relevant publications seen by respondents, opportunities for reading, preferences for different reading materials, opportunities (or the lack of them) for keeping up-to-date with research findings. |
| Familiarity with research publications | Identification of a randomised controlled trial, a quasi-experimental study or client opinion study known to the participant. |
| Existing levels of knowledge of research issues and terms | Current understanding of common research terms and issues such as statistical significance and factors influencing positive findings in a client opinion study other than the intervention. |
| Attitudes to evidence-based approaches | Perceived relevance of research in day-to-day practice, and perceived usefulness of greater access to research in practice. |
| Priorities for CEBSS project | Ranking of most important activities for CEBSS to undertake to achieve its aims and objectives. |

Results

At time one, a total of 1226 respondents (a 53.7% response rate) took part in the study, of whom 67 % were social workers, 9% were occupational therapists, and 24% were 'other social care professionals'. At time 2, a response rate of 58% was obtained, however, 233 responses had to be excluded, mainly because they had been filled in by people for whom the questionnaire was not intended (e.g. non-professional grade staff or non front-line staff). The same problem occurred at time 1 with 115 responses having to be dropped – but precautionary over-sampling reduced the potential statistical distortions created by this. In total, 1089 responses were included in the time two analysis. 65% of the respondents were social workers, 7% were occupational therapists, 9% were classified as 'other social care professionals' and 19% as frontline managers (mainly team leaders). Further details of the sample are provided in Table 2.

There were no statistically significant differences between the respondents at time 1 and time 2 on any of these demographic variables: gender ($\chi^2 = 2.99$, $df = 1$, ns); age ($\chi^2 = 1.95$, $df = 1$, ns); time in social services employment ($t = 0.86$, $df = 2282$, ns). This means that the two groups of respondents in 1998 and 2002 are comparable on principal demographic variables. Table 3 illustrates the professional qualifications held by respondents in both 1998 and 2002.

Demographic comparisons with the national workforce survey (see LGMB/ADSS, 1997) indicate that these findings are in line with national figures except for those regarding ethnicity. So, social services staff are predominantly women, predominantly middle-aged, with considerable experience behind them, and not, as the tabloid press would have it, 'earnest young people lacking in life experience' who flit from stressful job to (hopefully) less stressful job.

Departmental influences on the use of research

Both questionnaires investigated 'possible opportunities for, and obstacles to, the application of research findings to cases, and the level of consideration of such matters in supervision

Table 2
Characteristics of respondents

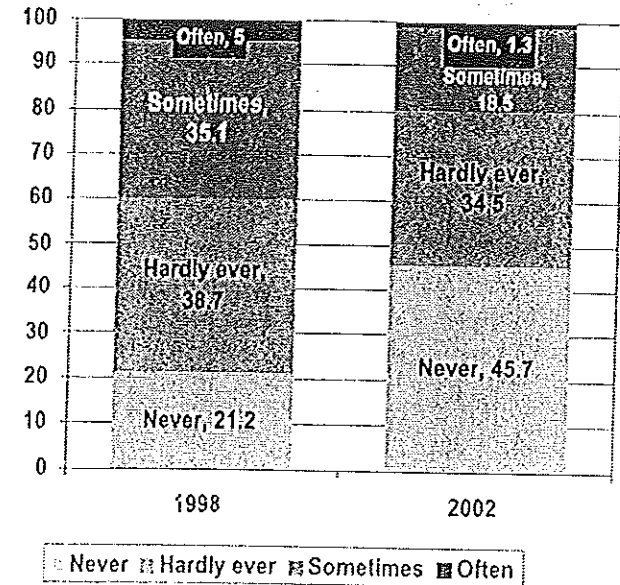
| | 1998 (N = 1226) | | 2002 (N = 1089) | |
|--|-----------------|-----|-----------------|-----|
| | n | % | n | % |
| Job title: | | | | |
| Social worker | 817 | 67 | 709 | 65 |
| Occupational therapist | 115 | 9 | 77 | 7 |
| Other social care professional | 294 | 24 | 303 | 28 |
| Gender: | | | | |
| Female | 881 | 72 | 746 | 75 |
| Male | 345 | 28 | 247 | 25 |
| Missing | 0 | | 96 | |
| Age: | | | | |
| 21-30 | 78 | 7 | 77 | 7 |
| 31-40 | 303 | 25 | 231 | 21 |
| 41-50 | 523 | 44 | 428 | 40 |
| 51-60 | 282 | 24 | 317 | 29 |
| Over 60 | 16 | 1 | 30 | 3 |
| Missing | 24 | | 6 | |
| Ethnicity: | | | | |
| British, European or Caucasian | 1201 | 98 | 1056 | 97 |
| Asian or Black | 25 | 2 | 33 | 3 |
| Missing | 12 | | 11 | |
| Mean (sd) time in Social Services employment in years | | | | |
| | 13 | (7) | 13 | (8) |

Table 3
Professional qualifications held by respondents.

| Qualification | 1998 | | 2002 | |
|--------------------------|------|------|------|-------|
| | n | % | n | % |
| DipSW | 228 | 21.5 | 441 | 40.5* |
| CQSW/CSS | 529 | 49.8 | 400 | 36.7 |
| DipCOT (or degree in OT) | 107 | 10.1 | 85 | 7.8 |
| Other | 198 | 18.6 | 163 | 15.0 |

* This figure reflects the changing titles of professional qualifications.

Fig. 1
Frequency of discussion of research findings in consultation or supervision meetings (%)



consultation meetings, departmental meetings, or on departmental training courses.

In both 1998 and 2002, staff supervision consultation occurred for most on a monthly basis (61% on both occasions). However, a sizeable minority of respondents had more frequent opportunities (24% in 1998 and 33% in 2002). In 1998, 15% reported having to rely upon less frequent and ad-hoc arrangements, with five respondents reporting that they received no supervision at all. By 2002, the situation had improved, with only 7% having to rely upon such unsatisfactory arrangements. So, more opportunities for supervision over four years, but what do staff think of it and what is its content? In 1998, 85% of respondents rated the quality of their supervision as being 'very' or 'quite satisfactory' and, in 2002, 88% described it in these terms - a finding to celebrate given the pressures on staff time.

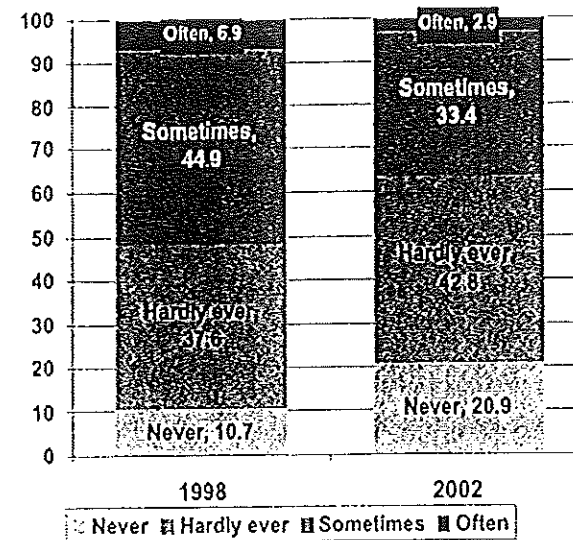
Turning next to the question of the extent to which research is discussed within supervision and consultation meetings, it will be seen from Figure 1 above that, by report, in 1998 only

5% of consultations contained regular and routine discussion of research findings and their possible applications and, by 2002 this had fallen to a mere 1%. 35% of respondents in 1998 stated that research was discussed 'sometimes' (which is mildly encouraging, however, if we consider the remaining 'hardly ever' and 'never' categories for 1998, we see that in 60% of consultations the issue was worryingly down the agenda. This concern is compounded by the finding that in 2002 these figures had worsened: now 80% stated that they 'hardly ever' or 'never' discussed research findings in supervision (this difference is statistically significant: $\chi^2 = 185.9$, $df = 3$, $p < 0.001$).

We say 'worryingly' (above) because all that research is, is the screened and codified experience of others working with similar problems, and so one might have thought it would be, if not the first port of call in such discussions (which is probably risk), then at least the second, and certainly not something to be left out much of the time. However, there is an interesting association in our data, in that those respondents who answered positively to a later question on the perceived relevance of research to their jobs are significantly more likely to be involved in such discussions with their supervisors both in 1998 and 2002 (1998: $\chi^2 = 14.98$ $df = 3$, $p < 0.005$; 2002: $\chi^2 = 5.95$, $df = 3$, $p < 0.05$). Therefore, these supervisors are a prime target audience for dissemination events and CEBSS is stepping up its courses on evidence-based practice for staff supervisors on evidence-based practice. These courses (N=21) have been positively evaluated in terms of content, relevance to practice and delivery, and so it looks as if we are up against a displacement effect here. That is, there is the inclination but simply not the time. Conference delegates (CEBSS has carried out 487 conferences and training events to date) tell us that risk monitoring (see Parsloe, 2000) and local and national target attainment and returns are the prime preoccupations.

At time one, discussion of research issues was more prevalent in departmental meetings with 52% reporting that this happened 'often' or 'sometimes', but only 36% saying likewise four years on (see Fig. 2). Again, this is a statistically significant deterioration ($\chi^2 = 79.2$, $df = 3$, $p < 0.001$) despite our exhaustive work in this area.

Fig. 2
Frequency of discussion of research findings in departmental meetings (%)



Departmental encouragement to integrate research and practice

In response to a general question on the issue, 66% of 1998's respondents reported having 'little' or 'no' encouragement from their department to keep abreast of the research literature and in 2002 the picture was worse (78%) which is depressing given the provision of 487 conferences and training courses on just this issue by CEBSS and the changing political climate in favour of evidence-based approaches. Evaluation data regarding satisfaction, relevance to practice, and teaching quality averaged 4.2 (out of a possible 5 score) across these events. Therefore it may be that staff do not credit their department's backing for the CEBSS project as part of the support provided to them, or perhaps expectations have risen.

In 1998, staff views were sought as to whether they felt it was primarily a personal/professional responsibility to keep abreast of literature on research trends, or whether it was a departmental responsibility. They were asked to indicate the extent to which they felt it was a personal, professional responsibility on a seven-

point scale, with 1 indicating 'a personal, professional responsibility' and 7 indicating 'not a personal, professional responsibility'. Respondents were also asked to mark, again on a seven-point scale, the extent to which they felt keeping abreast of research trends was a departmental responsibility (1 indicated 'a departmental responsibility' and 7 'not a departmental responsibility'). The mean (sd) ratings were 2.8 (1.3) and 2.3 (1.1), respectively. There was a statistically significant difference between these ratings ($t = 11.8, df = 1181, p < 0.001$) demonstrating that respondents felt keeping abreast of research literature was much more a departmental, rather than a personal, responsibility. In 2002, this issue was addressed using a less complicated questioning format and the picture was thus: 9% felt that they personally were responsible for keeping up-to-date with research findings, 11% thought it was mainly their department's responsibility, and 80% saw it, sensibly we think, as a joint responsibility.

Departmental facilities to assist staff in keeping abreast of the literature in the region leave much to be desired (Figs. 3 and 4 overleaf). In 1998, over one third of the respondents reported having no access to library facilities. In 2002, this had improved only slightly, to just over a quarter (26%) reporting no such facilities. There was a minimal increase (65% to 71%) in the proportion of people reporting the availability of journals. The number of respondents reporting having access to computer databases did go up between 1998 and 2002, but at this later date, still nearly half (42%) reported having no access to this tool which is crucial for being an evidence-based practitioner. Retrieving research findings via the Internet is predominantly an activity carried out at home. One can, equally plausibly, take two different views about this finding: (a) that work place conditions do not support such activities – though, as we have argued, they are an essential ingredient of evidence-based practice; (b) that staff now have enough enthusiasm for this idea that they are willing to accept that their professional role is semi-independent of their strict employment obligations and are willing to undertake these opportunities outside working hours.

In 1998, 27% had research discussion groups available to them and 21% had research presentations. The picture is better by 2002, 37% now reporting having evidence-based groups, and

Fig. 3
Reported availability of departmental facilities to assist staff in keeping up to date with research literature in 1998 (%)

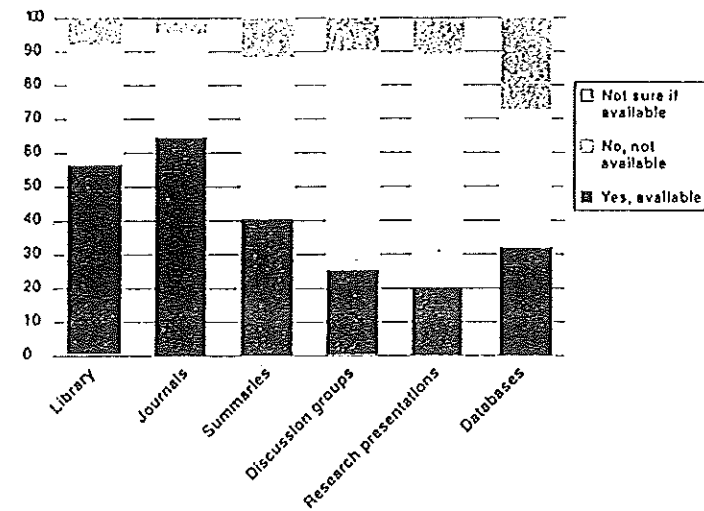
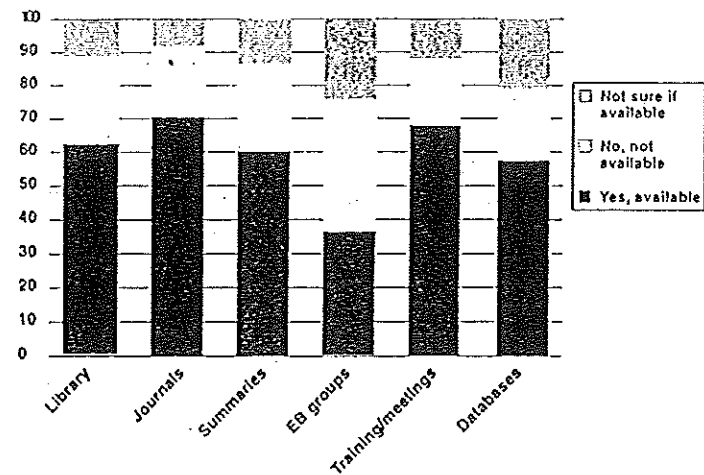


Fig. 4
Reported availability of departmental facilities to assist staff in keeping up to date with research literature in 2002 (%)



67% describing training courses or meetings with research content conducted within their departments. This is encouraging, particularly since the former events are set up and run by staff themselves. However, it is interesting to note that this increase in research content in training is not credited by respondents to the 'departmental support' account. Therefore, it is likely that they are responding to this question purely in terms of the level of practical backing supplied - such as access to computers and the Internet - which facilities are being made available all too slowly in comparison to those granted to colleagues in Health.

In the 1998 survey, respondents were asked to suggest methods that could be used by departments to encourage the practical use of research findings. Over one third nominated increased availability of technical research facilities (36%), with protected study time (20%) and opportunities to attend research meetings (21%) also being listed as important.

Opportunities for reading professionally relevant publications

Evidence-based practice depends upon readers - whether on screens or in articles or books. Therefore we were interested to evaluate the opportunities for this. It may be that at present we have too many writers and not enough readers. Academic researchers are thus largely writing to each other, as encouraged by the Research Assessment Exercise. In 1998, almost 75% of respondents reported having access to, or subscribing to, publications relevant to their work. In 2002 this figure was similar (79%). At both survey points the majority identified the publication to be *Community Care* (65% on both occasions), not a research journal, but an interesting publishing opportunity for people with strong messages to pass on. In 1998, only 19% of the respondents mentioned access to research or academic publications and this group was mostly made up of occupational therapists (55%) with the *British Journal of Occupational Therapy* and *Therapy Weekly* being the main publications mentioned (but then they drop onto the mat as a benefit of membership). There was a statistically significant association between respondents being members of a professional organization and having access to such literature ($\chi^2 =$

128.7, $df = 1$, $p < 0.001$). The issue being that so few social workers can be bothered with such affiliations, the problems that they confront in their day to day work being so politically neutral that there is no need for independent, representative bodies such as the BMA or the RCN (!). This 'learned helplessness' state urges us to remind readers of the advice given to depressed patients by the cognitive psychologist, Aaron Beck:

If you don't have plans for yourself, then you will very quickly become part of someone else's. (Beck, 1976, p.127)

Although nearly half the respondents reported having read literature pertinent to their work in the week prior (48% in 1998 and 46% in 2002), in the 1998 survey 45% reported that such reading took place at home and this had increased to 62% by 2002. In line with these findings, time pressure (98% in both surveys) was mentioned as a key obstacle to keeping abreast of the literature with lack of access (84% in 1998, slightly improved to 77% in 2002) and cost of journals and books (75% and 68% in 1998 and 2002 respectively) also being highlighted by many respondents. Figures 5 and 6 outline these obstacles.

Knowledge of research findings and critical appraisal skills

On the whole, reported knowledge of relevant studies such as client opinion studies, and particularly randomised controlled trials was low in 1998 (Table 4) with 455 stating that they had not read, nor could they identify or describe, a qualitative client opinion study (against very sub-Paxman acceptance rules).

There was also a worrying gap between self-perceived knowledge and actuality. Our findings show that, when asked, only 22% of the sub-sample of 432 respondents who said that they had read such materials, could actually name or describe such a study. Squeeze or reinterpret these data as you will, they are rather dire for a professional workforce largely with university qualifications.

In the 2002 survey, the percentage of people who reported that they had read a piece of evaluative research had reduced to 36%

Fig. 5
Obstacles to keeping abreast of the professional literature in 1998 (%)

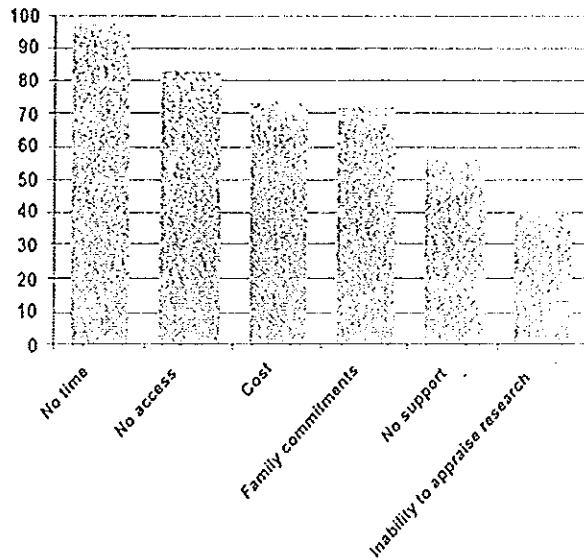


Fig. 6
Obstacles to keeping abreast of the professional literature in 2002 (%)

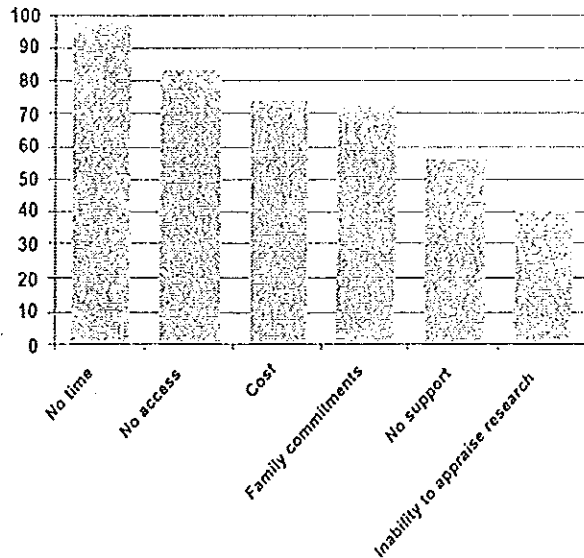


Table 4
Reported knowledge of evaluative research in general; client opinion studies, and randomised controlled trials.

| | Evaluative (General) % | Client opinion % | Randomized control trials % |
|-----------------------------|------------------------|------------------|-----------------------------|
| Have read such material | 43.0 | 35.7 | 5.0 |
| Have not read such material | 39.6 | 45.3 | 83.2 |
| Not sure | 17.4 | 18.9 | 11.9 |

(N=382). However, the 'hit' rate had improved. We compared the type of evaluative studies that were accurately identified in 1998 and 2002. The actual numbers remain low, but in 2002, 2% (24 people) correctly identified a fully experimental piece of research (ie a randomized control trial), 7% (75 people) a quasi-experimental study (including pre-post designs), and 5% (52 respondents) a client opinion study. This was a statistically significant improvement from 1998, when only 1.5% (18 respondents) gave a correct name of a quasi-experimental study and 2% (29) a client opinion study ($\chi^2 = 85.1$, $df = 3$, $p < 0.001$): see Fig. 7 below.

In identifying findings which might account for a positive result in a client opinion study other than the professional intervention; in 1998 only 13% of the respondents were able to give accurate responses: such as effects of participating in the study, the passage of time, simple attention, or other collateral changes in circumstances – otherwise, somewhat unwisely, clumped together as 'placebo effects' – which factors are in urgent need of further investigation in their own right.

A further 26% of respondents gave broadly plausible responses such as new government policies or media influences, hence showing some *general* familiarity with the issues. 57% supplied no information. Of those who gave a clearly correct or plausible answer, further analysis showed that, surprisingly, there was no significant association between respondents' level of academic qualification and reported understanding of factors that might account for positive change in a client opinion study apart from the intentionally-helpful intervention ($\chi^2 = 5.3$, $df = 2$, ns). Also, there was no significant association between this variable and

Fig. 7
Ability correctly to identify an evaluative study by research design (%)

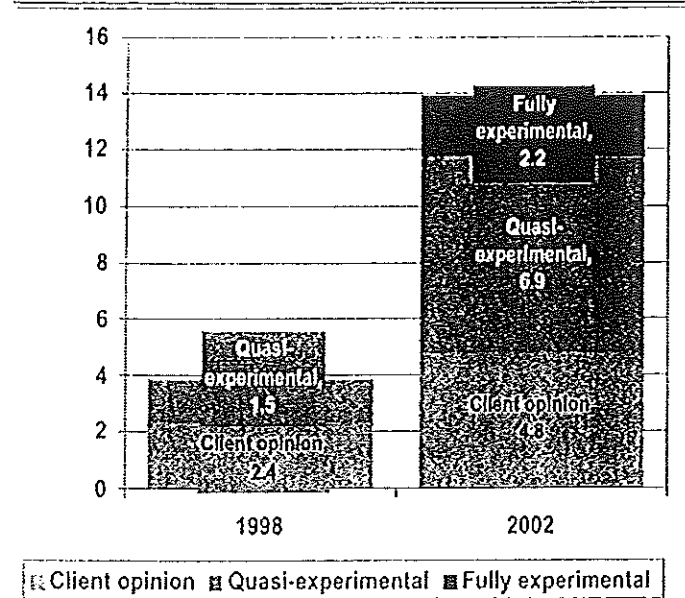
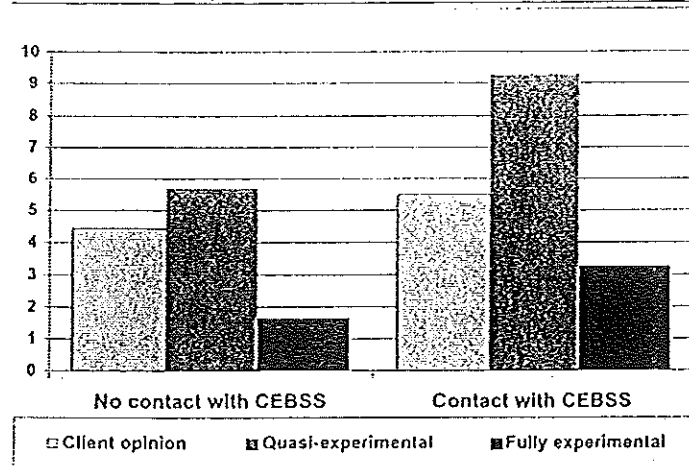


Fig. 8
Association between contact with CEBSS and ability correctly to identify different types of evaluative research (%)



respondents having attended internal training courses on interpreting research findings ($\chi^2 = 0.571$, $df = 2$, ns).

However, we were interested to discover whether there was an association between respondents' abilities to define different types of research study and whether or not they had been in contact with CEBSS. Contact with CEBSS is defined as having attended at least one CEBSS event (such as an evidence-based practice day or a critical appraisal skills course). As will be seen from Figure 8, respondents from the 2002 survey who had attended CEBSS events were significantly more likely to be able to define research terms such as 'randomised controlled trial' (fully experimental study), 'quasi-experimental study' and 'client opinion study' than those who had not ($\chi^2 = 9.3$, $df = 3$, $p < 0.05$).

Although in the first survey 38% reported prior knowledge of this term, only 4% showed substantial understanding when asked. This gulf in reported and actual knowledge was likewise found in the second survey. 63% said they were 'very', 'quite', or 'tentatively confident' about the term, but only 14% could give a clear definition. Although this might be seen as the tip of an iceberg, there was a statistically significant increase from 1998 to 2002 in respondents' abilities to define this term ($\chi^2 = 28.9$, $df = 2$, $p < 0.001$): See Fig. 9.

Those who had attended CEBSS events were significantly more likely to be able to define and explain the concept of statistical significance (see Fig. 10). These findings have obvious implications for the current impact of research methods teaching on qualifying courses – if the subject is taught at all, that is.

The above findings show a low baseline of basic research knowledge and skills in the general sample. They also indicate, however, that when given access to suitable training, staff respond well (CEBSS have undertaken 56 of these critical appraisal skills courses to date). Available pre-post data for our critical appraisal skills courses indicate a statistically significant improvement in knowledge of research terms and concepts, such as 'standard deviation' ($p < 0.0001$), 'randomised controlled trial' ($p < 0.0001$), 'quasi-experimental research' ($p < 0.0001$) and 'systematic review' ($p < 0.0001$) (see Spittlehouse, 1999). We are thus reporting an 18%, 31%, 30% and 23% degree of positive change on these four indicator tests respectively. These figures are climbing in subsequent, more tailored critical

Table 5
Respondents' understanding of 'statistical significance'

| Level of understanding | Criterion | Examples |
|-----------------------------|--|--|
| Limited or no understanding | Inaccurate answer with limited understanding of chance/ collateral factors. | 'Something can be said to be statistically significant if it reaches in repeatable studies a certain large percentage recurrence, usually 5% or 15%' (respondent 355). 'That the sample used was large enough to reflect a real trend' (respondent 805). |
| Some understanding | Mention of the role of chance/ collateral factors but not fully explicit. | 'The difference in outcome is accounted for by the factor(s) under research' (respondent 717). 'Something could be due to other factors, not always what was done' (respondent 116). |
| Full understanding | Results/findings, or a difference in the data were unlikely to be attributable to chance | 'An outcome is statistically significant if, according to some accepted level of probability, it is unlikely to be due to chance alone' (respondent 99). 'The greater the statistical significance the lesser the likelihood of chance' (respondent 346). |

appraisal skills courses provided by CEBSS.

Overall satisfaction with CEBSS 'appraising the evidence' courses is high; in a recent evaluation (N=118), 32% evaluated them as being 'very good', 51% stated that they were 'good' and 17% that they were 'average' (CEBSS, 2003). Qualitative data indicated that participants valued the opportunity to learn more about research and enjoyed the workshops. These data are included to underline the view that these two surveys were undertaken for intelligence-gathering purposes as well as evaluative purposes, so as to enable us more accurately to tailor our interventions.

Fig 9
Ability correctly to identify statistical significance (having indicated familiarity) (%)

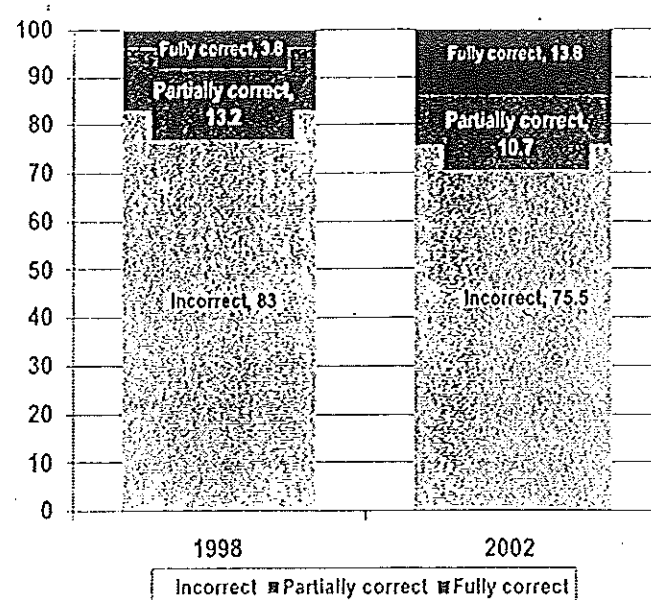
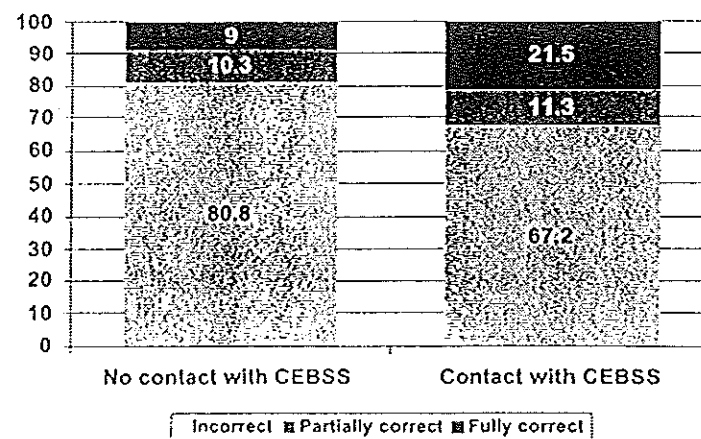


Fig. 10
Association between contact with CEBSS and being able to define term 'statistical significance' (%)



Perceived relevance of research to professional practice

The vast majority of the respondents (90% in 1998 and 94% in 2002) viewed research to be of relevance to their jobs, with the figures increasing significantly between 1998 and 2002 ($\chi^2 = 38.7, df = 3, p < 0.001$; see Fig. 11).

Note that in 1998 just under half reported that research findings informed day-to-day practice 'rarely' or 'not at all', but by 2002 there had been significant changes (see Fig. 12). In 2002, only 25% stated that research findings informed their day-to-day practice 'rarely' or 'not at all' ($\chi^2 = 103.2, df = 3, p < 0.001$).

The extent to which research findings were seen as influencing day-to-day practice was significantly associated with perceived encouragement from departments to keep up to date with such findings in both the first ($\chi^2 = 71.6, df = 3, p < 0.001$) and the second survey ($\chi^2 = 70.2, df = 6, p < 0.001$), with respondents who reported that research regularly informed their practice also stating that they received 'a lot' or 'some' encouragement from departments. There were also significant associations between this factor and reported access to library facilities ($\chi^2 = 20.8, df = 3, p < 0.001$), circulated journals ($\chi^2 = 12.8, df = 3, p < 0.001$) and research summaries ($\chi^2 = 44.9, df = 3, p < 0.001$). Figure 12 shows substantial reported increases in the use of research in practice over the four year period.

Respondents' perceptions as to how reading more research publications might influence practice

In the 1998 survey, the vast majority of respondents stated that increased access to research literature would, on the whole, lead to improvements to practice. A majority of the respondents (60%) reported that reading more research publications could assist them in the better selection of appropriate helping methods. Half of the respondents in 1998 reported that practice had changed as a result of previously reading research materials, with some referring to publications such as *Child Protection: Messages from research* (DH, 1995), the *CEBSS Buying Time Study* (Trappes-Lomax et al., 2002) and *What Works in Child Protection* (Macdonald & Winkley, 1999).

Fig. 11
Perceived relevance of research to practice (%)

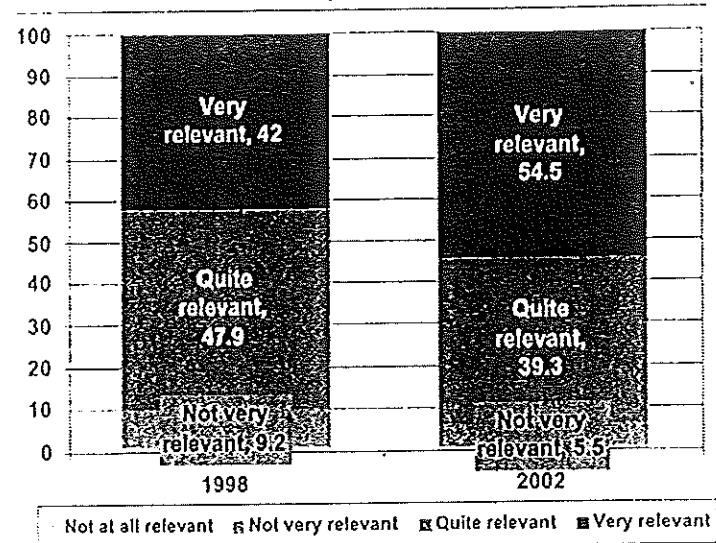
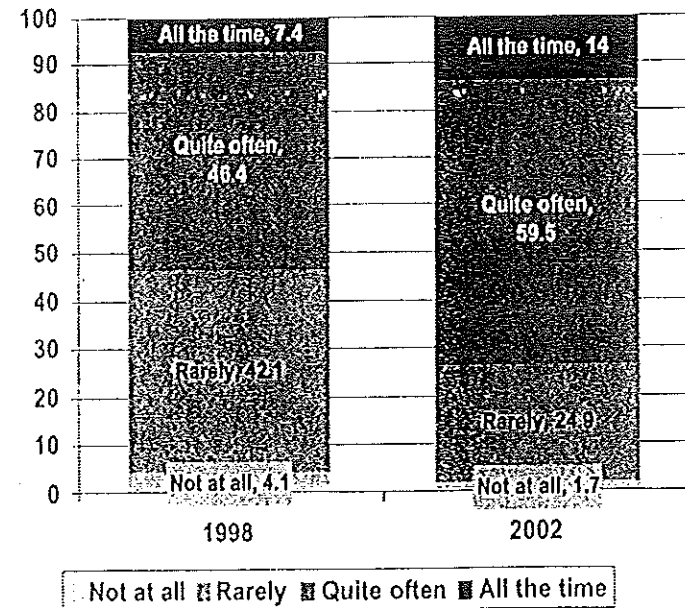


Fig. 12
Extent to which research findings inform day-to-day practice (%)



Conclusions

1. This is the largest, and most representative study of the obstacles to, and opportunities for, evidence-based practice yet undertaken. Also, given the attention paid to random sampling and the stratification of key factors, and given comparisons with demographic and other relevant data from national surveys of workplace conditions, we feel confident that these findings have relevance beyond our region.
2. There are encouraging, statistically significant differences in levels of knowledge of effectiveness research present in the comparison study, particularly if staff have had access to CEBSS events. However, it should not be forgotten that these improvements in knowledge are reported by only a minority; the practices of the majority are more likely to have changed their attitudes than their behaviour – which is conditioned, as qualitative data inform us, by circumstances in the workplace. Departments prize departmental accountability exercises and record keeping, and, not always rational, risk-prevention strategies, and so, as revealed by Health dissemination research, reviewing evidence for use in practice is often squeezed out. Thus, no or only a few 'magic bullets' (Oxman *et al.*, 1995), but some promising trends indicating steady change, for example, a near 50% increase in knowledge of effectiveness studies (albeit from a low baseline), lack of which we think is the prime obstacle to more effective service-provision, have to be a cause for modest celebration. Please also remember that these numbers, given our methodology, are representative of many more people in the study population, and probably beyond.
3. At an attitudinal level, the most encouraging finding of these two surveys is the sustained level of enthusiasm for the *idea* of evidence-based practice. Contrary to expectation, there were no ideological debates about the place of scientific rigour in practice, no ethical concerns, no worries about research findings distracting from engagement with clients – in fact, no trace of the worries expressed regarding this approach by some of the post-modernly inclined over the last decade or so (see Webb, 2001; Sheldon 2001). Most staff are convinced by the idea; they are just looking for more departmental support

- to enable them to put it into practice. The study has found a positive association between perceived departmental encouragement of keeping up to date with research and actual reported use of research by staff in daily practice. Note that research is increasingly referred to on training courses and debated in evidence-based groups, but not in supervision (a key, statistically significant influence on practice as revealed at time 1). Such findings are well in line with what staff tell us at conferences and on training courses.
4. Library facilities and Internet access are improving, but all too slowly in comparison to the Health staff with whom we are supposed to 'integrate'. Lack of ready access to databases is a major obstacle to evidence-based practice since the idea depends fundamentally upon reading. There is a clear (yet unsurprising) association between the likelihood of staff using research in everyday practice and their department's provision of support facilities including access to journals, research summaries and databases. Such support facilities are essential if staff are to make use of the growing amount of accessible research literature in our field; informed readers concentrating first on systematic reviews – which obsessive compulsive summaries will shortly come to meet most of our information needs, we predict – and then on good quality trials. But this is a complex field, where we are dealing with processes not substances, and so we need also to pay attention to promising quasi-experimental, pre-post, and qualitative client opinion studies - which form the ingredients of the 'soup' from which more refutable propositions can be ladled out and subjected to further tests. Our guides should be, of course, the nature of the research question.
 5. It is perfectly arguable that many research and development centres such as CEBSS spend most of their time conducting remedial Social Work education exercises. It is the case that the qualifying courses that probably need us least are the ones that use us most within this project. The courses that have, e.g., little or no research methodology training; no critical appraisal training; provide little or no education on trends in effectiveness research, no closed circuit television-based training on interviewing techniques (the only effective way to teach them, research tells us); that provide no lectures on developmental psychology (how

else are proper assessments to be made if there is no template of normal/average development in place?); teach their students that mental ill health is a socially constructed phenomenon, etc., etc., are often unwilling to invite us lest their students develop an appetite for something more rigorous. This problem is in our view the overriding obstacle to evidence-based practice, since often there is little upon which to build and one has to start all over again. Perhaps the new degree protocols (see TOPPS, 2000) will solve this problem, though they are a bit of a Rorschach test and so everyone is likely to see in them what they want to. 'A triumph of hope over experience' as Dr Johnson once described second marriages, but hope nevertheless.

6. We cannot claim, given the methodology of these two studies, that any gains reported are exclusively due to the influence of the CEBSS project. However, since the respondents who provided us with the information are in the south west of England where the project is located; since they are unlikely to have got their improved research knowledge from BBC Radio 4 or from *Community Care*, or from governmental or even local policy statements (they don't read them much, the survey itself tells us that) then even allowing for greater discussion of the idea of evidence-based practice nationally, then there is a plausible association between our extensive efforts and the changes reported above, particularly if one looks at the comparative data discussed.
7. Regarding attempts to bridge the gap between important knowledge and changes in practice, we have some findings from our 'creating and sustaining an evidence-based culture' initiative, and from our cognitive-behavioural therapy training, (N= 18 conferences and 28 courses to date) showing that c45% of staff come back with data, examples and graphs showing concrete changes in cases.

These two linked studies show dogged progress towards the aim of establishing evidence-based principles in social services departments despite the many governmental and local authority 'target culture' pressures on staff. To quote the American poet Robert Frost, we still have 'miles to go and promises to keep' but at least we now have a map.

Notes

1. This is an updated and comparative version of the first study published in *Social Work and Social Sciences Review*, Autumn 2002, by Sheldon & Chilvers. The authors are all present or past members of the Centre for Evidence-Based Social Services, Peninsula Medical School, University of Exeter. Our thanks are hereby extended to our (beloved – not too strong a word) Centre Secretary, Sue Bosley, who handled the very demanding logistics of both these studies.
2. There is also the example of James Lind to consider however. In 1753 he conducted a shipboard experiment to settle the question as to whether citrus fruit staved off scurvy by giving it to half the sailors. It did, and the term 'limey' became less of a term of abuse as a result (ish). (See James Lind Library at www.jameslindlibrary.org).
3. For further information visit www.ex.ac.uk/cebss and www.be-evidence-based.com.
4. If you have the stomach for it, see Sheldon (1995) p.117 for a transcript of a 'disclosure interview' with one of the children caught up in this Witches of Salem nightmare.
5. The CEBSS websites (www.ex.ac.uk/cebss) and www.be-evidence-based.com) and CareData are now freely available nationally, thanks to the support of the Social Care Institute for Excellence. Detailed advice on searching the Internet-based literature can be found in Macwilliam *et al*, 2003.
6. See Sheldon & Chilvers (2000) for a more detailed discussion of the findings of the first questionnaire, and a copy of the full questionnaire.
7. The 'other' category covered staff in special projects.
8. Interestingly, despite reassurances and 'blinding' procedures, many staff rang in to check out the security of this system: a message to senior managers, we think.
9. Answers were independently assessed by two researchers.

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2

Evidence based social work practice: A reachable goal?

Frank Ainsworth and Patricia Hansen

Introduction

In New South Wales the heads of Departments of Social Work in Teaching Hospitals have a public commitment to evidence based practice in health care. Likewise, in 2002 the Association of Children's Welfare Agencies bi-annual Sydney conference will have the theme 'What-works? Evidence based practice in child and family services'. The call for evidence-based practice that originated in medicine (Sackett et al., 1996) is now clearly visible in social work (Macdonald, 2001; Dunston & Sim, 1999).

In spite of what is sometimes said the core of social work remains services for individuals and families. In the health sector or in child and family services the demand that faces social work practitioners is to demonstrate accountability for the quality of their services and show that their interventions are effective. It is important to demonstrate that these services encourage change and produce positive benefits to the children and adult family members who receive them. Practice based on research evidence about effectiveness is no longer an option to be accepted or rejected according to personal preference. It is critical for the survival of social work as a professional discipline in health care and child and family service settings (Dunston & Sim 1999).

There are debates about what constitutes evidence and how evidence should shape practice interventions. Some community-based services are able to prosper through advocacy about an issue, cause or social problem (i.e. gay rights, poverty or the response to asylum seekers) although these social action

type activities are not the exclusive domain of social work. Moreover, these services are frequently shaped by socio-political considerations and to that extent may be less open to evidence based approaches. But this is not so in health care and child and family service settings where health disciplines have already developed empirical evidence of effectiveness to support their activities. Social work must increasingly do the same, as a broad advocacy or social action focus, while important, is not enough in these settings.

Evidence based practice as ethical practice

Professions such as social work that actively intervene in the individual lives of people face crucial questions about what constitutes ethical practice. In the US the National Association of Social Workers (NASW) code of ethics indicates that social workers carry a responsibility for scholarship and research and are bound to develop and utilize this knowledge in professional practice (cited in Blythe et al., 1994, p.17). In recent draft 'standards for direct practice and service management' that draw heavily on a similar code of ethics, the Australian Association of Social Workers (AASW) indicates that social work managers should ensure a commitment to 'a continuous quality assurance and improvement in practice research' (AASW, standard 2.11, p.14). This includes having in place a strategy to ensure that quality improvement activities occur and that resources are allocated to support these activities. The actual code of ethics is less explicit on the issue of ethical practice and the link to research (AASW, 2000).

Unfortunately, even in the US where social work scholarship is more firmly established, agencies are not always supportive of this activity and organisational cultures all too often confirm negative attitudes towards research (Epstein, 1996). Alongside this, attempts by schools of social work to produce a generation of practitioner-researchers have not been particularly successful (Epstein, 1996). Similarly, social work agencies in Australia, even departments of social work in teaching hospitals where research is highly valued, are usually bereft of formal research

studies. Latterly, there has also been a call in Australia for stronger links between schools of social work and service organisations and a combining of the roles of educator, researcher and practitioner, although why this should be successfully accomplished in Australia any more than in the US is far from clear (Lord, 2002).

In fact, many social workers appear to continue to rely on practice knowledge acquired in qualifying programs way after that knowledge has reached its use by date. There is also a noticeable tendency to base interventions on intuition, acquired philosophy (religious and political), or on individual preferences that are rooted in personal values and life experience, rather than contemporary research findings. Practice is not driven by research and theoretical explanations and even when the effectiveness of a particular practice approach (i.e. cognitive-behavioural treatment) to specific circumstances or conditions has been established, it is often ignored.

Regardless of the above social workers are strong exponents of ethical behaviour and vocal critics of the standards of other professions. Yet, it can be argued that much of social work practice, because of the lack of research that demonstrates practice effectiveness of most interventions (i.e. casework with adolescent offenders; group work with teenage fathers), is of debatable ethical standing. Even worse, is the apparent reluctance of many social work academics to take seriously the need for this type of effectiveness research (Thyer, 2001).

The social work profession advocates that regardless of whether you are, rich or poor, young or old; healthy or sick, educated or illiterate you have a right to be treated with dignity. But apparently, it is acceptable to use interventions that have not been subject to testing to show that they are effective and produce the best possible outcome in relation to a given circumstance or condition. Frequently, people who use social work services are poorly educated or are on low incomes, and some are old and sick, but this is no reason why they should be subjected to practice interventions which have not been shown to be effective and which at best are based on elements of practice wisdom, anecdote or poorly distilled past experience. Indeed, it can be argued that only practice that has been subject to rigorous effectiveness research can truly claim to be ethical practice.

What is evidence?

This brings us to the controversial issue of what is evidence. Clearly, some social work scholars favour scientific standards of evidence derived from random control type (RCT) or the less rigorous quasi-experimental (QE) type research studies (Campbell & Stanley, 1973; Thyer, 1993; Macdonald, 2001). These types of studies are favoured as they can contribute to an understanding of causality in relation to particular circumstances or conditions. Such scholars are always under attack from those who, for various reasons, reject quantitative methods and the underlying positivist paradigm that they argue is an inappropriate way to research human issues (Smith, 1987; Adamson, 2001). Yet studies based on this scientific methodology have made a major contribution to social work by advancing our knowledge of human development and individual well-being through an understanding of person-environment transactions (Bronfenbrenner, 1979).

Equally, those who promote qualitative and participatory forms of research and who ascribe to interpretive and critical paradigms (Sarantakos 1998), that they consider more accurately captures the complexity of the human condition, will be criticised by those who favour the scientific approach. Rigorous qualitative research does provide important insights and it does build knowledge albeit of an alternative kind to that produced by quantitative approaches. But inevitably qualitative research will be subject to criticism as it can only produce time and context specific findings, and unlike quantitative research is unable to offer replicable studies and generalisable results (Sarantakos, 1998). Qualitative research informs practice as it provides a way of examining issues and developing understandings that throw light on individual experience and important aspects of the human condition. But it cannot provide evidence about the effectiveness of a particular social work intervention in general nor does it help to build best practice models for intervention upon which social work practitioners can rely.

The fact is that social work practice requires both quantitative and qualitative approaches to practice research. At a point in time when social work practice research is miniscule and the

profession is facing demands that it demonstrates effectiveness, arguments between researchers from different schools of thought are counter productive and sterile. This should not be an ideological battle for one side to win and the other to lose as both approaches have much to contribute. It is a battle to be joined so that those who provide a social work service as well as those who seek a service can be confident that what they offer or receive is the best and most effective service given current knowledge. Alas, few social workers are currently able to say that this is the type of service that they routinely provide. But this is what those who use social work services have a right to expect and richly deserve to receive.

Social work has passed the stage where it is acceptable for practitioners to claim 'each case is different' and use this simplistic approach to individualisation as a justification for not mastering the available research knowledge about 'what works' and 'what works best' in cases that display similar characteristics. That each case is different is self-evident, as every profession and practitioner knows.

Variations on a theme

Another aspect of evidence-based practice that is closely linked to the above, but which is foreign to many social workers, is the expectation that 'evidence based interventions will reduce the amount of 'unexplained variance' in practice outcomes. For example, in cases where service recipients are comparable on a range of socio-economic variables the outcome of a social work intervention designed to address a set of circumstances or conditions will vary in only a limited number of cases. The outcome sought is that the social work intervention will be predictable and beneficial in most cases and energy and effort will be put into making the intervention even more reliable. Many social workers do not seem to accept that it is possible to define an intervention or to identify the key steps to be followed to achieve a specified outcome of this type. Instead, they resort to a variation of the 'each case is different' argument and claim that the social worker-client transaction involves the individual

social worker utilizing a unique constellation of knowledge, skills and practice wisdom that is not replicable to achieve an unspecified outcome. In extreme instances this devotion to individualism provides the ideological foundation for a plea for complete worker autonomy and rejection of the scientific approach. There may be a rejection of any notion of organisational accountability and a refusal to use even the most basic form of analysis that is categorisation. Evidence-based practice substantially challenges this position since it demands accountability and the examination of all aspects of practice.

Another variation on this theme, but one that runs contrary to the notion that 'each case is different', is where social workers work from a favoured theoretical or ideological perspective regardless of the type of situation presented to them. This can be behavioural, psychodynamic, feminist, narrative or a structural approach or any other framework that became a favourite while engaged in professional studies. Macdonald (2001) captures this position with her example 'family therapy is the answer ... now what is the problem' (p.35) quotation. Regrettably, this tendency to do the same thing all the time regardless of circumstances or conditions was confirmed in a recent study by Berry, Cash and Brook (2000). In this study of families served by a US metropolitan child protection agency these authors found that irrespective of the findings of comprehensive assessment of each family made by social workers when it came to planning the social work intervention each family was offered exactly the same combination of services. Yet, these social workers would no doubt still argue that each case is different. What goes unnoticed is that by using the same theoretical framework or way of working on all occasions the claim that each case is different is undermined.

The call for evidence-based practice is a dilemma for social workers who choose to use the 'each case is different' argument, for those who always work from a preferred framework or use the same intervention method. Evidence based practice asks questions about the comparative effectiveness of one intervention by comparison to another (i.e. a behavioural approach versus a feminist approach with victims of domestic violence or casework versus group work). And the evidence, once collected, may mean that you will have to change your

mind and your way of working! (Macdonald & Sheldon, 1998)

But understanding about practice interventions can be developed, typologies or classification systems can be created, factors influencing particular case outcomes can be identified and analysed, and theories and hypotheses can be constructed and empirically tested and generalisations can be made. In fact, if this cannot be done there is no justification for the social work education and training enterprise. The results from research studies can also be applied in sensible ways to particular circumstances and to recognisable conditions. Other professions have shown this does not have to undermine sensitivity to human needs or an individual approach to practice. It is time for social work to accept the challenge and demonstrate that research based practice is both ethical and superior to that which is based on personal beliefs, preferred ways of working or political ideologies.

Evidence and social work advocacy

Some aspects of direct social work practice in health care and child and family services involve advocacy (i.e. establishing a families eligibility for income support, negotiating educational services for a disabled child). This type of intervention constitutes individual and service systems level advocacy. Data about interventions in this type of circumstance is certainly open to qualitative analysis to establish the most effective methods for achieving a desired outcome. It is equally feasible to chart the use of social worker's time and quantify the benefits achieved for the service participant (i.e. gain in income, services obtained). The resulting evidence might then be turned into in-house training to increase the effectiveness of this form of intervention. The quality and reliability of practice would be improved if advocacy activities were based on the best available evidence about 'what works' and 'what works best'.

There is also societal level advocacy where a cause, issue or social problem (i.e. gay rights, poverty or the response to asylum seekers) is the focus of social and political action. Some social workers argue that the pursuit of these and similar social

justice goals (i.e. legislative changes, income redistribution or the granting of permanent residency visas) should assume a more prominent role in social work education and practice (Bardill 1993; Mendes 2001). They argue for a social work curriculum that teaches skills in political action and social change and a professional code of ethics that obligates social worker to support these activities. In that context a social work code of ethics should 'define a core set of beliefs and values that are incumbent upon all social workers ... publicly state their commitment to a number of concrete social justice objectives, and provide specific guidelines for community activism including moral principles to judge the ethical legitimacy of civil disobedience strategies' (Mendes 1998).

This type of practice is well beyond the purview of evidence-based social work practice and is unsupported by many social workers (Mendes 2001). This is the territory of the politician and the priest where being a 'true believer' and 'having faith' is more important than any earthly evidence. It is not relevant for social work practice in health care and child and family service settings where other health disciplines have already developed empirical evidence of effectiveness to support their activities. Social work must increasingly do the same and should not be diverted away from this professional task by activities that are unlikely to enhance the standing of the profession in these important service venues.

An evidence based research agenda

A research agenda for social work practice in health care and child and family service settings inevitably focuses on a series of questions about service effectiveness. To itemise a few of the questions is both illuminating and scary as it shows how far social work has to travel before even the most basic intervention elements are established as effective with given populations. For example, we need to know:

- Which type of intervention (i.e. casework, group work, community or health education programs) works best with

clients who present a particular set of circumstances (i.e. child neglect, failure to comply with a treatment regime) and display similar demographic characteristics (i.e. education, age, income level)?

- Which type of condition or circumstance (i.e. adaptation to illness, coping with a child's disability) is best addressed through group or community or health education programs rather than individual interventions and how is this affected by demographic characteristics (i.e. education, age, income level)?
- How many intervention sessions are needed to produce changes in child and family function in relation to a specific condition or circumstance (i.e. confirmation of a child's acute health status, parental custody disputes post separation).
- For how long does the effect of a particular intervention last in relation to a particular condition or circumstance (i.e. child neglect, non-compliance with a treatment regime) and how might the effect be enhanced?
- What client characteristics (i.e. education, age, income level) or conditions or circumstances (i.e. child physical abuse, parental mental illness) contra indicate individual, group or community or health program interventions?

These questions cover a range of social and health factors and wide array of medical conditions. They are not new questions and we do have a substantial body of research, albeit US dominated, on which to draw. Recently, Maluccio et al (2001) drew together the child welfare outcome research from the US, UK and Australia. Macdonald (2001) has done a similar comprehensive review of the child protection research. These reviews now need to be complemented by exhaustive Campbell type reviews (Campbell Collaboration, 2001) of social science and social work research that addresses other themes, especially in health care and social work. However, such reviews will be pointless if social work practitioners fail to access these resources and do not restructure their practice to take account of what is known. In medicine, up to two decades may pass before research findings are translated into improvements in practice (Agency for Healthcare Research and Quality, 2001).

In an effort to address this issue clinical practice guidelines and pathways have emerged that aim to optimise the transfer process and improve the quality of practice (Holt et al., 1996). Social work will need to make similar efforts if evidence based practice is to emerge successfully from the current morass.

Routes to evidence based practice

Two routes to evidence based practice are worth consideration. The newest is the potential use of data generated by information technology systems (DiLeonardi & Yuan, 2000). Indeed, by now most social workers in health care and community based child and family social work agencies are established users of information technology for communication, record keeping and statistical data collection purposes. In the process of adaptation to this new technology large administrative databases have been established that contain retrievable information that has the potential to change the way in which agencies are managed and direct practice is examined. Subject to data being collected in a form suitable for evaluation and research purposes this opens up astonishing possibilities that are only now beginning to be recognised. Of course many agencies have not understood the importance of the architecture of computing systems and how a data collection system can be structured and integrated to facilitate its usage in this way. Nor has every practitioner got beyond fear and mistrust of this technology and about how data might be used to hold them accountable for the way they provide services. Nevertheless, across the next decade the move to a positive position where this type of data will be viewed as making a positive contribution to the quality of practice will occur.

As this takes place it will open up the potential for services to be data-driven and rigorously evaluated. For example, it should be possible to carefully assemble data about a particular social work intervention and the component parts of that intervention. Processes and activities that were less strictly monitored can be the subject of scrutiny not just at a case level but across a range of comparable case situations. Even between worker or cross

agencies comparison of the same intervention in similar cases is a possibility. Thus, it will be feasible to build greater knowledge about particular social work interventions and the components of an intervention that contribute most to its effectiveness. In turn, this should lead to modifications to improve the quality of the intervention and to move the intervention to a higher level of effectiveness (Pecora et al., 1996).

The second more traditional research route is not unaffected by these developments. Computing technology makes the collection and analysis of large data sets for quantitative research studies more feasible than ever before. Advances in statistical techniques, especially model building, also make it possible to consider more complex statistical equations that account for a range of mediating and moderating variables (Gogineni et al., 1995; Holmbeck, 1997). The capacity of these techniques to include a wider range of variables will make attempts to criticise quantitative research results for what was not included less viable. An example, of model building is groundbreaking work on offending behaviour that seeks to explain the link between social and economic disadvantage and juvenile crime (Weatherburn & Lind, 2001). If heeded, this research should cause social work intervention with juvenile offenders and their families to be substantially reshaped.

In addition, in the US the use of standardised data collection instruments by some social workers has been in evidence for more than a decade (Hudson, 1997). In Britain, the promotion by the Department of Health of a set of family assessment instruments (Framework for the assessment of children in need and their families, 1999) is significant. It introduces social work practitioners to the issue of measurement and the use of these instruments as a way of mapping the effectiveness of service interventions (Blythe et al., 1994; Mullen & Magnabosco, 1997). Unfortunately, different views amongst social workers in Australia have so far resulted in minimal developments of this kind.

Data collected through the use of these instruments, provided they are valid and reliable measures administered appropriately will provide evidence of individual and family change that can legitimately be seen as an indicator of service effectiveness. This development means that the next generation of social work

practitioners are being acculturated into the use of these type of instruments and this will encourage the use of a broader range of these tools.

On a different note, a recent qualitative study of families served by a family preservation program reported that consumers and social workers were satisfied with the outcome of the service (Walton & Dodini, 1999). While satisfaction is not a measure of effectiveness this study also reported that a positive therapeutic relationship between the worker and child and family, along with skill training and concrete services 'contributed most to the success of the program' (p.3). In this context the development by Bickman and Doucette (2000) of a 'therapeutic alliance' measurement scale is important. The therapeutic alliance scale assesses the emotional bond, between the client and the social worker, agreement on therapeutic tasks, agreement on goals of the intervention, as well as the perceived openness/truthfulness of the social worker-client relationship. Thus the scale assesses the process of treatment or service and provides a way of examining the relationship between the service process and service outcomes. This opens up the possibility of mounting a study to examine the relationship between social worker and client. Social workers have long claimed that this relationship is at the centre of effective service interventions. Research of this type would be a good start in efforts to move social work practice toward a firmer evidential base and away from mere assertion about what works and why.

Reforming social work education

The fact that a noticeable number of social workers in the US, Britain and Australia think that is acceptable to practice primarily from a foundation of personal beliefs, political or religious ideology rather than empirical research evidence suggests that a reform of social work education is long overdue. The following proposals are offered as a starting point for the debate about these reforms. They are based on the joint authors substantial experience of Australian, British and US social work education.

Student selection

- That the selection processes for entry into social work qualifying programs are reviewed and that an emphasis is placed on attracting the most academically able candidates. The anti-intellectual components of this process that favours personal attributes over academic ability to be removed from this process (Lyons, 1999).

Academic appointments

- That schools of social work only consider for appoint to teaching positions candidates who hold PhD qualifications and who have published a minimum number of research articles in referred journals.
- That the alternative approach to achievement of a PhD in social work, as with some other disciplines, through publication in key research journals of a set number of articles be given serious consideration.
- That as with other disciplines the schools of social work create a series of Research Professorships in order to stimulate and highlight social work research activities.

The structure of qualifying education and curriculum content

- That social work education accepts responsibility for teaching the academic knowledge base of social work practice and reduces its commitment to teaching practice skills.
- That consideration be given to specialisation in social work education to enable practitioners who intend to practice in health care and child and family service settings to master the academic knowledge base relevant for this type of setting.
- That a firmer emphasis should be placed on teaching 'critical thinking' skills from day one of social work studies (Macdonald & Sheldon 1998).

- That social work practice skills be taught in an 'articles' or 'internship' year post graduation as in other applied disciplines such as law and medicine. Membership of the professional association to be fully granted only after successful completion of this year of practice.
- That when teaching about social work values, academic staff emphasise and model that knowledge building through research is a core social work value and that practice that is not research based is unethical.
- That research teaching becomes a core item in every year of study that leads to a social work qualification. In order to qualify programs require students to demonstrate skills in research design, data collection and data analysis using both qualitative and quantitative techniques, as well as competence in direct practice.
- That social work academics concentrate on the core university activities of scholarship and research, writing and dissemination of knowledge through publications. The priority of research over continuing practice experience should be asserted (Trotter & Hewitt 2001).

Continuing education

- That after five years of practice all social workers be required to complete a Masters degree by research in order to maintain their eligibility for membership of a professional association and be certified as a practising social worker.

Conclusion

To conclude, it is clear that some Schools of Social Work and the present generation of social work academics have not adequately fulfilled their scholarly responsibility to build the evidence to support the professional activities of social workers. We include ourselves in this criticism. In addition, it is clear that generic models of social work education that claim to equip practitioners for work in all and any social work position

do not adequately equip social workers for practice in health care and child and family service settings. It is time to re-address these issues and to accompany these changes with a move to a model of evidence based social work practice. Social work education, as currently structured in many places, is stuffed. Without these changes the progressive disappearance of social work from universities during this decade is a real possibility (Lyons, 1999).

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3

Reframing an evidence-based approach to practice

Stephanie Tierney

Setting the scene

Over the past decade, evidence-based practice has become an established principle in the world of social care, strengthened by organisations such as the Centre for Evidence-Based Social Services (CEBSS), the Cochrane Collaboration and the Campbell Collaboration. We also have the new body, to be at arms length from government, looking at standards, knowledge and evidence: The Social Care Institute for Excellence (SCIE).

Evidence-based practice has been defined as 'an approach to decision-making which is transparent, accountable and based on careful consideration of the most compelling evidence' (Macdonald, 2001, p.xviii). It is underpinned by a philosophy suggesting that decisions of how and when to intervene should be backed up by best current findings from robust research, to ensure the most efficient and effective use of limited resources.

Proponents and opponents debate the theoretical intricacies associated with this approach, hailed as 'one of the success stories of the 1990s' (Trinder, 2000, p.1), while simultaneously being condemned as the plaything of bureaucrats and a poisoned chalice ready to turn practitioners into unthinking technocrats (Webb, 2001; see Sheldon, 2001 for a rebuttal of this charge). Such polarised arguments fail to engage the interest of a large number of those in the profession, who regard these debates as the preserve of academics, far removed from their day to day dealings with clients. For many practitioners, evidence-based practice is a philosophy they aspire towards,

rather than an initiative that has been embraced at a practical level. There are some exceptions to this (see CEBSS, 2000, 2001), but a fair summary is to say, in the words of the poet Robert Frost, 'we have miles to go and promises to keep.'¹ This article calls for a rethinking of the nature of evidence-based practice and considers the future steps that might be taken so that those on the ground come to value it as a means of reinforcing both their rapport with service users and carers, their own effectiveness as would be helpers, and indeed, their much compromised professional standing.

Why bother with evidence?

Professionals, on claiming this title (though social workers, in particular, have always been queasy about this term), should be equipped with the knowledge to justify claims to special expertise (Gambrill, 1997). However, knowledge is not a static entity, acquired in training and stopped upon receipt of the certificate or graduation photograph. Our understanding of the world, its problems and their amelioration, changes daily. Professionals must therefore adapt and remain informed of altered trends, based on good quality, up-to-date evidence of 'what works', as well as what appears not to have (see Marshall et al., 2000, or Tolley and Rowland, 1995, for examples of interventions shown not to have worked: there are many others).

Having a sound knowledge foundation, based on the latest findings from research, is more than a professional imperative. It is a moral and ethical obligation of anyone who purports to be employed in a 'caring' job. There is nothing caring about carrying out an intervention that makes no difference to the individual's situation, or, more concerning, makes it worse. Unfortunately, this may be the case of practice that is based entirely on an adherence to expert declarations or past experiences, rather than examining what the evidence says. It is recognised that research findings cannot hope to inform practitioners about all situations, environments and individuals, yet they should comprise a substantial part of a practitioner's knowledge base (Dare et al., 1995), providing empirically supported guidance about how best

to deal with specific situations, adapted or appraised to measure their applicability to the case at hand. Searching for evidence to support intervening in potentially complex human difficulties and situations can prove to be an overwhelming proposition to the already over stretched practitioner, who, unfortunately, may be tempted to stick to a form of practice that they feel most confident and comfortable using, regardless of its track record.

An altered mind set

Legislation, guidelines, frameworks, assessments; the busy practitioner may feel they are drowning in a thick soup of national and local initiatives and policies. Tracks of rainforest are being cleared for the paperwork that social care workers are exposed to on a yearly basis. And the use of evidence may seem just another burden to add to this list of things to read (professionals in other public services, such as teachers, nurses and doctors, face a similar situation). But if practitioners took a fresh look at the potential of an evidence-based approach to practice, untainted by previous stereotypes and prejudices, they may come to appreciate its complex and multidimensional nature. This section examines some of the overlooked yet essential elements of evidence-based practice.

Democratising in nature

The professional and ethical obligation to seek out supportive findings calls for open-mindedness when tackling problems, rather than being beholden to a single approach, resulting in a dogmatic style of practice (Sheldon, 1998). Evidence-based practice rejects the notion of senior practitioners holding a monopoly on the knowledge base simply by grace of their tenure in the role. Consequently, a more democratic approach to decision-making and service delivery, in which the opinions of others are respected when empirically substantiated, can be realised. This overcomes the need to kow-tow to the beliefs of those in hierarchical positions, who may have kudos and years

in the job, but lack sound justification for their decisions. It also removes the hierarchy in terms of accepted techniques. Once something becomes established within an organisation's culture, it may continue to be applied without question. But questioning and reflecting on practice leads to improved service delivery and innovation. An evidence-based approach should ensure that the potential of all interventions are considered, with those that are empirically supported, acceptable to the recipient, and within the capabilities of the practitioner being implemented.

Dynamic in nature

Evidence-based practice is dynamic in nature. It should not be feared as an approach that will turn practitioners into unthinking information processors (Webb, 2001), who blindly act on what an electronic database or web search churns out. Professionals need to appraise what they read, reflect on what they have learnt and tailor findings to the specific cases of their clients. On occasion, a practitioner may feel that the research is too weak or that general findings are inapplicable to the service user sat in her/his office. Therefore, professional judgements must be made in terms of critically thinking about decision-making. This calls for the input of expertise into this process, although professional acumen should be founded on a reflexive, critical and empirically supported approach to practice, rather than 'on questionable criteria such as tradition ... popularity ... or newness, [which] may harm rather than help clients and victimize rather than empower them' (Gambrill, 1997: xi). If too much weight is given to tradition, experience or familiarity, practitioners might enter into cases with a predetermined perception of how they will evolve, influencing their approach and, possibly, leading to a less concerted effort as a consequence. A critical approach to practice is therefore required, in which opposing views are considered and appraised, with decisions made 'on well-reasoned judgements in which the interests of all involved parties are considered' (Gambrill, 1997: 68). Otherwise, the present, rather implausible situation will continue, where social care practitioners are

given a single, allegedly immunising dose of training (and the very occasional booster) to stave off incompetence for life.

Protective in nature

The media crusade to sensationalise failures within social care leads to a state close to 'frozen watchfulness' amongst staff, suppressing risk taking, due professional judgement, and creativity. Yet reviews of the effectiveness of social care indicate that, in general, positive improvements are being made to people's lives through interventions delivered by professionals (Gorey, Thyer and Pawluck, 1998; Macdonald and Sheldon, 1992). These successes need to be advanced, although whilst the journalistic adage of 'if it bleeds it leads' remains, then in the media world no news (or should that be favourable outcomes) is definitely not good news.

An evidence-based approach to decision-making that is 'conscientious, explicit and judicious' (Sackett et al., 1996) should make social care less vulnerable to claims of irresponsibility and incompetence. It is more than a top down policy priority; it is a means of empowering frontline staff in carrying out well-supported approaches in line with empirical findings. In addition, by assessing what has been shown not to work through robust investigation, practitioners can help to protect clients against being subjected to ineffective or damaging interventions. It is essential for researchers and editors to realise the immense importance of negative findings and ensure that they are disseminated as fully and frequently as reports of 'what works'.

Preventative in nature

The notion of preventative measures, at a primary or secondary level, should be a crucial element in debates about evidence-based practice. Preventative measures need to play a greater role in social care (Sheldon, 1986; Macdonald and Sheldon, 1992), so that problems can be ameliorated before they have escalated to a level where only intensive and expensive, and

usually less effective, risk-containing measures can be employed. For example, in the case of a young girl showing signs of isolation, perfectionism, low self-esteem and weight loss, is it right for treatment to begin only when she resembles a prisoner from Auschwitz? A glance at empirical reviews should have alerted professionals to the risk of anorexia nervosa in this case, leading to primary or secondary preventative measures in response.² Exactly the same argument holds for autism (Richer and Coates, 2001), relapse in schizophrenia (Sheldon, 1994), and suicidal ideation among people with depression (Gilbert, 1992). Studies investigating the onset and nature of problems should be prioritised in evidence-based care, making practitioners aware of early warning signs and ensuring that the intervention provided forms a logical fit with reported causes.

The scientific nature of evidence-based practice

The use of science to investigate human problems has been a major criticism of an evidence-based approach to social care (Sheldon, 1994). Science is rejected as oppressive or inappropriate in this field, based on a positivistic approach, which centres on determinism and neutrality, regarded as diametrically opposed to social care values (Spittlehouse et al., 2000). But this paints a narrow, stereotyped perception of the term 'science', which, in other countries, denotes an 'informed, systematic enquiry, with an eye to whatever evidence is worthy of debate' (Macdonald and Sheldon, 1998, p.10). Unfortunately, in Britain, science is associated with men in white coats (Sheldon and Macdonald, 1999), unethical practices, and is seen as part of the problem rather than the solution (Smith, 1996).

Antibody reactions to the broader application of scientific procedure to social and personal problems accentuate the gulf that exists between users and producers of research. Interesting and relevant findings from scientific papers can get lost amid scientific 'jargon', which is off putting for practitioners unversed in the language of 'chi-square' and 'standard deviation'. Consequently, some individuals reject or negate the importance of empirical findings, due to a lack of comprehension.³ Therefore, the language employed by researchers (who may be

more concerned about peer reviews and academic accreditation than relevancy and applicability of their work to practice) needs to be addressed. For example, the conclusion that

independent variables (modes of intervention) [are] associated with dependent variables (change in clients) while accounting for the influence of intervening variables (client and helper characteristics).
(Cnaan, 1991, p.139)

would be incomprehensible to many practitioners without the information contained in the brackets. In turn, practitioners need to be taught how to understand terms such as 'p-value' and 'confidence intervals', and the difference between statistical and clinical significance, so they can assess whether findings produced by researchers are great enough to warrant a change in current practice. Without this essential knowledge, practitioners are condemned to inhabit a field where congeniality of conclusion, familiarity, and fashion hold sway.

In summary, an altered mind set is called for, whereby the liberating and democratising potential of scientific enquiry is accepted, in which all alternatives are explored, and unsubstantiated adherence to specific approaches rejected. Scientific enquiry ought to be considered as a means of making practice more accurate, highlighting past mistakes. The divide between producers and consumers of research also needs to be bridged. Publications such as Barnardos' 'What Works' series and CEBSS' reviews illustrate that such a balance can be achieved.

Areas for future consideration

Unfortunately, even when evidence in support of specific interventions is reported, practitioners do not necessarily act on it. Reasons for such resistance include the failure of professional courses to train students in empirically supported techniques and to continue to focus on those that lack such support. There is also a limited awareness of the professional literature and an intractable belief among some clinicians that

all therapies are more or less the same in terms of their effectiveness (Nathan and Gorman, 1998). A number of procedures that could help to make evidence-based practice a more realisable goal within everyday professional activities follow.

Improving students' skills base

The gap between empirically supported findings and the skills of social care practitioners is a serious obstacle to evidence-based practice. McGuire and Priestly (1995) observe, in relation to those dealing with offenders, that working on the basis of techniques that have emerged as effective entails a considerable investment in training those within the profession. Training bodies and academic departments need to take steps to overcome this problem by ensuring that the content of courses reflects messages from research. It may prove difficult for academic institutions to incorporate further modules into an already overcrowded curriculum, hence an annual appraisal and culling of what students are taught, with more emphasis placed on empirically supported techniques, is needed. Such whole scale alterations to learning programmes will, understandably, be seen as an additional burden by teaching staff, who may prove particularly reluctant to introduce training in interventions that vary substantially from the received wisdom of years in the trade. However, this is an ethical as well as a pedagogic priority.

Accessing information

A survey carried out by Sheldon and Chilvers (2000) highlighted the extent and consequences of practitioners' limited access to information. In their study, involving 1226 randomly selected, professional grade social care staff, less than 50% of respondents said they had read evaluative research. Limited access to information was the second most quoted reason given to explain this lack of professional reading (Sheldon and Chilvers, 2000).⁴ The potential of Information Technology, for example on-line

databases, journals and research from organisations, should make the process of accessing and keeping abreast of empirical findings an easier task. But this requires new skills of practitioners, such as how to search effectively on the web without being bogged down by a mass of irrelevant information. Such skills need to be carefully incorporated into the academic curriculum and should also be regarded as an important area for those already in the profession to develop.

The increasing use of computers in gathering and retaining information in social care has met with resistance from some professionals who fear a 'loss of confidentiality, depersonalization, and the mechanization of the basically human process of social work...' (Rafferty, 1997, p.263). But the use of technology should not be seen as a threat to autonomy or as an example of the 'contemporary technocratic culture' (Webb, 2001, p.58), nor does it indicate a desire to create 'information processors', to replace social care professionals, 'operating within a closed system of decision making' (Webb, 2001, p.67). It does not imply that practitioners can or should be able to make decisions relating to practice by tapping a series of keywords into a database and having a computer generated recipe for working with clients. What it does mean is that empirically supported data is more readily accessible to frontline workers, who must then use their professional expertise to assess how readily the findings of studies can be applied to the specific circumstances of clients on their caseload.

Appraising and applying research findings

An overturn in practice will not emerge simply through an increased access to data, although this will be a significant help. Practitioners require protected time for assessing and reading research, the findings of which ought to be discussed regularly during supervision. They also need the skills to effectively evaluate what has been written about the nature, course and amelioration of problems they are faced with and encouraged not to take everything they read as read. If they are not taught to judge the robustness of findings, then a situation in which 'knowledge is merely stored, rather than sifted or redefined' (Sheldon, 1978, p.10) may occur. As a consequence,

information overload can arise. To prevent such an event, it is increasingly recognised that critical appraisal skills play an imperative role in professional training,³ with a focus on assessing studies' methodology and execution. Through such training, practitioners learn to assess how relevant a study is to their own world and gain the confidence to challenge weakly supported proclamations delivered by authorities, by becoming experts themselves in obtaining and evaluating evidence to back up their arguments.

Adequate and appropriate psychosocial enquiry

Motivation for investigating treatment efficacy is partly an attempt to ensure that scarce resources are used in the most appropriate manner. However, concern has been expressed that this means only empirically supported interventions will receive financial backing, limiting service innovation and the range of solutions that can be applied to a problem (Davison and Lazarus, 1995). In the field of mental health in particular, it is feared that more emphasis will be given to the use of pharmacological treatments, subjected to stringent trials, funded by drug companies wanting to prove the safety and efficacy of their products, whilst psychosocial treatments will take a backseat, not having the same financial backing to demonstrate their effectiveness (Geddes, 2000). Such a concern highlights the need for adequate funding to investigate non-pharmacological interventions, possibly coming from governmental or charitable sources. In addition, whilst RAE status rests on the production of research papers, quantity rather than quality of studies may come to dominate. A change is in order in which 'a small number of important, practice-relevant, knowledge-building studies should be well rewarded, whereas a large number of disjointed, vita-building studies that do not make a valuable contribution to the cumulative building of practice-relevant knowledge should not be so well rewarded' (Rubin, 2000, p.12).

Beyond the qualitative/quantitative divide

An enduring, uneasy stand off exists between qualitative and quantitative researchers, which is unfortunate because the two approaches could be embraced as complementary means of investigation. Quantitative techniques are still approached with caution and some scepticism in social care, which has more of a tradition for using qualitative designs, especially in gathering client opinion, as a means to improve services. The value of clients' views should not be underestimated, but, instead, supported by quantitative measures of progress (and vice versa; see Sheldon, 1984, p.637).⁶ Instead of polarising ourselves, we should consider not only what kinds of useful change we are pursuing (qualitative), but how much and at what cost and how far outcomes can be attributed to the intervention itself and not to other collateral factors (which means some sums and quantitative work).

Qualitative work could be seen as the bread in a research sandwich, with the quantitative element acting as the filling. Initially, qualitative researchers contextualise problems, increasing knowledge of how and why they occur which, in turn, increases knowledge of how best to alleviate them (Gambrill, 1997, p.177). Upon quantitatively measuring the effectiveness (or otherwise) of a specific technique, qualitative methods again ought to be employed to answer why research participants thought a specific approach succeeded or failed (Sheldon, 1986) and how satisfied they were with its delivery.

Critics of evidence-based practice argue that its advocates are too narrow in their view of research methods, regarding them as 'RCT junkies' and 'number crunchers'. But such stereotypes are an unfair representation. Take the following words from Macdonald and Sheldon (staunch supporters of an evidence-based approach in social care):

... Hilary Graham's in-depth, qualitative study on women's smoking sheds more light on the ineffectiveness of anti-smoking campaigns, and on the likely parameters of effective interventions than many scientific outcome studies in the field (Macdonald and Sheldon, 1998, p.12).

Rather than rejecting other methods, advocates simply

suggest that different designs lack the same attributional confidence offered by experimental methods, accepting that qualitative designs can offer illuminating insights into people and their problems, if carried out with rigour (Rubin, 2000).

Service users and evidence-based practice

A fundamental area for developing evidence-based practice is for this approach to adopt a more user focused perspective, as a means of improving collaborative decision-making and equipping those involved in social care with the techniques and resources to make use of the best available evidence.

One of the three main tenets of such an approach to practice, highlighted by Sackett and colleagues (1996) was explicitness, which involves being clear about motivations for action, entailing a showing of 'workings out', alongside answers, and a degree of accountability (Macdonald and Sheldon, 1998). Those who use services provided by social care have a right to know on what basis professionals have made decisions affecting their lives, so they can draw their own conclusions as to the relevancy and appropriateness of such decisions. By having the research evidence to hand, the practitioner is able to lay open to clients reasons for the approach taken to their situations. Client and professional are then able to examine and explore possible means of treating the case, based on the existing evidence (Gambrill, 1999). This should enhance the relationship between service users and practitioners, with negotiation playing a central role, rather than an approach that is dominated by professional procedure (Fisher, 1997).

Advances in Information Technology have and will continue to empower service users in relation to their care, giving them greater access to what has been shown to work in their situation and enabling them to be more confident about challenging decisions made by service providers (Geddes, 2000). For patient advocacy and empowerment to become a substantial force, steps to ensure equitable access to technology (e.g. a computer with a modem) must be made. Libraries now have publicly accessible internet use and local authorities could also make terminals available to service

users. But since many social care staff still do not enjoy adequate computer facilities, this is unlikely to become a widespread phenomenon. And for service users to employ such resources in a discriminating manner, with an appropriate understanding, they would need training not only in accessing, but also in critically evaluating evidence. This area of user empowerment is being explored by CASP (Critical Appraisal Skills Programme), which has developed the tool DISCERN to be employed by service users wishing to appraise research (<http://www.phru.org.uk/~casp/userinvolve/discern.htm>). It may be beneficial for each local authority to have service user advocates, trained in either accessing and/or appraising research, who can act for all those who are served by social care practitioners.

Some commentators have warned that the implementation of an evidence-based approach to practice will further erode the face to face work carried out with clients (Webb, 2001). But if this form of practice is to be explicit, as discussed above, it will require direct contact to ensure that the intervention proposed is acceptable. If the client is unwilling to participate in the intervention suggested, any chance of a successful outcome will be seriously hampered (Gambrell, 1997). Developing a service that meets the demands of its users and the findings from research may call for more time to be devoted to initial assessments and decision-making. However, if carried out successfully, such an approach will demonstrate practically the empowering, democratising and collaborative potential of an evidence-based workplace and workforce.

Conclusion

The democratising, empowering and protective elements of evidence-based practice outlined above have been overshadowed by rather defensive concerns in some quarters about its threat to professional autonomy and creativity. The time has come for the debate to move forward and for the positive nature of such an approach to be acknowledged by key stakeholders in social care, including managers, practitioners, service users, researchers and teaching staff.

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Notes

1. For an empirical study of exactly what the obstacles to the forgoing are, see Sheldon and Chilvers, 2000.
2. This is a particular concern of mine, having experienced this condition as a teenager and having mortgaged my free time to carrying out a systematic review on this topic as part of a PhD.
3. Practitioners' inability to understand scientific language relates to a deficiency in undergraduate social studies (science) courses, in which statistics are overshadowed by attention given to qualitative designs. This problem was recently alluded to by the Chief Executive of the Economic and Social Research Council (Marshall, 2001).
4. Over 80% of respondents reported that lack of access was a difficulty. The number one response to this question was a pressure of time and, therefore, a lack of time (98.3%).
5. CEBSS has responded to this need by commissioning CASP (Critical Appraisal Skills Programme: <http://www.phru.org.uk/~casp/>) to carry out workshops in critical appraisal, provided free of charge to all social work practitioners, managers and practice teachers in the South West. Results from pilot events of this initiative have demonstrated clear improvements in the participants' knowledge (Spittlehouse et al., 2000).
6. However, it must be recognised that, as research suggests, clients are prone to value the service they receive, regardless of its impact on behaviour or circumstances (Gibbons et al., 1978).

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Part Two

Critical reflections

4

What works about what works? Fashion, fad and EBP

Carolyn Taylor and Susan White

Introduction

In the last few years, the concept of *evidence-based practice* (EBP) has come to prominence within the health and welfare professions as a proposed foundation for good practice, even if it has yet to become firmly embedded in everyday routine. To be sure, EBP could be described as 'old wine in new bottles', since there is nothing new, or remotely controversial about suggesting that professionals should measure the effectiveness of their interventions and modify their work accordingly. For example, Brian Sheldon, a leading UK proponent of EBP in social care, refers approvingly to work undertaken in the United States from the 1930s (see for example Lehrman, 1949; Powers and Witmer, 1951) and in the UK since the 1960s (reviewed in Sheldon, 1986; see also Sheldon and MacDonald, 1999) to evaluate systematically the effects of social work interventions. In more critical vein, Wendy Hollway (2001) draws parallels between the development of Taylorism and scientific management in the early twentieth century as a means to control manufacturing production and current attempts to control professional practice through EBP.

What is new, perhaps, is the espousal and promotion by the UK government of the concept of EBP across the public services generally. There is growing reference made to EBP, or knowledge-based practice, in government publications (see for example Department of Health *et al.*, 2000; Department of Health, 2001; TOPSS, 1999) and we have also seen the creation of the National Institute for Clinical Excellence (NICE) and the

Social Care Institute for Excellence (SCIE). The remit of both these organizations is to review and make available in their respective fields rigorously assessed research findings and best practice guidelines. The role of SCIE, for example, is described thus:

SCIE will make a unique contribution to improving the quality and consistency of social care practice and provision through the creation and dissemination of best practice guidelines in social care. . . SCIE will rigorously review research and practice, and the views, experience and expertise of users and carers. It will identify what works in social care, and produce best practice guidance, and will work to ensure their implementation at a local level. SCIE will create a knowledge base of what works through:

- rigorous methodology to assess evidence and knowledge from academic research, user and carer expertise and existing practice
- assessment of the strength and quality of the evidence
- a transparent review process

(www.scie.org.uk/aboutscie.about.htm)

It is clear then that EBP has the backing of the current government and investment is being made in the process of knowledge acquisition and dissemination through the funding of various centres for EBP, for example, the Centre for Evidence-Based Social Services at Exeter University and the Centre for Evidence-Based Nursing at York University (for a list of related websites and so forth see Reynolds, 2000, p. 18). Just as clearly, from our discussions with candidates on a post-qualifying child care award, there is growing awareness among childcare practitioners of the imperative to underpin decision-making with evidence. However, those charged with disseminating EBP are clearly worried about the scope and scale of their task, Brian Sheldon and Rupatharshini Chilvers (2000, 2002) report a lack of research literacy and limited knowledge of research findings among social care staff. From such a standpoint, there is clearly an urgent need to press on with the implementation of EBP and it is perhaps understandable that criticism may be treated as an unwelcome and unnecessary diversion (Sheldon, 2001, in response to Webb, 2001).

However, before we rush to embrace EBP as the latest good

thing for social work, it is appropriate to take stock of what EBP has to offer and to pose questions about its key assumptions and the likelihood of it achieving its aims. Such scrutiny can assist practitioners to understand better both EBP and its implications. After all, if we want critical and reflective practitioners, and it would appear foolhardy to propose otherwise, then we need to ensure that they are able to appraise the limitation of EBP as well as its strengths. What follows is a contribution to this process of appraisal. We begin by briefly outlining the key premises of EBP and its underlying assumptions before considering what are its limits and how it may usefully be supplemented by other approaches. In particular we argue for a more methodologically inclusive reframing of what is meant by EBP.

EBP: what it is, what it is against and what it promises to deliver

Readers may, of course, wish to refer to other articles on EBP in this volume for definitions of EBP. Yet, we must begin by outlining what we understand by the concept. There is widespread consensus that evidence-based practice means:

The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients [or service users], based on skills which allow the [practitioner] to evaluate both personal experience and external evidence in a systemic and objective manner. (Sackett et al, 1997, p.71)

It is noteworthy that this definition has been truncated by proponents of EBP within social care. Sheldon (1998) for example refers only to the application of evidence to decision making and ignores the reference to skills and the role of experience. He has further explicated his definition by seeking to clarify what is meant by 'conscientious, explicit and judicious'. To be conscientious is to eschew subjectivity and to 'resist falling in love with favourite ideas and theories' (Sheldon, 1998, p.16); to be explicit is to show not simply what has been

decided but how that decision has been arrived at and why it is the correct one; judicious means basing 'our helping recipes on best available evidence and applying them cautiously within their known scope' rather than more indiscriminately according to prevailing trends (Sheldon, 1998, p.16). Significantly Sheldon does not define 'evidence-based', a point to which we return later.

To what question or problem is EBP the solution? There is a clear motif running through the EBP literature of a 'crisis in the professions' and the parlous state of past and present practice. It is suggested that practitioners are (or at least have been) insufficiently accountable for their practice and fail to utilise or draw upon research findings to determine or guide their actions. Instead practitioners depend in their decision making upon other, less reliable indicators such as knowledge gained during initial training, opinion and prejudice, prevailing fads and fashions, collegial advice and the outcomes of previous cases (Trinder, 2000a). Practitioners' work is, therefore, too often based on outmoded thinking, personal opinion and dubious common sense. The consequence of this situation, according to advocates of EBP, is that 'practitioners continue to utilise interventions that have been shown to be ineffective or harmful, that there is a slow or limited adoption of interventions that have been proven to be effective or more effective, and that there continue to be [unacceptable] variations in practice' (Trinder, 2000a, p.3-4). Within medicine, several examples are offered of 'ritual-based practice', for example: the ongoing use of grommets to treat glue ear in children despite evidence to the contrary (Appleby et al, 1995) and the failure to use newer, more effective treatments such as clot-busting drugs to treat heart attacks (Department of Health, 1998a)

EBP thus seeks to sweep away outmoded practice and ideas past their sell-by date. In opposition to ritual-based practice, EBP extends the promise of overcoming the gap between research and clinical practice. It can, it is claimed, assist practitioners to sift out what is directly relevant in terms of evidence and it can provide a 'simple set of rules for evaluating research evidence' (Reynolds, 2000, p.19). In so doing, it provides an objective basis on which to make sound decisions in health and welfare practice. Only then will we avoid situations

where interventions of no known benefit are offered and, better still, practitioners will 'avoid doing more harm than good'. Its champions posit EBP as the single solution to the malaise of poor practice:

In the 21st century, the healthcare decision maker, that is, anyone who makes decisions about groups of patients or populations will have to practise evidence-based decision-making. Every decision will have to be based on a systematic appraisal of the best evidence available. (Gray, 1997, p.1)

Proponents of EBP thus advocate the production of 'really useful knowledge' for health and welfare organisations and practitioners. They argue that a more rational approach to research can result so that the emphasis is placed on key areas of need (for example cancer care and heart disease in health) and not the whims and fancies of researchers who may be much more interested in more esoteric subjects (for example rare brain disease), preferring to research the rare rather than the mundane. Where practice has been previously rather disorderly and ad hoc it can now be made orderly and rational. Two aspects are vitally important elements of EBP: the hierarchy of evidence and the use of clinical questions.

The hierarchy of evidence

Shaw has expressed some scepticism about the definition of EBP:

What do we mean by 'evidence'? What do we mean by 'practice'? How is one 'based' on the other? Far too much is assumed. But of course one does not describe a Holy Grail - one simply searches. (Shaw, 1999, p.3)

It is true that phrases such as EBP become so well assimilated into our vocabularies that we cease to ponder their meaning and instead take them entirely for granted. Although a relatively new phrase, EBP is in danger of becoming naturalised in this way. It is important, therefore, to consider what 'evidence-

based' means in practice. Within EBP 'evidence' seems to equate to research findings but not all research data carry equal weight. A hierarchy of evidence has been proposed that runs like this:

1. Strong evidence from at least one systematic review of multiple well-designed randomised control trials (RCTs)
2. Strong evidence from at least one properly designed RCT of appropriate size.
3. Evidence from well-designed trials without randomisation, single group pre-post, cohort, time series, or matched case-control studies.
4. Evidence from well-designed non-experimental studies from more than one centre or research group.
5. Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert committee.

(Gray, 1998 reproduced in Geddes, 2000, p.78)

Developed in the medicine and health care context, this hierarchy is nonetheless being reproduced within social work and social care, for example Gomm argues:

The properly conducted, correctly interpreted RCT (randomised controlled trial) is superior to any other method for producing evidence about cause and effect. This includes evidence about the effectiveness of health and social care interventions. (Gomm, 2000, p.51)

Whilst SCIE (www.scie.org.uk/aboutscie/about.htm) does intimate that it will take into account the opinions, experiences and expertise of service users these sources of information will clearly have to take their place within the hierarchy of evidence and will not carry equal weight to the rigorous methodology of the RCT. This method is rapidly achieving iconic status as the gold standard for assessing the efficacy of treatments because it eliminates (allegedly) all sources of bias and error. Evidence, once gathered and reviewed in a rigorous manner, can then be applied to a variety of aspects of practice for example in relation to assessment/diagnosis, intervention/treatment, prognosis and cost effectiveness.

Clinical questions: Applying EBP

The application of evidence to practice is clearly crucial to the success of EBP and the use of *clinical question* lies at its core (Sackett *et al*, 1997). In order to deal effectively with patients/service users, either singly or collectively, practitioners need to conduct a staged process, beginning with the construction of a specific question concerning patient/service user care. They should then seek to answer the question by appraising the best available evidence about what works in such a situation (and we should note that only recently has information technology enabled this process to be possible across a range of health and welfare settings). These findings should then be applied and the outcome evaluated. Clinical questions might ask which drugs are most (cost) effective or whether surgery is more effective than chemotherapy in cancer treatment. Whilst they are often aimed at treatment/intervention this need not necessarily be the case as the examples in figure 1 indicate.

Re-evaluating EBP

As we have noted elsewhere (Taylor and White, 2000) the main strength of EBP is surely its appeal to rationality. In the current climate of intense scrutiny and vociferous criticism of health and welfare professionals and their practice it is difficult to resist the argument that current practice is unsatisfactory in many respects. There are far too many instances of inadequate practice (or worse) within social work and social care, medicine, nursing, health screening services and so forth (as readers you will be able to make your own list of examples) for us to contemplate contradicting the 'poor practice' thesis of EBP. Although, we should note that not all practice is poor and it is not always easy to determine how representative are the headline-hitting examples we can think of. EBP, then, strikes a chord with public disquiet about professional competence and care in the late twentieth and early twenty-first centuries. It promises not only better treatments/interventions but also

Figure 1

| | |
|------------------|--|
| <i>Treatment</i> | |
| Patient: | In children with depression |
| Clinical action: | does cognitive therapy |
| Comparison: | when compared with tricyclic antidepressants alone |
| Outcomes: | lead to fewer symptoms of depression? |
| <i>Diagnosis</i> | |
| Patient: | In non-symptomatic adults |
| Clinical action: | does routine screening for colorectal cancer |
| Comparison: | compared with no routine screening |
| Outcomes: | increase diagnosis and lead to reduced mortality? |

(Reynolds, 2000, p.24)

greater fairness in the distribution of scarce resources both at local and national levels. We have heard much in recent times of resources allocated on the basis of age, ability to pay or the vagaries of postcode rather than on the basis of need and/or equal right to treatment. The EBP movement and its various satellite organizations such as NICE and SCIE hold out the promise of equity, consistency and up-to-date methods of treatment and intervention. It is hardly surprising then that it accords so well with the modernizing agenda of the current government (Department of Health, 1998b, 1998c).

As a result of this apparent 'fit' with the problems affecting health and social care practice, it is easy to portray any criticism of EBP as the height of folly and irrationality. From this perspective, to disagree with its claims, is to ensure that practice remains dominated by ad-hocery, commonsense and personal opinion (Sheldon, 2001). Notwithstanding this resistance to criticism, we cannot and should not simply rush to embrace EBP without considering in more detail its underlying assumptions and questioning whether it has the potential to

achieve its goals. First, we want to state plainly that we are not opposed to the use of research findings in practice. In situations where it is possible to make a clear assessment or diagnosis and determine the most efficacious treatments then, like other people, we would want to receive that treatment rather than something less efficacious. If TPA (tissue plasminogen activator) works better than streptokinase in the treatment of myocardial infarction then that seems the more reasonable choice (Gray, 2001). However to acknowledge the potential of EBP in certain aspects of practice is not to argue that it is amenable to being unproblematically applied to practice, nor that it could or should assume a monopoly position as the cornerstone of health and welfare policy initiatives.

There have been several criticisms made of EBP (see inter alia Harrison, 1998; Hunter, 1998; Trinder with Reynolds, 2000; Webb, 2001). One focus of these has been the concern that EBP will be used as a tool of managerialism to promote further technical-procedural control over health and welfare practice (Hunter, 1998; Trinder, 2000; Webb, 2001). This is perhaps to be expected given that a major impetus for EBP within medicine has been the recognition of scarce health care resources and the consequent need to address the issue of the most efficient and effective deployment of resources (Cochrane, 1972). Similar resource constraints bedevil the delivery of social care. We recognize these concerns about the utility of EBP to an 'audit society' (Power, 1997) but this is not the thrust of our argument here. Our intention is to problematize the hierarchy of evidence and the processes of applying evidence to practice. We further suggest that EBP fails to recognize and attend to the complexities of knowledge production in health and welfare practice by proposing a particular version of science and method. It is these issues that we now address.

Rationality or misplaced concreteness?

At first glance the process of EBP and the use of clinical questions seem entirely appropriate. They are geared to establishing 'what works?' and agreeing preferred methods by

comparing and contrasting alternative approaches. They avoid the trap of plumping for a preferred option as part of routinized and unthinking practice. This process of evaluating the evidence in a rigorous and scientific manner should lead to sound answers about how to proceed in practice. And yet there are difficulties with the approach that, certainly within social care, remain unacknowledged.

First we are being asked to accept a very narrow and rigid definition of science that has been seriously under fire for many decades, and indeed centuries (as the Duhem-Quine debate demonstrates; see also Kuhn, 1970). Put simply, it is assumed by EBP that: '[s]cience is concerned with the formulation and attempted falsification of hypotheses using reproducible methods that allow the construction of generalisable statements about how the universe behaves' (Greenhalgh, 1999, p.323). Second, as part of this scientific project we are being asked to accept a 'hierarchy of evidence' that privileges certain research techniques and, by default, renders others as less consequential and less likely to generate 'scientific' knowledge. Sheldon's intemperate dismissal of the potential contribution of sociological knowledge (Sheldon, 2001), to which we return later, is indicative of just how entrenched this hierarchy may become. Third, specific parallels are being drawn between science and health and welfare practice: social care practitioners (and their counterparts in health) are being asked to behave as impartial investigators who base their assessments on the formulation and falsification of competing hypotheses about service users or patients. Certainly within social work this view pervades most thinking on assessment, which is presented as a logical sequence of fact gathering, hypothesis generation, and deciding among options (see *inter alia*, Sheppard, 1995; 1998, for an alternative view see Milner and O'Byrne, 1998). The insertion of clinical questions (or their social care equivalent) is entirely consistent with this staged approach. As Trinder notes:

... there is an unshakeable belief in the capacity of science, and the rational, and systematic application of science, to bring about effective, accountable practice . . . [EBP] is presented as a radical approach, where the neutrality of science and the transparency of the process provides the opportunity for both practitioners and

consumers to participate. Knowledge, rather than authority or position, is privileged, and access to knowledge is available to anyone willing to learn the techniques or with access to the evidence. (Trinder, 2000b, p.215)

Fourth, EBP implicitly accepts a biomedical approach to health and welfare underpinned by strict adherence to a particular set of rules about how knowledge (evidence) should be gathered. Even within the context of medicine this approach is open to criticism, indeed from the leading proponents of evidence-based medicine:

Evidence-based medicine is not 'cook-book' medicine. Because it requires a bottom-up approach that integrates the best external evidence with individual clinical expertise and patient choice, it cannot result in slavish cook-book approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise and it is this expertise that decides whether external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision...Clinicians who fear top-down cook-books will find the advocates of evidence-based medicine joining them at the barricades. (Sackett et al. 1997 p.4)

Moreover, Hunter (1998), as a health policy analyst, argues that EBP runs counter to the methodological challenges presented outside acute medicine. Rather than focusing on what works to make people better when they get ill (as EBP does), Hunter argues that we need to focus much more on developing an understanding of 'the forces that keep people well, not only those that make them ill' and 'a refocusing of public health research on the root causes of ill-health and disease' (Hunter, 1998: 5). In other words we would prioritise preventive healthcare strategies. This would have important methodological implications since it would require a move away from a formal hierarchy of evidence privileging quantitative methods and a focus on outcomes of acute interventions towards a pluralistic approach acknowledging the equal contribution of qualitative methods.

The assumptions underpinning EBP cannot be simply

accepted without challenge. What is science, how it is conducted, whether the natural sciences have intrinsic elements in common or intrinsic difference is a matter of profound debate (that should not be equated with the banalities of the 'Science Wars'). It is surely noteworthy that this appears to achieve much greater acknowledgement within medicine and health care than in social work. The latter seems to need to cling to narrow and formulaic versions of science, that is scientism rather than science. For example, Sheldon seems to advocate a version of science exclusively based on deductive reasoning, concerned not with the generation of ideas, but with testing them. We can see the attraction of this rather arid reading of science. If we start from a falsifiable hypothesis and pare down our questions accordingly, we may indeed produce a neat answer to our question. Of course, this activity can have considerable value - it is the mainstay of much pharmacological research - but its value depends on the appropriateness of the question and without inductive reasoning driven by data or experience, there would quite simply be few ideas to test. Moreover, professional practice is itself often dependent on inductive reasoning, as Downie and MacNaughton note:

The concept of evidence, as it is used by scientists, is logically related to that of an hypothesis. Information, data, observations and experiments become 'evidence' when they are for or against a specific hypothesis...The concept of evidence as used by detectives or forensically differs in two respects: the data and observations suggest a hypothesis...about a specific or particular state of affairs. The concept of evidence that applies to medical research is like that of the scientist, and the concept that applies to clinical consultations is like that of the detective (Downie and MacNaughton, 2000, p.183).

Thus, both induction and deduction, often as part of a productive, recursive process, are important aspects of professional knowledge production - but induction is messier and rather than answering questions, it often generates them.

As we have suggested elsewhere (Taylor and White, 2000) an understanding of the philosophy of science and the sociology of scientific knowledge would not go amiss in social work. It

would help us to understand the complexities of knowledge generation in the natural sciences and to appreciate that within science itself 'the impossibility of making theory-free observation ... has long been understood ... Duhem, Quine, Goodman and Kuhn are but a few of those who have challenged the traditional views of empiricism and argue against the possibility of simple, 'objective' observations in science' (Harari, 2001: 725).

If science and medicine can cope with having more sophisticated understandings of the processes involved why cannot social work? We should be particularly wary of buying into the hierarchy of evidence proposed by EBP. It makes no sense to put RCTs at the pinnacle and others in descending order of worth. Methods are just that, methods. A whole panoply of methods should be available for us to use. Which one we will choose will depend on the questions we want to ask and the sorts of answers we want to come up with. RCTS will do fine for certain kinds of questions (for example to compare the efficacy of drugs among broad populations) but patently be useless for others. It would seem ridiculous to want to restrict ourselves to asking the sorts of questions that RCTs are suited to, particularly in the field of social work, where problems do not come neatly packaged.

Moreover, evidence from RCTs cannot be treated as the unvarnished truth. For example, strong criticism has been made of the Cochrane review of case management for people with severe mental disorders. This study concluded that case management did not improve mental state, social functioning or quality of care (Marshall et al, 1996). Rosen and Teesson (2001) argue among other things that the review: a) utilized a very narrow definition and set of principles of care management; b) excluded all RCTs involving other, more active models of care management; c) excluded all RCTs of acute patients who were case managed; d) the outcome objectives (negative outcomes were linked to contact with services and admission) might be interpreted as being 'underpinned by political and philosophical motives'. In other words we cannot assume that RCTs automatically possess scientific purity. Any method has to deal with issues of rigour, validity and reliability (see Silverman, 2000). From their close scrutiny of the Cochrane

review and other studies Rosen and Teesson (2001, p.739) conclude that, despite its credentials as an evidence-based review for an internationally esteemed organization, the findings were 'astoundingly passionate and parochial'. Parker (1997) too was critical of this review, arguing that the control condition, 'standard care', was ill defined and insufficiently different from the experimental intervention, 'care management'. Indeed he was moved to comment rather acerbically:

A number of their [i.e. Marshall et al's] conclusions illustrate how evidence-based researchers can (once freed of their strict protocols) spring from the bedrock of the evidence base into subjective musings. In this context it might be of benefit for the Cochrane Collaborators to incorporate another set of variables (ie the reviewer's a-priori biases or beliefs: did the evidence change such beliefs; if so, or if not, why?) into their protocols. (p.263)

The unquestioning acceptance of RCTs and the hierarchy of evidence would thus be wrong. Wrong, too, is the assumption of practitioners as technicians, if by that we mean those who derive formal, propositional knowledge from outside their day-to-day work and apply it straightforwardly to practice. This technical-rational view of the relationship between knowledge and practice (Schön, 1983, 1987) has been strongly critiqued in recent years (see Taylor and White, 2001). Practice, many would argue, just isn't like that. And this is not because of error and incompetence on the part of practitioners. Practice is more than the application of formal knowledge. Research knowledge may play its part but other things are also involved. Practitioners are not simply making rational choices between competing hypotheses in order to assess/diagnose or intervene. They are involved in complex interactions with service users and professionals in which they arrive at partial understandings of complex and ambiguous situations and draw on other forms of knowledge, particularly moral judgements, in order to decide what to do.

Sheldon (2001) derides sociology, equating it with the crude version of structural Marxism popular in the 1970s, but as we show below, it is precisely certain forms of sociological or anthropological inquiry that can assist us in the process of

understanding the taken-for-granted aspects of practice. For example ethnomethodology, conversation analysis and discourse analysis (see Taylor and White, 2000, 2001 for a detailed exposition of these approaches and their relevance to health and welfare) can enrich our understanding of the minutiae of decision-making and clinical judgement.

Making sense of decision making

A major drawback of EBP is its focus on interventions and outcomes. Not in the sense that these are unimportant but in the sense that in so doing it seriously underestimates the difficulties of diagnosis, assessment and case formulation. Deciding what sort of a problem the practitioner faces is a rather taken-for-granted part of the process in EBP whereas in everyday practice it is far from straightforward. The treatment example in Figure 1 above hints at this: 'Children with depression' is taken to be an unproblematic categorization and yet other studies on decision making evidence would suggest that this is by no means the case (Kahneman et al, 1982; Greenhalgh, 1999; White, forthcoming; White and Stancombe, forthcoming).

Focusing all the attention on what to do when the diagnosis has been made obscures the fact that diagnosis (or assessment) is a complicated and contentious process. Sackett *et al* (1991), for example, acknowledge that doctors struggle to reach clinical agreement in routine clinical procedures such as detecting the presence/absence of pulses in the feet, classifying diabetic retinopathy as mild or severe, assessing the height of jugular venous pressure. Moreover cardiologists agreed more often in diagnosing angina from patients' descriptions of chest pain and often failed to reach agreement when interpreting 'the abstracted, hard reality' of electrocardiographic tracings (Greenhalgh, 1999). Atkinson (1995) shows how the interpretation of laboratory slides in haematology requires that the observer select from a vast range of available descriptions to account for what they see and there are frequent disagreements between clinicians. That is, to do the work of diagnosis, the

descriptions of the cells under the microscope are actively selected and negotiated in the talk. Of course, the cells themselves do not change, but how they are classified is subject to negotiation in interaction. This should not surprise us. Work in the sociology of science has shown how esoteric scientific domains are in fact characterised by high levels of uncertainty, tentativeness and equivocation (Fleck, 1979). Incidentally, Fleck was himself a microbiologist and his comments were certainly not intended to be pejorative about science and its contribution to human life.

Thus, the clinical questions promoted by EBP promise to eradicate disorderly decision-making by imposing an ordered process of rational thinking, but by focusing on the 'what to do when this occurs?' part of the question they seriously underestimate the difficulty of deciding what it is that is occurring. If this is difficult within the arena of medicine with its supposed greater certainties about symptoms and diagnoses and its use of technology in these processes (X-rays, CAT scans and the like), then the problems are magnified within social work, notably in childcare where deciding whether child abuse and neglect has occurred is highly problematic, as we know from inquiries into child abuse and the controversies about child sexual abuse (see for example London Borough of Brent, 1985, Department of Health, 1988 and the Climbié inquiry available on line). *Making* knowledge is damned hard work and it is *making* knowledge, or crafting formulations about their cases that is the primary pre-occupation of practitioners. Should this domain simply be left unexplored? We think not.

Interrogating the tacit dimension: An exemplar

We have argued that there are some serious omissions in the current incarnation of EBP. We suggest that the concept of 'evidence' be broadened to include methods more suited to examining those aspects of practice that must rely on other forms of reasoning. Let us work with one of Sheldon's own examples. In his response to Stephen Webb, Sheldon notes:

The popular idea (who dared challenge it?) that child sexual abuse was absolutely rampant in Britain in the 1980s, fed by bad medicine, and politically inspired feminist methodology, led to the catastrophes at Cleveland and Orkney I propose that evidence-based training, supervision, management and practice are the most promising correctives to all this. (Sheldon, 2001, p.804).

We share Sheldon's concerns about the influence of fashion and fad in social work, but disagree that experimentally-based inquiries are likely to provide adequate means by which such taken-for-granted ideas may be defamiliarized and opened up for debate. Sheldon is referring to events in the 1980s in Cleveland, UK (Department of Health, 1988) when a large number of children were removed from their families because of suspected sexual abuse. The principal evidence in their cases was not a disclosure from the children, but a since discredited diagnostic procedure 'reflex anal dilatation', favoured at the time by a local paediatrician, Dr. Marietta Higgs. If a child's anus dilated in response to the test, the theory was that they had been subject to sexual abuse. This may now seem a preposterous assertion, but that is the benefit of the critical eye lent by history. At the time Higgs' persuasive rhetoric, presumably invoking all kinds of scientific evidence, was sufficiently potent to persuade members of the judiciary to grant court orders in respect of the children. This took place at a time when population figures for sexual abuse in childhood as high as one in four were routinely invoked to justify such interventions (Lloyd, 1992).

Sheldon thinks experimentally based EBP would have prevented this, but how? Clearly, the production of reliable and valid population indices on the prevalence of child sexual abuse is, and always will be, deeply problematic. EBP would certainly have provided social workers and medics with training in scepticism, which is no bad thing, but it would not have been enough. Sheldon is disparaging of the validity and reliability of sociology, but it is precisely the methods originating in that discipline that can help unmask 'fashion and fad'. Sociology does not equate with hubris.

For example, White's (1997) ethnographic study of child care social work, completed a decade after Cleveland, picked out exactly the taken-for-granted beliefs about child sexual

abuse and the climate of fear associated with questioning them, to which Sheldon refers. She notes:

It is hazardous [for social workers] to dispute the truism 'believe the child' ... The competent individual will whisper their doubts in corners, will swear the accomplice to secrecy. Since the mid to late 1980s (when social work involvement in cases of child sexual abuse increased), I can recall hearing this orthodoxy explicitly challenged only once or twice (White, 1997, p.150).

However, whilst social workers normally privilege the child's voice, a child's account is less likely to be believed if they are asserting that all is well at home, when social workers' suspicion has been aroused that it is not, either by a referral, or by a previous statement from the child. Under these circumstances, the scepticism usually reserved for parental versions is reinstated and the child's account loses its privileged status. Clearly, this may often be absolutely the right way to proceed to protect children, but the taken-for-granted assumption about its intrinsic, always and forever correctness potentially makes allegations of sexual abuse virtually incorrigible - which is precisely what happened with some of the cases in Cleveland.

At a more micro-analytic level, Lloyd (1992) used conversation analysis to study the linguistic practices of therapists and social workers in the USA during forensic interviews with children in cases of suspected sexual abuse. His data illustrate how denials from children that abuse had taken place were dispreferred by the adult interviewers, who would respond to such denials with subtle censure or with further questions. Lloyd summarises his findings as follows:

The adults elicit children's confirmations by producing candidate response initiations [suggesting the answer], ratifying confirming turns, censuring children's non-confirming responses, producing subsequent versions of initiations [suggesting the answer again] and treating children's weak agreements as strong agreements. (1992, p.109).

The techniques in vogue at the time for eliciting children's involved the use of puppets and play acting. The following is an

example of an adult censuring a child for producing a non-confirming response:

(Adult treats Nicole as animating the Houndy puppet)

Adult: Do you remember that part?

Child: No I don't

Adult: Oh Houndy. You were doing so good. I think you're losing your memory. How about... (Lloyd, 1992, p.115).

Lloyd does not pass judgement on whether abuse had actually taken place. He does not have the data to support such an assertion. Does this make his analysis irrelevant to practitioners? No it does not. Lloyd's data illustrate perfectly the local reproduction of certain ideas that were dominant at the time, which were treated by practitioners working with sexual abuse as the only right and proper way to think. It makes this process transparent - it makes the familiar strange. Making the familiar strange is important in professions which rely to a large extent on moral reasoning. Thus, we contend that Sheldon is mistaken on two counts. First, he gives no adequate account of how EBP in its current incarnation may have prevented Cleveland, and second he fails to recognise the value of sociological inquiry in rendering the taken-for-granted explicit and therefore open to debate and challenge (White, 2001). Social work is intrinsically interactional and is saturated with moral and cultural influences. If we are properly to understand their impact we need some analytic tools to help us to interrogate them. We agree that the version of structural Marxism, adopted by social work in the 1970s is not perhaps the most promising candidate, but discourse analysis and the sociology of everyday life meet the job specification very nicely.

Summary and conclusions

EBP holds much promise, but before deciding on its particular shape in a social care context, we need to have a much better picture of what social workers do. We suggest that certain forms of sociological inquiry which eschew prescription in

favour of description are perhaps best suited to this task. Moreover, we need to acknowledge that in their decision-making and in crafting their categorizations of clients social workers work up versions of events which are often based on moral assumptions about the rights/adequacies of service users. With this in mind, we need to think carefully about how we can improve skills in reasoning and critical analysis. In order to develop such skills, social workers will need to become more explicitly aware of what they take for granted.

In seeking a more inclusive version of EBP, we need to avoid irate and acrimonious exchanges, which caricature and ironize opposing positions (see for example Sheldon, 2001). Good knockabout fun they may be but, in reality, they generate more heat than light. They are unlikely to aid practitioners and are no substitute for reasoned, rigorous argument. Sheldon himself exhorts us to recognize the need 'to resist falling in love with favourite ideas and methods – stopping our ears to anything compromising said about them . . .' (Sheldon, 1998, p.16) This injunction applies just as much to proponents of the current, rather narrow version of EBP as to those who are more sceptical of what it has to offer. EBP invokes (its own version of) 'science' or 'rationality'. Valued cultural artefacts these may be – but this should not render the assumptions, presuppositions and promises of EBP immune from constructive critical analysis. By knowing its limits, we may be helped to see EBP's strengths.

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5

The limits of positivism revisited

David Smith

Evidence-based practice

The title of this chapter alludes to a paper (Smith, 1987) in the *British Journal of Social Work* called 'The limits of positivism in social work research'. At the time it was written, it was not unusual to hear academic colleagues argue that there was something inherently conservative about positivist approaches to social research, and that such approaches inevitably served the interests of the powerful and maintained the status quo. I was never clear about the stages involved in this argument and remained unpersuaded by it, and this was not the line followed in the article (though I might be more readily persuaded now, for reasons discussed later in this paper). Instead, the 1987 article was mainly taken up with a critique of the work of Brian Sheldon, as the leading advocate over the previous ten years - and, as it turned out, over the next fifteen - of what would now be called 'evidence-based practice'.

The paper argued that Sheldon's traditional version of positivism, and his rejection of other research approaches, were epistemologically and methodologically limited and limiting, since if we were to take Sheldon's advice a number of other useful research approaches would be lost to the social work community, whether of practitioners or of researchers. It also suggested that Sheldon was wrong to argue that social workers were unique among comparable professional groups in neglecting the evidence of evaluative research, since much of the evaluation literature would be incomprehensible if it were the case that teachers, for example, attended as a matter of course to evaluations of educational practices and modified

their own practice accordingly. The article argued for attention to processes as well as to outcomes, on the grounds that measuring and counting outcomes was of little use unless one knew what had produced them (a naïve version of the 'realistic evaluation' more recently advocated by Pawson and Tilley (1997)), and it was this part of the argument that received most attention and gave the article whatever influence it had (Cheetham et al., 1992).

Now that positivist outcome-oriented evaluation has made a dramatic reappearance in the guise of advocacy of 'evidence-based practice', and, in the field of criminal justice social work at least, in managerial and political demands that practice should be based on 'what works', it may be useful to try to take the arguments of the 1987 paper on a stage, and take a critical look at just what it would mean to take seriously the expectation that practice should be evidence-based, and what we might make of the claim that there is something wrong, and in need of managerial correction, with any practice that cannot demonstrate that it has this quality.

On the face of it, it is very hard to argue with the proposition that practice in social work should be 'evidence-based'. The same demand has recently been stressed in relation to medicine, and most of us are likely to find that reassuring. What else could practice be based on? Intuition, gut conviction, habit, whim, obsession, mania?

But in the language of politicians and of many social work - and, in England and Wales, probation - managers, the demand that practice should be based on evidence reveals an over-simplified and over-certain view of what evidence does or might consist of, and of how it should be interpreted and used. In trying to justify this claim and suggest a more nuanced, more modest, but also more helpful approach to evidence in the field of social work I shall move from the general to the particular, arguing first that the demand for evidence-based practice often rests on a misconception about the nature of the social sciences, and then drawing on my own experience and the work of other evaluation researchers to support the argument that knowing what counts as evidence, what it is evidence of, and how we should use it rationally is more complicated and also more interesting and creative than managers and politicians would like to believe.

One way of beginning to look at the question of the nature of social science knowledge is to note that social work seems recently, and perhaps for the first time, to have embraced a most uncritical version of positivism just as the most closely related academic disciplines are tending to move away from it (for a very polarised exchange on the implications of this see Webb (2001) and Sheldon (2001); Webb's anti- or post-modernist critique of the evidence-based practice movement is not the position I want to argue for here). In my use of the term, as in Sheldon's, positivism means the assumption that social science should proceed on the model of the natural sciences, and that the more it resembles them the better (more rigorous, more valid, more useful and so on) it will be.

It is intelligible that social work should suddenly embrace evidence as a source of practice, because there is truth in the charge (Sheldon and Chilvers, 2001) that it has done without it for too long (not that this makes it unique among the helping professions), and it is now being told that its very existence is at risk if it does not mend its ways. But there is no need for the social work professional community to adopt a view of evidence which encourages exactly the misconceptions about what it means and how to use it which are dear to the hearts of bureaucrats and politicians.

The nature of the social sciences

The philosopher Alasdair MacIntyre (1985) puts the matter thus:

What managerial expertise requires for its vindication is a justified conception of social science as providing a stock of law-like generalisations with strong predictive power. (p.90)

This is, according to MacIntyre, exactly the conventional image of social science over the past 200 years, the period of positivist domination. But MacIntyre argues that this position is based on a misunderstanding of the nature of the social sciences and the kinds of generalisation they can produce. In practice, theories can survive in the social sciences alongside plenty of instances

in which their predictions fail to be confirmed, and still be found useful, which is not the case in the natural sciences. An example given by MacIntyre is Oscar Newman's (1973) theory of defensible space. Based on impressive and extensive research, this predicts, among other things, that crime rates will rise with the height of buildings up to a height of thirteen storeys, and then level off. This is a risky prediction, and positivist criminologists were not slow to test it, find disconfirming cases, and claim that the theory was wrong. But, with some modifications, the theory has survived, and now routinely informs decisions in architecture and town planning.

This suggests that the logic of theory in the social sciences is different from that of theory in the natural sciences, and, according to MacIntyre, this is inevitable because the social world is ineradicably unpredictable; Machiavelli knew this, and called the element of chance, of unpredictability, *fortuna*. Those positivist social scientists, like their bureaucratic counterparts, who want to remove all sources of uncertainty are yearning for a God-like omniscience (God knows everything that will ever have happened)—and of course they keep failing to achieve it (MacIntyre's main examples are economics and demography).

Empirical social science, which is just as old as the natural sciences (the Greeks did both) relies on induction from research to produce its generalisations, and these take the form not of universal laws but of statements which begin with something like 'Characteristically and for the most part...', not 'If x is the case then, given that certain conditions hold, y will always follow'. This is so because social science generalisations are rooted in the form of human life, and the practice of social science reveals that its ancestry and tradition are different from those of the natural sciences. Positivists, or some of them, forget this when they aspire to total control of all that is unpredictable; and the same is true of some managers and politicians.

The realist tradition

One source of unpredictability for social work is the context, changing with time and space, in which it is practised. This is

crucial for the main alternative to the positivist tradition, evaluation within the philosophical tradition of realism. Realist evaluators (e.g. Pawson and Tilley, 1997) are right to stress that context (and not outcomes alone) is crucial in the evaluation of any social programme. So are the 'mechanisms' which generate change - the choices and capacities which are made available to participants - and their operation is always contingent on context: 'subjects will only act upon the resources and choices offered by a program if they are in conducive settings' (Pawson and Tilley, 1997, p. 216). Understanding the contexts that are needed for the mechanisms for change to work is essential for understanding how outcomes are produced. Pawson and Tilley write of context-mechanism-outcome configurations, which are propositions stating what it is about programmes that works for some people in some circumstances. The same programme will work in different ways in different circumstances, and sometimes it will not work at all. So rather than trying to replicate programmes which seem to work in the hope that they will work everywhere and always, we should try to generalise about programmes by developing middle range theories about context-mechanism-outcome patterns which will allow us to interpret differences and similarities among groups of programmes. This is the realist alternative to the aspirations of the experimental method of positivism, which, hypnotised by method to the point where theory is forgotten, has rarely managed to tell us anything helpful about the questions that matter: what is it about this programme that works for whom in what specifiable conditions and given what contextual features?

This is because positivist ways of thinking about evaluation ignore contexts and (despite some claims to the contrary) generally also ignore processes, or mechanisms in Pawson and Tilley's terms. Its decontextualised preoccupation with outcomes inevitably means that most of the results of positivist research are non-significant and inconclusive, because the theories that it is supposed to be testing depend crucially on the specific context in which they are implemented. The philosopher Russell Keat (1981) indicated the ground which a realist philosophy might occupy in trying to understand how outcomes are produced, and some of the problems in connecting processes with outcomes. I quoted this in the 1987 article, and

still do not know of any clearer statement of the problem. Keat is referring to the relationship between the truth or falsehood of psychoanalytic theory and the success or failure of psychoanalytic practice:

the failure of therapeutic techniques is compatible with the truth of this theory, whilst the success of those techniques may provide little support for it ... this is primarily due to the fact that in deriving predictions about therapeutic outcomes from psychoanalytic theory, a number of auxiliary statements must typically be assumed, whose own truth or falsity may display various degrees of independence from the explanatory claims made within this theory. Such auxiliaries may usefully be said to comprise a 'theory of technique': that is, an attempt to specify and explain the effects upon the patient of various elements of the therapeutic process. Thus even in those cases where predicted therapeutic success is achieved, it is possible that neither psychoanalytic theory nor its associated theory of technique are significantly supported, since it may be that this success is better explained by another theory of technique (Keat, 1981, p. 159).

So the relationship between outcomes and the theory on which the programme is based (and some kind of theory or theories necessarily lie behind any social work intervention) is nothing like as straightforward as the managerial culture which demands single right answers requires it to be.

The positivist programme of theory falsification is thus not only ill-founded philosophically, since it misunderstands the nature of social science generalisations, but usually unhelpful to practitioners and policy-makers. John Braithwaite (1993), writing about criminological positivism, has suggested that what is important is to develop a range of theories that are sometimes useful. These will often be theories which positivists say explain less variance than others across sets of decontextualised cases: that is, they will be theories which have less predictive power. Braithwaite suggests that a useful way of thinking about theory is to see it as metaphor. Practitioners concerned with a particular problem in a local context can then scan lists of theories to see which supplies a helpful or interesting metaphor. 'In the world of problem solving that matters, it is contextualised usefulness that counts, not

decontextualised statistical power' (Braithwaite, 1993, p. 386). In social work too, what is likely to be helpful is to use theory for the generation of interesting hypotheses about what might work in a particular local context, not to search for a universal one best way of responding to a given problem.

Difficulties in evaluation research

There are other reasons why what appears to be evidence is less straightforward to interpret and use in practice than we are being encouraged to believe. One is that a great deal of evaluative research is not very good. Positivism deserves some of the blame for this: as Co-Editor for four years of the *British Journal of Social Work* I read more papers than was good for me, some by quite distinguished social work academics, that showed a preoccupation with statistical testing combined with very little understanding of what statistical tests are for and in what circumstances they are useful. Even without any statistical expertise, it was not difficult to recognise that the way statistics were used in some of these papers was nonsensical. The preoccupation with scientific method meant that tests were used on data for which they were sometimes literally meaningless.

As an aside on statistics, whose application to social data is one of the main achievements of positivism, one piece of learning in the editorship was that this is not the exact and settled science that I had taken it to be. People who clearly knew what they were talking about often disagreed radically about what statistical procedure should be used when, and for what purpose. The fact of having been around for a long time, and looking scientific, does not, apparently, make statistical analysis any more beyond argument than any other approach in the social sciences.

Another indication of the quality of much evaluative research comes from Andrew Underdown's (1998) review for the Home Office of groupwork programmes in probation services in England and Wales. This is, of course, preceded by a management summary, but if the managers were to go on and

read the body of the report, described by the Chief Inspector of Probation as the most important he had ever written an introduction to, they would find that from the 267 replies on programmes received in the initial trawl, 210 were judged to have been evaluated in some way, 33 had produced enough evaluation material for analysis, and eleven were identified as having some value as indications of good evaluative practice. (And this at a time when the evidence-based, or 'What Works', agenda was well established in probation, and the old orthodoxy of 'Nothing works' had been firmly rejected by managers and policy-makers.) Of the evaluations obtained by Underdown, the clearest model for imitation was that by Raynor and Vanstone (1996; 1997) of the STOP (Straight Thinking on Probation) project in mid-Glamorgan, a careful and rigorous piece of external evaluation covering process as well as outcomes and examining implementation issues, levels of compliance and completion, and attitudinal change as well as reconvictions after one and two years, compared with those for several similar groups of offenders as well as against a statistical predictor. This was an evaluation of practice which was itself already evidence-based, since the STOP programme was designed as an adaptation to local conditions of the Reasoning and Rehabilitation programme developed by Robert Ross and his colleagues in Canada, and the conditions for its successful implementation and maintenance seem to have been near to ideal.

So it is as well to remember that while the one-year reconviction rates were promising for those who completed the programme (though not for those who did not), the two-year rates were much less so (though they were still better in terms of offence seriousness than for the comparison groups). The researchers concluded that the falling-off in performance was attributable to the absence of relevant reinforcement and support after people had left the programme. That is, for continued good results the programme would have needed to be supplemented by opportunities to build on the learning and solving of problems participants had achieved; it should have been part of a broader network of resources integrated with the programme's aims and methods (Raynor and Vanstone, 1996). I will come back later to the importance of strategies that are

contextual, integrated and multi-modal, and that, necessarily, draw on more than one strand of theory.

The reason why there are so few adequate evaluations of practice, and therefore so (relatively) little evidence to base practice on, is that evaluation is difficult. My own work, undertaken with colleagues, on two projects for persistent juvenile offenders in Scotland provided a strong reminder of this (Lobley and Smith, 1999; Lobley *et al.*, 2001). The collection of rich process data that allow confident conclusions to be drawn about what the important aspects of a programme are, associated with success or failure, requires close, time-consuming observation and analysis of what is observed. It needs to be able to chart changes over time, and to incorporate the understandings and theories of both staff and participants. For quantitative data, it is necessary to have or develop systems of collection which are reliable and consistent, and give access to data sources that are reliable and complete. A particularly sharp reminder concerned the limitations of reconviction data as a measure of change (though reconvictions are often treated as 'harder' data than what is usually available in evaluating social work interventions in other fields (Cheetham *et al.*, 1992)).

In both projects we had access to details on the number and nature of charges faced by the young people in the twelve months before they started at the projects. This material on charges stopped being collected when the young people reached the age of sixteen, after which the only source for a record of offending was the Scottish Criminal Records Office, covering only offences for which the young people were convicted. While of course the young people may not have committed some of the offences with which they were charged, it is still the case that the SCRO record gives a much attenuated account of the volume and rate of offending, and that the time lag between charge and conviction, or at least the appearance of the conviction on the official record, is often very long. It also proved far from straightforward to find a suitable comparison group.

After a good deal of effort on the part of Scottish Office colleagues and two time-wasting false starts, we identified a comparison group which was useful, though not ideal, for evaluative purposes, but the data on the comparison group were of course subject to the limitations of the SCRO record. Mair *et al.*

(1997) among others have discussed the limitations and problems of using reconviction rates, and a health warning about their limitations customarily accompanies research reports using reconvictions as the main outcome measure. But the warning could do with being strengthened, and issued more than once. It is probably rare for a persistent offender to avoid convictions altogether, at least in the long run, though there is plenty of anecdotal evidence to suggest that it can happen over a year or two, but there is no certain fit between recorded convictions and amount of crime actually committed. Thus some of the hardest-looking data available in social work evaluation become noticeably softer when subjected to close inspection.

Another area in which there is currently a strong demand for evidence is on cost-effectiveness. Since this was a prescribed element of the evaluation of the two Scottish Office projects, I tried to read the relevant literature conscientiously, get my head round the maths, and understand the assumptions which are characteristically built into such analyses in the field of criminal justice interventions about what would have happened without the intervention (it is possible that fewer assumptions are required in other fields, such as the evaluation of health services, in which cost-benefit evaluation seems to be more firmly established). Most writers in this area advocate comprehensiveness, but the more comprehensive the evaluation gets the more complex it is likely to become, and the more assumptions need to be built into the analysis.

For instance, there have been various attempts to assess the cost of a 'typical' crime (itself a difficult concept) some of which have tried to measure only criminal justice system costs, while some have tried to assess the cost to the victim, to insurance companies, to employers, and so on ... because once you start down the road of inclusiveness the possibilities multiply. Even studies which consider only criminal justice system costs typically have to make assumptions about the marginal cost saving of each offence prevented, and, still more fundamentally, seem almost universally to consider all criminal justice costs as net social costs, whereas one could easily argue that the creation of jobs, and therefore wealth, and the avoidance of unemployment among criminal justice personnel count as overall social and economic benefits (and the private sector in criminal justice is of course a notable

current case of economic success). Finally, it is worth noting that in a recent Rand Corporation (Karoly *et al.*, 1998) report on the effectiveness of early intervention with children the researchers decided that there were only two studies which provided sufficiently high quality and long term data to use in their effort to assess cost savings (their preferred term).

We could all wish that cost-benefit or cost-savings analysis were an exact science, as those who seek to control the social world require it to be; but it is not. This is not to say that nothing sensible can be said about these issues, and (too late for their suggestions to be incorporated in the Scottish Office evaluations) the Home Office produced guidance on them that was a good deal more sophisticated than previous efforts (Dhiri and Brand, 1999; Colledge *et al.*, 1999), but what is said will generally be - and certainly ought to be - tentative and qualified, and the assumptions behind the conclusions should be explicit (it is reasonable to say, for instance, that someone who has been free of convictions for two years at the age of eighteen is less likely to get into a criminal career as an adult than someone who has 20 convictions over the same period, but the unpredictability of social life means that this assumption will sometimes be false).

Conclusions

In this chapter I have dealt briefly with the nature of generalisations in social science, the importance of context and processes in making sense of outcomes, the inevitability of theoretical pluralism, and various more mundane and technical matters which have a bearing on the production and interpretation of evidence. Given that the status of any evidence is therefore qualified and ambiguous, how should practitioners and policy-makers use it? I think that Braithwaite's (1993) argument for what he calls 'contextual, integrated strategies' (p. 395) in tackling crime problems can be adapted to apply to the social work field more generally, and, combined with my own and colleagues' experiences of the Scottish projects for juvenile offenders, can be used to suggest a number of pieces of prescriptive advice for evaluators.

The first of these might be to put positivism in its place. In criminology and in social work, positivist evaluations have been vital in enabling the detection of nonsense; but the positivist (and managerialist) claim that such evaluations can produce - or have produced - law-like universals should be rejected. Secondly, remember that context matters, and that it makes little sense to try to understand any kind of intervention without reference to the local environment which sustains it (or fails to do so); and this means (Tilley, 1996) that replication is strictly speaking impossible. Thirdly, and despite some current orthodoxies about 'programme integrity', it is unhelpful to practitioners to encourage them to rely on a single type of theory, and therefore on a single form of intervention; nothing should be expected always to work on its own, and integrated approaches that are responsive to changes in the social, political and policy environment are preferable to static approaches based on the supposition that all the available evidence points in a single direction. Fourthly, theoretical pluralism and tolerance, within limits set by positivist achievements in identifying nonsense and making it manifest, are virtues, not vices. Finally, take seriously the realist stress on processes or mechanisms, on what it is that makes a difference (in either direction).

If evaluators were to think and work along these lines, the claims they would make, and what they would encourage managers and bureaucrats to believe, would be more modest, but also more realistic, than the most confident claims of positivism.

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6

A problematic relationship? Evidence and practice in the workplace

Nick Frost

Introduction

In recent years in the United Kingdom, and elsewhere in the world, we have witnessed a shift towards the promotion of what is variously referred to as an 'evidence-led' or 'evidence-based' approach to practice and policy in a range of professional fields (see Pawson, 2001, Solesbury, 2001). This paper aims to develop a critique of this approach with particular reference to social work practice with children, young people and their families.

The emphasis on evidence as the key determinant of professional practice has been encouraged by the U.K. government through research funding, by State sponsored educational initiatives and a stated political commitment to ensure that policy is informed by evidence (see Blunkett, 2000, Solesbury, 2001). This movement has become associated with the phrase 'what works', which is used in both government and academic circles (see McGuire, 1995, for example).

The origins of the evidence model are to be found in the field of medical practice—most notably through the work of the Cochrane Collaboration (see Oakley, 2000). An oft-quoted definition comes from McKibbin and colleagues:

Evidence-based medicine is an approach to health care that promotes the collection, interpretation, and integration of valid, important and applicable patient-reported, clinician-observed, and research-

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derived evidence. The best available evidence, moderated by patient circumstances and preferences, is applied to improve the quality of clinical judgements. (McKibbin, et al, 1995)

I will simply note at this stage that this definition includes the important phrase 'moderated by patient circumstances and preferences': this issue will be come central to our argument later in this paper, as it is a qualification not always recognized by advocates of the evidence school within social work.

The evidence-based approach has become widespread across a number of professional practices in the United Kingdom in recent years. Solesbury identifies a contemporary movement to what he calls 'the ascendancy of evidence' (2001, p.4).

How is this approach being applied to social work? First of all it is important to note that within what we might call the 'evidence' school there exists a continuum of views. These range from 'hard line' advocates of 'evidence-led' approach to a softer 'evidence-based' approach. It would need a paper in its own right to properly distinguish the gradations of position within this spectrum. However, whilst this paper addresses the issues in a way that can be applied throughout this complex spectrum, the force of the critique applies mainly to what we may describe as proponents of evidence-led practice. The fundamental argument of this paper is that the move towards evidence-led practice tends to over simplify the complex issues and challenges facing professional social workers in their day-to-day practice.

First of all it is necessary to establish that I am simply not developing a 'soft target'. What exactly is being advocated by the 'evidence' school and which concrete initiatives demonstrate that it is currently in good health? I wish to quote directly from some of the leading proponents of the evidence school and thus, hopefully, escape any claims that the critique I develop is aimed at an imaginary target.

Probably the leading advocate in the U.K. of such an evidence-led approach is Professor Ann Oakley, of the Social Science Research Unit. She argues, with colleagues Newman and Roberts that:

Practitioners who adopt a particular approach must be able to

describe what evidence has led them to do so, what the intended outcomes will be and what the probability is of such outcomes occurring' (Newman et al, Guardian, 10.1.96)

This is a very eloquent and pithy definition which I will take this as a core definition of the approach taken by the evidence school. I have chosen this in particular as it was published in a forum which specifically aimed to popularize the approach amongst human services professions – the Society supplement of the Guardian newspaper.

There are however a range of similar definitions which are proposed by other major proponents. Professor Brain Sheldon has been a champion of the evidence school for many years. His Centre, drawing on the medical model definition used above, utilises the following definition:

Evidence-based practice in social care is the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare of service-users and carers.
(www.exeter.ac.uk/cebss)

It is these two definitions, developed by the advocates of the evidence school, which will be critically addressed in this paper. The reader may wish to note that both the definitions we have used demonstrate links between the promotion of an evidence-based approach and the establishment of institutional forms aimed at promoting forms of evidence-based practice. Professor Oakley has helped to establish the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI), funded by the Department for Education and Employment, which focuses on educational and research. Professor Sheldon is associated with the Centre For Evidence-Based Social Services at the University of Exeter, which is partly funded by the Department of Health. A different, but related organizational form is that demonstrated by the child welfare organisation, Barnardo's. They have particularly advocated the 'What Works' approach through their series of publications, the titles of which commence with that key phrase.

At this stage the paper aims to have established two key points – first that the emphasis on evidence as a key determinant

of professional practice has become an influential movement in the U.K. and second that this takes an institutional form. I now want to move on to the more critical element of the paper, which questions the validity of the emphasis on the link between evidence and practice which is proposed by the champions of all forms of 'evidence-led' practice, 'evidence-based' practice or the 'What Works' school. The paper concludes by proposing what the author suggests is a more realistic model of the link between evidence and practice.

Developing a critique of the evidence school

At first glance the claims of the evidence school may seem to be perfectly plausible. It seems that there should be a clear link between evidence and practice. Further one would think that such a development would be welcomed by the academic community – at last our research is being listened to and utilised.

Initially I need to establish what is not being argued in this paper. The paper is not taking what might be called a 'post-modernist' approach – it is not being argued here, for example, that no truth claims at all can be or that we all have a unique narrative relationship to social reality. Nor is it being argued that the process of gathering evidence is a futile exercise and that there can be no impact on policy and practice. The model at the end of the paper demonstrates a more realistic approach to the utilization of evidence. The aims of the paper are perhaps modest – to contribute to what might be called a 'pragmatic' opposition to the evidence school.

It will be argued that the evidence movement is flawed and represents a false promise for professional policy and practice and for researchers alike. In this paper it is argued that there are four key problems with the approach advocated by the 'evidence' school. These four problems can be identified as follows:

- the problem of 'evidence'
- the problem of applying 'evidence' to practice
- the relationship between 'evidence' and values

- the relationship between providers and users of services

Each of these four issues will be examined in turn, before an alternative model is proposed (see also Frost, 2002).

The problem of 'evidence'

First of all it needs to be asked exactly what is the evidence referred to by the 'evidence' school and what status should social scientific evidence, in general, be granted?

The proponents of the evidence-based approach set themselves high standards. They often call for practice drawing on research of the highest scientific standards and based on the 'gold standard' of a randomised controlled trial (RCT), and have a tendency to refer to 'robust' and 'high quality' evidence (MacDonald, Sheldon and Gillespie, 1992). According to the evidence school these high quality research and evaluation projects in turn produce the highest quality evidence – 'which should then in turn be applied by professional practitioners.

If only the world was this simple. First, this approach presents knowledge as if it is static and therefore reaches some unproblematic standard at which it should then be 'applied' to professional practice. However it is argued here that knowledge rarely reaches this unproblematic standard and tends to be enhanced through critique and development. Knowledge is produced which is then debated and challenged and this in order turn produces new forms of knowledge. Knowledge in social science thus is rarely unproblematic or unchallenged.

Second, research and knowledge generation tends to be carried out within particular theoretical frameworks or paradigms. Thus Sheldon, for example, a leading proponent of evidence led practice in social work, takes a cognitive behavioral approach.

Those of us who come from differing theoretical schools would tend to be critical of Sheldon's findings, as a result of their fundamental epistemological position. For example, someone from a psychoanalytical school would argue that the cognitive approach underplays the role of the unconscious.

Thus presentations of evidence are usually subject to what Pawson and Tilley (1997) call 'paradigm wars' – fundamental disputes over theory, methods, concepts and so on. Given these differences it is hard to assess at which point any given form of knowledge reaches a status at which it can then be applied.

Third, much social scientific evidence, particularly that gathered through evaluation, tends to be situational. Pawson and Tilley argue this forcibly in their text 'Realistic Evaluation' (1997):

Evaluators will always construct their explanations around three crucial ingredients of any initiative: context (C), mechanism (M) and outcome (O). There will always be contextual variation within and between programs, a corresponding variation in the effectiveness of causal mechanisms triggered, and a consequential variation in patterns of outcomes. (Pawson and Tilley, 1997, p.77).

Thus they argue that any evaluation has to measure how a mechanism leads to an outcome in a particular context. It is not possible simply to transfer this mechanism to another context and assume that it will 'work'. For example, one might produce rigorous evidence on a given topic in year x – 'inevitably given the pace of legislative, policy and social change the context for this work will have changed, sometimes fundamentally, even by year $x + 2$. Thus evidence is essentially situational and contextual – making the application of evidence a complex process.

The problem of applying 'evidence' to practice.

Let us assume for the sake of argument that there were indeed no problems in gathering evidence. Let us assume that researchers are able to gather robust and reliable evidence, which then achieves universal acclaim. Even given this assumption it is still not clear how such evidence could be applied in practice.

To illustrate this argument I will take an example from social work practice. First, let us accept that, generally, children

looked after by relatives seem to do better in terms of outcomes than children looked after by foster carers they have never met before (Rowe et al, 1989). This seems to be a perfectly acceptable and unproblematic finding. However, how can this be translated this into practice?

All we can say is that a given child is likely to do better if placed with a relative than another foster carer. It does not mean that placement with, say, her actual grandmother will be necessarily be successful, or even better than placement with a different foster carer. Thus whilst the research evidence can be contextual and informative it cannot be determinative in a given situation. Hammersley quotes a similar example from medical practice:

There are also problems surrounding the application of information about aggregates to particular patients. The authors of key text in clinical epidemiology report a senior doctor as opining that it is immoral to combine epidemiology with clinical practice. (Hammersley, 1997, p.152)

Already the case for becomes ELP is severely limited. How can we decide when evidence can be applied and when in cannot?

Second, and this is a purely pragmatic point, but nonetheless a serious one, the pure volume of evaluation and research is problematic. If I might be allowed a personal example: as an academic specialising in the child welfare field, I know there are always journals, books and research reports in my area which I have not read. The explosion of the information age makes it difficult for any of us to claim expertise in any particular field. Whilst academics and the Department of Health in the U.K. have recently made serious efforts to disseminate research evidence in summary and in 'popular' form the scale of this issue for busy practitioners and managers should not be underestimated. Professionals take many hundreds of 'micro' decisions' per day and it is not feasible to imagine that these could be 'evidence-based' in any realistic sense.

Third, the pleas for practitioners to privilege research' and evaluation findings in practice seem to ignore the distinction between what leading theorists of education and practice such as

Oakeshot, Eraut, Schon, Tanjoru, Leadbetter and others have variously identified as 'codified' (explicit) and 'tacit' (implicit) knowledge (see Frost, 2001, and Leadbeater, 2000, for discussions of these distinctions). Basically codified knowledge is that which is written down, can be taught and assessed. In contrast tacit knowledge is that we pick up from doing the job, and is more difficult to communicate, measure and transfer.

Take the example of a (mythical) team leader who chaired the team meeting last week. She has 'tacitly' picked up that the staff seem to be unmotivated and generally uninterested by the meeting. The team leader makes a mental note to be more upbeat next week'—perhaps to start and end the meeting a positive note. Whilst there is some professional guidance on chairing meetings and some limited research, this is an example which crucially relies on 'tacit' knowledge, which is central to professional competence. Even if the topic has been extensively researched the knowledge is clearly situational and specific. It can be argued therefore that such 'tacit' knowledge is not peripheral but central to professional practice'—yet seems to be fundamentally undervalued by the evidence-led practice school.

The relationship between 'evidence' and values

The evidence school also seems to have what we may define as a technician approach to social problems. Thus social problems and issues seem to be presented as if they are:

1. neutrally defined;
2. responded to with best possible 'knowledge' in response to the seemingly neutral question;
3. amenable to a 'what works' approach

It will be argued here that at stages 1, 2, 3 are implicitly value questions. If this can be shown to be the case it is a serious blow to the evidence-based practice project.

First of all let us examine how social problems are identified and defined. The vast literature on 'moral panics' and the amplification of social problems has demonstrated that this

process is indeed far from neutral. Famously, Stan Cohen has identified how social problems are identified partially through series of moral panics which identify and amplify these problems (see Cohen, 1985).

In the social work field take the example of 'home alone' children. Sporadically the media pick up on this issue and report a number of cases over a few days – and then the story seems to reach an end before emerging again after the passage of some time. This pattern follows the classic description of 'moral panics' by Cohen. As any fieldwork social worker reading this article will know this is actually a regular occurrence in Britain's inner cities and housing estates. The media pick up on one case and apply the 'home alone' label from a Hollywood movie. This process happens time and time again, not least in the fields of child abuse (Parton, 1985) and youth crime (Muncie, 1998) areas of practice which are particularly vulnerable to 'moral panics'. Thus we know that the process by which social problems are identified is actually a political and social process – and not a neutral, scientific process.

Second, the 'knowledge' to be mobilised in relation to these problems is not neutral. As we have seen the evidence school in social work, for example, tends to privilege evidence from the cognitive behavioural school (see MacDonald, Sheldon and Gillespie, 1992). Sheldon defends this position as follows:

the reason for the appearance of cognitive-behavioural references in (Sheldon's research centre) work on childcare, mental health, learning disability and rehabilitation of frail elderly people, is that most rigorous (that is, the most bias-reducing) studies in these fields and many related ones, show that nothing ever does better. (Sheldon, 2001, p.807)

Far from being a neutral or rigorous position, this like all other 'schools' is a value-based school. Many would argue that cognitive-behavioural approaches reduce people to response mechanisms, ignores the reflective element of the self, underplays the social context and so on. Thus in the human professions we have value conflicts between the various schools – feminist, behaviourist, radical, task-centred, psychotherapeutic and so on (see Adams et

al, 1998). Whilst we maybe able to back up our case with evidence, these are ultimately competing ideological positions and should not be presented as neutral claims to expertise. As Braye argues:

To assume that it (evidence) will show us the 'one best way' is to devalue the complexity of professional decision-making. Ethical practice requires us to respond to the unique features of the situation ... (2000, p.30)

Third, the 'what works' question cannot be posed neutrally as the evidence-based practice school seem to wish. Let us take an example from outside of the human professions. A motor company, let us say, have discovered that 'what works' for them is a new fuel which would make their cars cheaper to run. 'What works' for the motor company therefore is the new fuel, which will make their cars more popular. However, environmentalists may argue that the new fuel will lead to increased mileage and therefore is even more polluting than current fuels. Therefore 'what works' for the environmentalist is entirely different that what works for the motor company. I hope to have illustrated here that 'what works' is indeed not a neutral question, and cannot be presented as an 'answer' to social problems.

Indeed it is theoretically plausible that we may find some rigorous, 'gold standard' evidence on a particular issue and decide not to apply it on moral grounds. Say, for example, that evidence was found that imprisoning young people for shoplifting was a powerful deterrent. It is still possible that we may wish to reject the implications for professional practice on the grounds that we have an ethical objection to imprisoning young people. Again the call for applying evidence to practice is highly complex and problematic.

If the arguments above are sound it would seem that we have undermine the evidence-led practice case at three crucial points:

1. social problems are not neutrally defined;
2. the best possible 'knowledge' cannot be neutrally defined;
3. 'what works' in the human professions is a value question, not technical question.

The relationship between providers and users of services

Let me at this stage concede some ground. I am willing to believe that evidence led practice is applicable to technical areas such as engineering and medicine (see Sheldon, 2001). The dimension that makes ELP difficult in the *human* professions is precisely that – the *human*, relational nature of teaching, social work, counselling and so on. These professional roles are about recognising human subjectivity and, hopefully, responding in some form of partnership and co-operation with service user, student or client. Thus professional practice needs to be negotiated, disputed and where possible agreed.

This again undermines the claims of the evidence school. The practitioner for example may 'know' that approach x is 'what works'. However, the service user may not want to co-operate with x and might prefer y, as a form of intervention. Surely this is the very complexity of the human professions – negotiation, conflict and compromise. Without this complexity and situated nature surely the professions could be taught or even carried out by computers.

Thus evidence-based practice immediately dismantles the possibility of any partnership approach to working with service users. For indeed if I, as a professional, am in possession of the *evidence* then I have no choice but to implement it – even if you, as a service user, disagree. Thus the claim made earlier by Newman et al (1996) is spurious as they argue that professionals have a duty to base their work on evidence and that a failure to do this is a breach of trust.

A way forward?

The evidence approach is an attempt to present a rational model of decision-making. In proposing an alternative I wish to challenge this as a basis for understanding public policy and professional practice. What then might replace the evidence-based practice model? As I have already stated I do not want to argue a purely relativist or indeed post-modernist position that

there is no 'reality' only discourses. Nor do I wish to totally undermine the role of research – which I see as a worthwhile and valuable undertaking. What I want to take is a pragmatic and realist position which locates evidence within a range of other significant factors which form both policy and practice.

I have my identified my provisional model by the acronym 'RIPE', perhaps suggesting that when certain factors come together the time may be 'ripe' for change. The model hopes to demonstrate that policy, practice and professional development are determined by a complex and dynamic process, which combines the influences of research and evaluation findings (R), ideological positions (I), politics disputes (P) and economic realities (E). I will explore each of these in turn.

By ideology I mean the values and perspectives that social work practitioners use to guide and steer their practice. Ideology can sometimes be devalued as a second order set of beliefs which are seen as of lesser value to scientific or evidence-based perspectives. It is argued here that is not helpful. Think for example about motivation: I would be surprised if there is a social worker in the world who entered the profession for 'scientific' reasons, influenced by a perspective which suggested that they eagerly wished to apply 'evidence' to problem-solving with people. Reality suggests that a moral, or indeed ideological motivation, lies at the heart of social work practice. Finsterbusch and Bender Motz argue that the rational model is unable to, 'handle value conflict. Whenever various people desire (value) different policies, there is value conflict. Unfortunately, almost all decisions involve value conflict' (1980, p.26). The proponents of the evidence school seem to want to wish away this value influence, which must surely be at the heart of social work practice.

By politics I mean politics in the widest sense – 'disputes over the distribution of power and decision-making. Politics – organisational, local and national – are central to the policy making process, but again the relationship between evidence and politics is contested. 'A major reason why actual policy decisions invariably deviate from the rational model is the intrusion of political factors into the decision-making process. Such intrusion should not be viewed as necessarily undesirable democracies must allow groups to act politically on their own behalf' (Finsterbusch and Bender Motz, 1980, p.32).

Sometimes politicians will ignore even the most robust of evidence for political reasons, an often quoted example being former Home Secretary Michael Howard's view that 'prison works', despite evidence to the contrary (Pawson and Tilley, 1997, p.3). Whilst the current (New Labour) government have a rhetorical commitment to 'what works' and 'evidence' one would have to be naive in the extreme to think that fundamental political beliefs can be changed by neutrally presented 'evidence'.

Economics and resources are also crucial to this debate. Our practice and policy environments are crucially framed by the realities of resources and funding. Robust evidence may suggest a particular policy direction, for which resources are not made available. Equally there may be economic reasons for hanging on to a practice, which evidence has questioned. As Finsterbusch and Bender Motz argue:

A major defect of the rational model is its failure to recognize limits. It fails to take into account the costs of the decision-making process, the limits of human knowledge, and other real world constraints. (1980, p.25)

There is therefore a complex interplay between evidence, resources questions and evidence- to propose that evidence should in some way take a lead role is therefore idealism in the extreme.

The RIPE model proposed here is an attempt to recognise the complex interaction of factors which influence social work, and indeed other forms of, policy and practice. As Weiss argues:

The process is not linear order from research to decision but a disorderly set of interconnections and back-and-forthness that defies neat diagrams. All kinds of people involved in an area pool their talents, beliefs, and understandings in an effort to make sense of a problem (Weiss, 1997, quoted by Eraut, 1994, p.55)

The reality of social work practice is that there is a role for clear and well-disseminated research and evaluation findings, but that they have to exist a world of competing ideologies, of

political conflict and of economic possibility and restraints. This complex mix forms the context in which reflective social work practitioners and managers practice. The RIPE model attempts to move away from the uncausal, static and rationalist elements of the evidence model towards a much more complex, real world, dynamic and 'messy' model of decision-making.

Conclusion

This article has attempted to question the increasing dominance of the evidence school. I have examined four key areas in which the evidence school seems to be presented with considerable difficulties. I have concluded by proposing a model of policy and practice formation which takes the role of evidence seriously, but which recognises that in the real world of policy and practice formation evaluation has to take its place alongside ideology, politics and economics. The evidence led model is not adequate to understanding the messy, real world of decision-making, both within and outside of social work practice.

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Part Three

Implementation

7

The Social Care Institute for Excellence: The role of a national institute in developing knowledge and practice in social care

Mike Fisher

Introduction

The UK government's drive towards modernisation has brought substantial changes to the infrastructure of UK society, and the welfare state is now a prime focus for reform. The role of public services in particular has been re-examined with a view to whether they offer best value, and what changes are required to make services genuinely responsive. Within this strategy, there has been particular concern about quality and variation - whether the current balance between regulation and professional discretion is the right one to ensure high quality services, whether the workforce has the skills and knowledge to deliver the kind of quality required, and whether there are remedies to the significant variations in services that cannot be justified by local circumstances.

In 1998, *Modernising Social Services* (Department of Health, 1998) announced a new structure for regulating standards of care (the National Care Standards Commission - NCSC), for training (the Training Organisation for the Personal Social Services - TOPSS) and for registering and setting standards for the social care workforce (the General Social Care Council - GSCC). In children's services, a special initiative called Quality Protects is raising standards, and the whole scheme was underpinned by an extra £1.3bn investment in social services

over the three years from 1998-2001. In relation to the workforce, the policy outlined the need to improve the commitment of staff and highlighted the need to improve interdisciplinary training to underpin better collaboration between health and social care staff.

This was shortly followed by *A Quality Strategy for Social Care*, a detailed examination of how to enhance the quality of social services (Department of Health, 2000). This policy document established a new Social Care Institute for Excellence - SCIE - as the major means by which quality and excellence would be defined, it set in place a framework within which local service providers and commissioners would be expected to ensure quality, it conferred a major responsibility on the local Director of Social Services to secure quality, and it reformed social work education and workforce planning. National Service Frameworks would provide models of joint service provision by health and social care and agreed ways of measuring their impact.

SCIE was established in October 2001 as a government-funded, but independent body, dedicated to raising standards of practice across the social care sector, through the better use of knowledge and research. It will be based on a vision of social care which empowers users and promotes the independence of the individual. Building on the Government's concern with knowledge and quality, it will review research and practice, and the views, experience and expertise of users and carers; will use the results of this assessment to create guides for social care practitioners; and will disseminate these across the social care field. (SCIE Prospectus, Department of Health, 2001).

Seeking to highlight the particular role of SCIE in the new set of agencies for social care, the then Social Services Minister John Hutton described it in late 2000 as 'the motor in the engine'. It was therefore designed from the outset to be the key source of evidence-based policy for other agencies to employ in their work, a touchstone and a reference point in a social care arena lacking authoritative bodies of knowledge. This inevitably casts SCIE in a mediating role between different stakeholders in social care, and with a key function to make working relationships with a wide range of organisations offering views of what constitutes the knowledge base. I will return to this theme later.

At the practical level, the Department of Health established SCIE in collaboration with the National Institute for Social Work (NISW), which contributed much of the thinking and practical experience of providing evidence-based policy and practice. SCIE is a small organisation, with a core staff of 35, grouped into four sections covering institutional infrastructure, research reviews, information provision and knowledge management, and quality improvement (including the development of practice guides). A 12-strong board of governors is chaired by Jane Campbell, a leading advocate from the service user movement, whose appointment signals some of the important issues SCIE will have to address, including how to incorporate the views, values and expertise of service users and how to mesh the agendas of a wide range of stakeholders. SCIE will also have a Partners' Council, involving a wide range of stakeholders in SCIE's work.

SCIE was set up to serve England and Wales, with a grant of £2.3m in 2000-01, and £3.4m in 2002-03. SCIE's work is due to extend to Northern Ireland during 2002-03, and it is likely that there will be links with policy developments in the Republic of Ireland. Scotland has a different structure for ensuring quality in social care, including a network of regional centres: it will, however, continue to support and benefit from the development of electronic access to social care knowledge (www.researchweb.org.uk, www.elsc.org.uk).

Social care knowledge and knowledge production

As its prospectus makes clear, SCIE has the initial job of identifying and reviewing material that constitutes the knowledge base in social care. This raises far-reaching questions about the nature of social care knowledge and about ways of assessing its quality, questions to which I will turn later. In the first instance, however, it raises questions about whether the infrastructure is in place to deliver the knowledge that SCIE will evaluate.

Although SCIE's reference points to sister organisations are evolving, during the initial planning there was a clear parallel

with the recently established National Institute for Clinical Excellence - a special Health Authority established in 1999 to produce guidance in health care. This parallel was used for instance to evidence the need to ensure that SCIE commissioned its research externally, rather than possessing a fully fledged research capacity in its own right, in order to ensure full independence of its review function. This in turn means that such bodies are designed to operate as 'intelligent customers' of research.

NICE's planned expenditure in 2000/01 was £10.7m, or almost 5 times SCIE's initial budget. Although its staff complement is similar, it spent almost £8m on clinical development, i.e. on developing exactly the kind of infrastructure lacking in social care. This allowed it to mount a programme (in 2000/01) of 26 appraisals, and 10 guides. This is evidence that NICE possesses a very different infrastructure for the supply of knowledge from that available in social care. For example, the NHS generates system-wide priorities for R&D through its largely centralised research policy-making, based on identified priorities for the health of the nation, and operates an R&D levy that generates over £450m p.a. for health research. This allows the development of coherent and reliable bodies of research, which in turn feeds a well-established review and synthesis industry, including the Centre for Reviews and Dissemination at the University of York and the 40+ review groups working under the methodological aegis of the Cochrane Collaboration.

In contrast, there is no centralised framework for organising coherent and cumulative knowledge production in social care. Funding for social work research in the university sector is small-scale: for example, the sum of £3.5m was allocated to English universities in 2001, equivalent to under £10K per head per annum for the research active staff in English universities. Moreover, it is distributed through the Higher Education Funding Councils directly to universities as part of their basic funding, not to support specific programmes of research. The Department of Health invests around £30m p.a. into a policy research programme designed primarily to inform central government policy-makers. Within this, it funds and coordinates research programmes on specific issues, such as

the Outcomes in Social Care (OSCA) programme. The Economic and Social Research Council (ESRC) has a responsive programme, which recognises social policy but not (yet) social work as a disciplinary subject: its major commissioned programmes are not specifically targeted at social work or social care, although elements of the recent initiatives on Growing Older and on Evidence-based Policy and Practice do contain relevant research (see www.evidencenetwork.org). Substantial funding amounting to around £20m p.a. is directed towards social care research by the charitable foundations (such as the Joseph Rowntree and the Nuffield Foundations.) Criteria for funding clearly reflect issues of national importance, and foundations do liaise to ensure complementary rather than competitive priorities: however, funding must primarily reflect the purposes of the charitable foundations and it is difficult to conceive of such funding as comprising a clear and coordinated national programme.

The absence of a nationally coordinated programme and of agreed national priorities, is compounded by the absence of any agreed system of reviewing and synthesising knowledge. The sister to the Cochrane Collaboration, known as the Campbell Collaboration, held its inaugural plenary in February 2001 and addresses criminal justice and education as well as social care. It has a single group overseeing all work in social work and social care, although this group will draw on members of two methods groups, and there may be some overlap with the other groups in education and criminal justice. In social care, there is no equivalent to the Centre for Reviews and Dissemination at the University of York. Several research-into-practice organisations offer access to research reviews and to practice improvement, but these are either subscription-based and therefore limited to subscribers, based on a specific service user group (e.g. Research Into Practice - RIP - focusing on services to children and families) or service a specific region (e.g. the Centre for Evidence-Based Social Services - CEBSS). While the largest group, RIP, has over 40 member agencies and can make some claim to national salience, the lack of coordination between these groups and, critically, the lack of free access to the knowledge base they have developed, means they do not constitute a nationally coordinated programme.

Table 1
Volume and quality of university-based R&D in health and social care, RAE 1996/2001

| Unit of Assessment | No. Units | | No. Staff | | % 5 or 4 | | Average size | |
|----------------------------|-----------|------|-----------|------|----------|------|--------------|------|
| | 1996 | 2001 | 1996 | 2001 | 1996 | 2001 | 1996 | 2001 |
| Clinical laboratory | 32 | 25 | 1097 | 1107 | 53 | 88 | 34 | 41 |
| Community-based clinical | 35 | 31 | 1213 | 1177 | 37 | 77 | 35 | 38 |
| Hospital-based clinical | 34 | 31 | 2814 | 2473 | 56 | 81 | 83 | 80 |
| Nursing | 35 | 43 | 397 | 575 | 8 | 23 | 11 | 13 |
| Other - allied to medicine | 68 | 75 | 661 | 1016 | 24 | 37 | 10 | 14 |
| Total | 205 | 205 | 6812 | 6348 | | | | |
| Social Work | 32 | 30 | 354 | 383 | 34 | 43 | 11 | 13 |
| Social Policy | 46 | 47 | 642 | 958 | 41 | 54 | 14 | 20 |
| Total | 78 | 77 | 996 | 1341 | | | | |

Note: a full list of university research centres in social work and social policy appears in the Appendix.

The problems of coordination that distinguish social from health care research are overshadowed, however, by the differences in sheer volume. As indicated above, social care R&D spending is probably between 1/8 and 1/10 that of health care (with several caveats about the distinctions between social and health care and what gets counted). The effect is that in social care there are fewer research groups, with fewer staff, and fewer centres of national excellence. Table 1 uses data from the 1996 and 2001 Research Assessment Exercises to show the differences between the health and social care research workforce. Although there are difficulties in mapping social care or health research directly onto Higher Education Funding Councils (HEFC) subject areas, the table gives a rough estimate of size differences, and some indications of differences in quality.

The data show that there are roughly 2.7 times as many research centres in health as in social care, and roughly 4.7 times as many research-active staff. The table uses the RAE rating of 4, 5 or 5* as a measure of the presence of substantial, nationally and internationally relevant research in a centre's work, and this indicates that there is generally a higher proportion and a greater absolute number of centres of research excellence in health care. As a subject area, social work possesses 13 centres of national excellence, while there are 25 in social policy. The 13 social work research centres returned 196.1

research staff (average 15) while the social policy centres returned 588.7 (average 24). Size of staff group is important in terms of continuity of excellence, the interdisciplinarity necessary to explore complex social phenomena, and the ability to respond to short-term demands (such as urgent systematic reviews).

Thus the knowledge industry supporting SCIE is very different from that supporting the development of excellence in health care. There are fewer suppliers, fewer centres of excellence, with fewer staff and less flexibility. Critically, the field lacks cumulative and programmatic research designed to throw concentrated light on specific fields. Moreover, social care research often lacks tested theoretical frameworks and reliable and validated research tools. For technical reasons concerning confidence in the results, social care R&D directed at testing interventions needs to be replicated using such theoretical frameworks and tools in cumulative bodies of research.

In other words, it is not just that the main source of social care R&D - the universities - have much less capacity than their health care counterparts to supply the material for which SCIE would be a customer, it is also that technical confidence in social care R&D as a basis for national policy-making requires coordinated and cumulative research programmes, within an agreed national framework, that the field currently lacks. This points to the need for SCIE to operate differently from its health care counterparts, and in particular to the need to consider a role for SCIE in coordinating and sponsoring social care R&D. There are three main reasons to pursue this.

First, there is no other mechanism for achieving the degree of national coordination required if social care R&D is to serve as the basis for national policy-making, and the modest resources for R&D in this field means that it is all the more critical that it should yield maximum benefit. SCIE should thus act as a focus for generating an overview of the social care R&D agenda, working with the central government, service user and provider organisations, regulatory agencies, with Higher Education, and with independent funders, to identify capacity and gaps, to prioritise research topics and to establish the programme specifications that would lead to a cumulative,

programmatic approach. This work resembles that undertaken by ESRC when it establishes a programme of research: it involves commissioning acknowledged experts or expert groups in particular fields, but retaining an overview of the overall framework under development. It is vital to underline the term a degree of national coordination: just as in the case of ESRC, the strategic outline developed by SCIE should not dictate the subsequent work undertaken, but rather should provide a framework within which the social care R&D community can respond in a coordinated and cumulative way. In section 3 of this paper I address some of the issues in identifying and accessing the knowledge base for social care, and, in the conclusions to this paper, I will return to SCIE's role in sponsoring a national research agenda.

The second reason for SCIE adopting a coordinating and sponsoring role is that social care R&D lacks capacity in specific, vital fields. Particularly scarce is research on the social care workforce and on knowledge utilisation. Existing research on the social care workforce is fragmented and unable to generate convincing research-based findings to underpin training and education strategies required for empirically-based practice. Current cross-sectional survey work needs to be aligned with strategic longitudinal and qualitative studies in order to provide this foundation. In the area of knowledge utilisation, important strands of work on knowledge mapping, critical thinking, the development of expertise, and on methods of integrating guidance into professional practice need to be woven together into a strategy to inform the work of social care training and education policy-makers and providers. Section 4 of this paper outlines some of the factors SCIE will take into account in promoting R&D into professional change.

Thirdly, there is no simple parallel in social care to the Cochrane-developed hierarchy of research-based knowledge. Four different approaches - evidence-based practice, knowledge-based practice, realistic evaluation and pluralistic evaluation - highlight the difficulty for SCIE in assembling and filtering knowledge without a working consensus. Developments within the Campbell Collaboration will provide another perspective, although key aspects of the social science debate in the UK appear to be underplayed in current Campbell

materials (such as the role of user-defined outcomes, the question of the durability of outcomes and issues in achieving professional change). In the absence of academic consensus on the question of quality, SCIE has commissioned important studies of the classification and quality rating of social science knowledge, in order to offer users a quality guide to accompany the knowledge base. This work draws on existing approaches from various organisations, but divisions within the social care R&D community mean that it is vital that SCIE promote its own approach, with sufficient authority and credibility to achieve a working consensus.

Identifying and accessing social care knowledge

It follows from the argument so far that, in many fields, social care knowledge will inevitably lack coherence and comprehensiveness. In order to develop reliable and relevant guidance, social care requires developed bodies of knowledge, rather than a succession of individual studies (however well executed). Prerequisites for such bodies of knowledge are concerted, intensive effort in well-defined fields of investigation, with cumulative, long-term planned research programmes, incorporating a degree of replication, the capacity to test theoretical frameworks and to undertake the methodological development of reliable tools.

The development of such bodies of knowledge will be characterised by tensions between breadth and depth. The funding system for social care research will not permit the progression of all the required fields simultaneously, and the need to ensure the development of agreed national standards for research requires methodological consensus about the tools for reviewing and synthesising knowledge. This tension between breadth and depth is well illustrated in the balance SCIE must seek between producing research reviews, and resolving the questions about what counts as reliable knowledge. For example, one approach to defining empirically grounded therapeutic interventions requires evidence of statistical superiority and moderate effect size favouring the intervention

from at least two randomised controlled comparisons (Chambless and Hollon, 1998). To this it might be added that SCIE will give significant attention to users' and carers' views, so that the question is not merely what works, but what is acceptable to and wanted by service users and carers: gaining such perspectives, and designing and executing research with user and carer involvement as a permeating principle, demands time and resources, and adds complexity to the analysis. Such approaches in turn tax the policies of funding bodies, where demands for large scale work, for genuine user involvement and for replication in order to produce nationally reliable knowledge compete with demands for research in new fields. SCIE must therefore work, initially at least, with very imperfect tools. In this context, the use within RIP of the phrase 'best available evidence' constitutes an important recognition of the state of the knowledge base to support practice.

In another sense, the question whether appropriate research is available is a test of the relationship between research producers and key stakeholders in social care. Funders can obtain the research they want, within the constraints of the skills and availability of researchers. The charitable foundations and the ESRC increasingly require evidence of utility to the end-users of research before funding studies, although there are varying definitions of what is meant by end-users. Only foundations such as Rowntree and Nuffield require evidence of involvement by service users in proposals: other funders may see users primarily in terms of the academic, policymaking and commercial sectors. There is thus a key question whether research production currently takes account of the interests of service users. Increasingly, service user groups are demanding involvement in research production, and in the UK the disability movement has led the critique of research that fails to address the need for change in the social circumstances of disabled people and that fails to involve disabled users (see e.g. Oliver, 1992; Zarb, 1992; Lindow and Morris, 1995; Barnes and Mercer, 1997). Out of this grew the demand for emancipatory research, that is, research aligned from the outset with the views of service users about their priorities and with a clear goal to increase the power of service users to enhance their quality of life.

The call for a new kind of relationship between researchers and service users extends beyond the disability field. For

example, the Shaping Our Lives group is a user-led organisation working on user-defined outcomes of different kinds of community care, while the Toronto Group is an alliance of users and researchers established to encourage and support user involvement in research generally. The group Consumers in NHS Research is funded by the NHS to act as a stimulus for user involvement in health care research, and its brief has recently been extended to the social care and public health research funded through the Department of Health's Policy Research Programme.

In one sense social care research cannot progress at all without some involvement of service users, but it should be clear that the concept of emancipatory research goes well beyond mere participation. SCIE is founded on the concept that users should be involved in all stages of reviewing the knowledge base for social care, and this includes a role in setting the research agenda that generates knowledge in the first place. There are now examples of research led throughout by service users (Beresford and Turner, 1997; Beresford and Wallcroft, 1997; Evans and Fisher, 1999b; Evans and Fisher, 1999a), and at least a theoretical case that user-controlled research can enhance research quality (Fisher, 2002).

However, it is not only service users who have been marginalised in research production. The lack of a strategic framework for social care research has meant that practitioners have had almost no voice in determining the key questions that research should address. UK social work research in particular has a poor track record of collaborative knowledge building in partnership with practitioners (Fisher, 2001), and research-in-practice organisations such as RIP and Making Research Count (MRC) have had to invest substantial resources in creating a voice for the practitioner constituency in their subscriber agencies. Small groups such as the Social Work Research Association have tried to bridge the gap between the research and practice communities, but their impact has so far been small-scale. This necessarily raises questions about relevance to practice: since practice concerns have not hitherto informed the research agenda, there is unlikely to be research available on key issues. If research relevant to practice is not available, reviews and practice guidance cannot be entirely driven by

research findings, and will have to draw on examples of best practice, and inspection and audit material.

This issue about the relationship between research production and marginalized stakeholders in social care is one that requires a long-term perspective. Of immediate concern, however, is the question whether SCIE can identify and access relevant existing research. This is usually achieved by searching cumulative literature databases, such as Medline, CINAHL or ASSIA. One of the first issues is that social work and social care are based on a multidisciplinary knowledge base (Fisher, 1998) and searching within databases designed to service other academic fields is highly problematic (Howard and Jenson, 1999a). Not only does the literature lie in several disciplines, but those disciplines in addition employ different concepts and conventions. A current expert review under way at Kings' College, London, on social assessment of older people with mental health needs is a case in point: the literature stretches across the medical and nursing literature as well as the social sciences (Moriarty, 2001).

Attempting to focus on more closely defined aspects, such as empowering or participative approaches to assessment, it becomes quickly apparent that, although some concepts may be shared with other disciplines, the specific descriptive terms are often not. Moreover, the reporting conventions, and adherence to them, will differ between disciplines: a relatively well-developed system of structured abstracts in health care literature assists searching (which is often, at the initial stage, undertaken on abstracts or keywords alone), but, despite over a decade of use, authors' adherence to criteria for structured abstracts remains patchy (Sheldon et al., 2001). Abstracting conventions in disciplines outside health care are different or remain to be developed. Searching across disciplines is therefore fundamentally problematic.

The UK has no database that is capable of indexing the vast range of interdisciplinary knowledge required in social care. The SCIE CareData database perhaps comes closest, but is inevitably selective in the fields covered, has not employed a quality filter for inclusion, and does not resolve the question of a universal, structured abstract that would ensure reliable retrieval. The future probably lies in creating translators that

take search terms in one database and convert them to the corresponding terms in others.

Even within narrowly defined fields, searching can be unreliable. For example, Dickersin et al. explored whether Medline could identify a particular kind of scientific review known as meta-analysis (where data is pooled from various studies and reanalysed to generate more reliable findings). Using handsearching and citation tracking, the research group's knowledge of the field permitted them to identify 119 such studies: a Medline search found just 57 of these, missing over half (Dickersin et al., 1990). Although this problem has since been addressed within Medline, it illustrates the general point that searching using keywords works only if the keywords are used consistently and reliably, both by authors and by information scientists creating and maintaining the databases.

Searching such databases is potentially undermined by publication bias, meaning both the questions whether all the relevant studies have been published in indexed journals, and whether there is any systematic bias towards publishing particular kinds of reports? In the social care field, much R&D is not published in the 'official' literature, and there is no central research register against which published reports may be checked. Since much R&D goes unreported, basing a review of any given field on the published literature risks ignoring important and relevant work.

A more complex problem is that publication tends to favour 'successful' studies, that is, those that report results in favour of the intervention under scrutiny. Simes' groundbreaking study of cancer treatment showed that taking unpublished studies into account removed the statistical significance of patient benefits reported in the published studies (Simes, 1986). Another investigation into the publication of randomised controlled trials (RCTs) compared the reporting of statistically significant favourable outcomes in published and unpublished studies: of the published trials, 55% contained favourable outcomes, compared with 15% of unpublished trials (Dickersin, 1997). Clearly, if we want to know whether research supports the use of particular interventions, we need to access all the reports, whether published or not. This in turn requires the establishment of a register of all research into particular fields,

so that reviewers can check whether all studies have been reported in whatever form. It also places an ethical obligation on researchers to make available to the public record reports of all outcome studies.

In the social care field, this creates particular problems for the durability of any research review. The difficulties in accessing social care knowledge mean that any review is likely to be unable to draw on all the knowledge that is - theoretically - available. It is common for health care reviews to be reviewed every 4-5 years, largely because of the volume and pace of new work. In social care, reviews may have a shorter 'shelf-life' simply because they surface knowledge that has hitherto been inaccessible.

Lastly, research is fraught with epistemological and methodological complexity. All studies have flaws of varying importance and different claims to offer valid and reliable accounts. The question whether the research supports the use of particular interventions therefore requires a scientific assessment of the methodological quality of the work. This raises two distinct questions - whether the report contains the methodological detail required to assess scientific quality, and what kind of measure of quality is to be used.

Most authors are familiar with the problem that publishers encourage abbreviation of methodological detail. Although this may reduce the volume of a given report and enhance its chances of being read, it also risks removing precisely the material that would allow the reviewer to evaluate the findings. Two recent methodological studies of reviews in the social sciences illustrate the issue (Long et al., 2000; Sheldon et al., 2001): both contain examples of reviewed studies where elements of the methodological evaluation are either missing or inconclusive. We do not know from such summaries whether the methodological quality was lacking or whether the report simply did not contain the material to permit an assessment. SCIE's development of this aspect of research reviews will need to incorporate two refinements: to distinguish reports where key aspects of methodological quality have not been observed from those where the methodological material is simply omitted; and in the longer term to establish minimum reporting criteria for methodological detail.

Measures of quality concern not only what kind of rating system is to be used but also whether different kinds of research require different systems. The Cochrane and Campbell Collaborations offer a clear perspective of methods of evaluating experimental studies of the effects of interventions, and promise valuable rigour and consistency. However, there are several problems in prioritising this approach above all others. First, experimental designs require a well-developed existing knowledge base about feasible interventions and ways of measuring their outcomes, and a considerable investment in time and funds. A recent review of studies of changing professional behaviour advises caution, for example, in designing expensive experimental evaluations when there may be little a priori reason to consider that the interventions under investigation are likely to effect change (Freemantle et al., 1999). This is one of the reasons why experimental studies remain relatively rare in social care research. This, in turn, raises key questions about the development of systematic methods of synthesising qualitative studies, on which systematic reviews in social care will often depend.

A second problem in the prioritisation of experimental methods is that these studies often fail to generate relevant knowledge, that is, knowledge that can be used in practice. Problems include whether the intervention is replicable in day to day practice, whether eligibility criteria exclude people from the experimental intervention who are nevertheless eligible for a service, and lack of attention to the views of service users on what counts as good outcomes (Fisher, 1998). A related point is made by critics from a realist evaluation perspective, who caution that much experimental research underplays the context in which an intervention takes place: instead of identifying 'what works', we should aim to know what 'works for whom in what specifiable conditions and given what contextual features' (Smith, 2000). A recent experimental study of health promotion concluded that the method was not best suited to testing interventions that require active participation of the respondents in achieving change (contrasted with the passive mode of patients receiving treatment), and the numbers required for secure analysis were beyond the likely reach of sample recruitment strategies (Barlow et al., 2001). Although

(in order to focus on the tacit element in practice that requires acquisition through means other than written material or direct influence), and to examine descriptions of practice improvisation ('traffic sense') that inevitably accompany the adoption of any guide.

Clinical reasoning

The evidence-based practice movement draws on a long tradition of studying practitioners' reasoning. The main text here is Gambrill's work on critical thinking (Gambrill, 1990), recently restated in the context of evidence-based practice (Macdonald and Sheldon, 1998; Gambrill, 1999). The concern here is to identify sources of error in the way practitioners think about their work (reasoning). Typical sources of error include:

- getting the facts wrong;
- assuming two things are connected when they are not;
- assuming one thing has caused another, when it has not;
- assuming one thing will cause another, when it will not (Gambrill, 1990: 2).

The connection with practice guides is two-fold: practitioners should have an explicit rationale for the choice of intervention (i.e. be able to reason a case for it) and guides may need to challenge accepted wisdom that contains faulty reasoning or has not been subject to logical scrutiny (for a good example of accepted wisdom in medicine about the relationship between salt and blood pressure, see Freedman and Pettiti, 2001). There is a further connection with evidence-based practice, in the sense that faulty reasoning may prevent adherence to the core definition of such practice as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals' (Sackett et al., 1997: 2).

Lastly, the study of practitioners' reasoning may give clues as to how to structure guides. At a very basic level, for example, guides may be constructed to challenge assumptions commonly held by practitioners. However, if we make a connection between the literature on clinical reasoning and on expertise,

we can see several further dimensions affecting the construction of guides.

Gambrill connects the two issues by discussing the differences between novices and experts in their reasoning processes. She argues for example that experts are better at problem-solving and at reviewing their decision in the light of evidence (Gambrill, 1990: 14-15). Reviews of critical reasoning in medicine, nursing and occupational therapy suggest that what differentiates expert from non-expert practitioners is that they use some form of mental schemata or pattern recognition to reach conclusions - that is they draw on past experience to match the current problems with previous patterns they have observed. This fits Wakefield's definition of expertise as

the ability to perceive holistic relations between the current problem and a vast array of previously experienced situations. (Wakefield, 1990)

Eraut makes similar observations when he argues that

progression from proficiency to expertise finally happens when the decision-making as well as the situational understanding becomes instinctive rather than analytic; and this requires significantly more experience. (Eraut, 1994, pp.125-126)

In a study of occupational therapists, Roberts argues that practitioners spend substantial time hypothesis-testing and cue-searching (Roberts, 1996). Studies of clinical assessment in medicine also show that hypothesis testing is a critical part of the reasoning process: typically assessment includes consideration of no more than five initial hypotheses, and one of these is likely to prove the 'correct' interpretation (Elstein et al., 1979). The more experienced the practitioner, the more rapid the cue-searching and hypothesis-testing, because it draws to a greater degree on mental schemata. In social work, Sheppard's recent work on hypothesis-testing suggests a relationship between expertise and the depth and complexity of the hypotheses generated (Sheppard et al., 2000a; 2000b).

It would be a mistake, however, to suggest that experts would always agree about appropriate intervention, or all deliver it in exactly the same way. For example, Fook and her colleagues show that,

among several experts, there were a variety of ways of performing the same tasks, and the authors suggest indeed that standardisation risks stultifying expertise (Fook et al., 1997, p.412).

There are several key implications for SCIE's work on practice guides. Firstly, guides should offer different access points and presentation approaches to cater for the wide range of reasoning that will be in use among practitioners consulting the guides. For example, few practitioners with any experience are likely to welcome a step by step primer, whereas such an approach may be more appropriate in qualifying training. Secondly, guides should contain credible case examples (preferably from actual practice), since this will aid practitioner recognition of patterns or mental schemata. Thirdly, guides should name the range of possible hypotheses, and possible supporting cues, in order to assist the hypothesis-testing that is already part of practitioners' reasoning. Lastly, guides should be clear where different forms of intervention are equally valid, and leave scope for practitioners to exercise their expertise in selecting and delivering services: the objective is to assist better decision-making, not to dictate what decision should be made.

Guides

More explicit attention to the role of guides in practice change is available from the US literature, particularly a special edition of *Research in Practice*, May 1999. In the US, the emphasis on guides increased as it became clear that other methods of enhancing the use of evidence were failing. The profession moved towards practice guides as a means of embedding research in advice without requiring practitioners to have access to the original research or competence in its interpretation (Howard and Jenson, 1999b). In contrast, guides development in the UK has a much stronger basis in the attempt to achieve managerial control over professional discretion (and of course, to the extent that such discretion produces unacceptable variation, this does underpin SCIE's emphasis on guides). Although guides are used in the US to enforce standards of practice, including in litigation, this was not the primary reason for their development.

The US debate highlights several key problems (Howard and

Jenson, 1999b; Howard and Jenson, 1999a; Jackson, 1999; Kirk, 1999; Nurius et al., 1999; Richey and Roffman, 1999; Wambach et al., 1999), including

- the difficulty of building strong stakeholder communities in order to ensure guide development properly reflects different interests;
- the need for economic evaluation, particularly where guides indicate a number of viable interventions;
- the need for a viable literature base from which to derive research-based evidence, and problems in defining the appropriate literature to search;
- whether the published literature is representative of empirical knowledge about what does and does not work (Richey & Roffman cite evidence, supporting the earlier discussion in this paper, that studies reporting positive effects are more likely to be published);
- the difficulty of ensuring effective dissemination and effective access to the literature base for practitioners;
- the dangers of developing guides that are too long or too qualified to be helpful (Kirk illustrates with a guide relating to schizophrenia that is 63 pages long with 518 citations, and which hedges each key questions with reservations such that a practitioner could not possibly gain a clear direction for practice);
- lack of evidence of a positive relationship between the use of guides and better outcomes;
- the fact that implementation in the field requires adaptation ('Implementing clinical guides in the field will always require some tinkering by practitioners who strive to incorporate unique client, agency and community factors': Richey and Roffman, p.316), and that it becomes difficult to know when an intervention has been adapted to such a degree that it is not longer that recommended in the guide;
- the disjunction between the predominant emphasis in guides on individual behaviour in contrast to the potential for change via better use of community support systems;
- the need for guides, like practice, to be multidisciplinary;
- the need to link guides to fundamental value systems held by practitioners.

Perhaps the best statement of guide requirements is by Proctor and Rosen (Proctor and Rosen, 2000), who define guides as 'a set of systematically compiled and organized knowledge statements that are designed to enable practitioners to find, select and use the interventions that are most effective and appropriate.' They call for guides to include

- targets for intervention, and for each target an array of alternative interventions;
- how to choose interventions, and to identify gaps and qualifications in the underpinning knowledge base.
- a positive orientation towards including outcomes that focus on harm reduction or maintenance of current well-being (contrasted with many health care guides that assume problem elimination is the goal). An example would be spouse abuse, which may well be best prevented by shelter placement than by attempting behavioural change in the abusing spouse;
- recognition that there will normally be a number of intermediate outcomes leading towards an outcome that requires long-term change;
- attention to what degree or intensity of intervention is required to achieve what degree of effect ('dose' effect);
- for each intervention, known factors affecting its efficacy should be mentioned (e.g. age);
- recognition that 'practice guides are not immutable and infallible knowledge statements. On the contrary, such statements should make clear that in practically every situation, practitioners will encounter gaps in knowledge' (p.16).

Evidence-based practice and the adoption of guides in health care

If SCIE is to profit from such lessons in the construction of guides, it may also learn from the work in the health care sector on the adoption of guides. This is all the more necessary given that the study of guides and professional change is under-developed in the UK: a Nuffield paper on the implementation of guides shows that only 14 of 91 studies examined were UK

based (Nuffield Institute for Health et al., 1994). The potential in this field of study is demonstrated in the finding that 81 of the 87 studies on clinical process reported significant improvements, as did 12 of 17 studies of patient outcomes. However, as in other key fields, SCIE will need to promote and foster a systematic programme of UK-based studies of the adoption of research-based guides.

The starting point for this discussion is the increasing evidence that some interventions to change professional behaviour are so poorly conceptualised that it makes little sense to invest in carefully controlled studies to evaluate their effectiveness (Freemantle et al., 1999). This reinforces the need to undertake exploratory development work to test the plausibility of interventions before undertaking expensive controlled trials. This kind of R&D is most likely to require what are called non-equivalent group designs, in which the unit of analysis is the team, rather than the individual practitioner. Studies of health care professionals more widely confirm the importance of teams as the basis for learning (Hart and Fletcher, 1999). Non-equivalent group designs require large numbers of teams for study (in order to reflect the range of team characteristics and in statistical terms to minimise bias arising from unknown factors within teams), and sampling to achieve adequate representation of the conditions under which the intervention is to be tested. In addition, these designs require extensive pre- and post-intervention measures in order to assess whether observed changes have been influenced by pre-existing trends. The implications for SCIE are that:

1. it will need to foster research characterised by long-term relationships with a wide range of teams, and
2. to ensure research covers the range of teams and their characteristics in order to achieve representative samples.

Professional change is most successful if promoted through a variety of methods: the printed word, coaching, consultation and educational outreach and so on (Freemantle et al., 1999). There is a graded effect, where single interventions (such as information transfer) are less often effective than single interventions plus feedback, which in turn are less effective

than multiple interventions: 'information transfer is probably always needed at some point in the process of implementing change, but more interventions are usually needed to achieve real changes in the practice routines of clinicians' (Wensing et al., 1998). Similarly, education is less often cited as a factor in prompting change in clinical practice than organisational factors (Allery et al., 1997). In addition, intervention methods must be closely specified and controlled in order to be replicable, and they must be designed so as to be achievable in ordinary, everyday practice in social care (Fisher, 1998).

Research in this field will also need to recognise that change effects are typically very small: it is not just that professional behaviour is difficult to change, it is that the evidence for any changes is likely to be marginal, and capable of different interpretation (see e.g. Cohen and Fisher, 1987). The solution is to replicate studies so that assessments may be made of the validity and reliability of small effect sizes. This means that SCIE will need to focus R&D effort on particular areas in order to build cumulative and reliable bodies of evidence. This is most likely to be achieved through a combination of in-house effort (in order to test designs and offer authoritative leadership) and focused, collaborative commissioning (in order to promote cumulative knowledge building in specific fields).

Conclusions

The reshaping of social care under the aegis of modernisation brings into focus key questions about what we mean by knowledge, and about its role in creating and maintaining high quality services. The establishment of a national institute with a mission to define, create and promote excellence inevitably raises questions about hubris and control: is it realistic, let alone possible, to reach for excellence, and will the effect be to control and regulate knowledge production and utilisation rather than to foster diversity and dynamism in the R&D community?

These are the major challenges that SCIE is tasked to confront. Modernisation may be construed as the attempt to undermine professional discretion and local judgement, rather

than to provide better grounds for decision-making; and to dictate what counts as knowledge, rather than to create consensus and coherence in the epistemology of social care.

Only time will tell, but two factors suggest optimism. First, SCIE has no regulatory powers: its work must necessarily be based on persuasion and collaboration, and on winning 'hearts and minds'. Only if practitioners, policy-makers, and users and carers are convinced, will change follow. Secondly, SCIE starts with an inclusive stance: there are no pre-existing 'regimes of truth' (Shaw and Gould, 2001) that seek to marginalize some voices and to prioritise others. SCIE's initial work included a consultation exercise and commissioned work to seek a wide range of stakeholders' views about what counts as knowledge and as best practice. Certainly, it will be necessary to bring coherence to the field, and to prioritise development in some fields over others, but this must be achieved through accountable, transparent decision-making, rather than through dogma or doctrine. As the prospectus cited in the introduction suggests, SCIE also recognises the knowledge and experience of service users and carers as a key source of change in social policy in recent years, and these voices are assured a prominent role in SCIE's work.

As a national organisation, SCIE must therefore operate according to inclusive principles, aiming to coordinate and foster, rather than to regulate and stifle. In providing a national focus for knowledge production, dissemination and implementation, SCIE's approach must be aimed at providing a framework, rather than a straitjacket, for research, development and practice in social care.

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APPENDIX

RAE results in Social Policy and Social Work, UK, 1992, 1996, 2001

| | Social Work | | | Social Policy | | |
|--------------------|-------------|------|------|---------------|------|--------|
| | 1992 | 1996 | 2001 | 1992 | 1996 | 2001 |
| Anglia Polytechnic | - | 2 | 3a | | | |
| Bath | 2 | 3a | - | 5 | 5 | 5 |
| Birmingham | 3 | 3a | - | 4 | 4 | 4 (PP) |
| +(SP/SW) | | | | | | |
| Bolton | | | | - | - | 2 |
| Bradford | 3 | 3a | - | | | 4 |
| Brighton | | | | 2 | 3b | 3b |
| Bristol | 3 | 4 | 5* | 3 | 5 | 5 |
| Brunel College | 2 | 3b | 3a | 4 | 4 | - |
| Central Lancashire | - | - | 3a | | | |
| Buckinghamshire | | | - | - | 3b | 3b |
| Cheltenham & Glos | | | - | - | 2 | |
| Chichester | | | | - | - | 2 |
| City | | | | - | - | 3a |
| Coventry | - | - | 3b | | | |
| De Montfort | 1 | 2 | 3a | | | |
| Durham | - | - | 4 | | | |
| East Anglia | 5 | 5 | 5 | | | |
| East London | - | - | 3b | | | |
| Edge Hill | | | | - | 3b | 3b |
| Exeter | 2 | 3b | 4 | | | |
| Goldsmiths | 2 | 2 | - | 3 | 3a | 4 |
| Hertfordshire | - | - | 3b | | | |
| Huddersfield | 2 | 4 | 5 | | | |
| Hull | 4 | 3a | 3a | 3 | 4 | 4 |
| Keele | 3 | 4 | - | - | 4 | 5 |
| Kent | 3 | 3b | 4 | 5 | 5 | 5* |
| Lancaster | 4 | 5 | 5 | | | |
| Leeds | | | | | | 5 |
| Leeds Met | | | | 3 | 3b | |
| Leicester | 3 | 4 | - | - | 3a | 3a |
| Lincs/Humberside | | | | 1 | 3b | 3a |
| Liverpool | 1 | 3a | - | | | 4 |

Evidence-based practice in social work

| | | | | | | |
|--------------------|---|----|----|---|----|----|
| Liverpool JM | - | 2 | 3b | - | 3b | 3b |
| LSE | | | | 5 | 5* | 5* |
| London Guildhall | | | | - | 2 | |
| Luton | - | 3b | 3a | - | 2 | |
| Manchester | | | | - | 4 | 5 |
| Manchester Met. | - | 2 | 3a | | | |
| Middlesex | 2 | 3b | - | - | 4 | 4 |
| Newcastle | | | | 2 | 3a | 4 |
| North London | | | | 2 | 2 | 3a |
| Northumbria | | | | 2 | 3b | 3a |
| Nottingham | - | - | 3b | | | 4 |
| Nottingham Trent | | | | | | 3a |
| Open | | | | 3 | 4 | 3a |
| Oxford | | | | - | 3a | 4 |
| Portsmouth | | | | 2 | 3b | |
| Plymouth | | | | | | 4 |
| Reading | - | - | 3b | | | |
| Royal Holloway | | | | 3 | 3a | 4 |
| St Martins | | | | - | 1 | |
| Sheffield | | | | 4 | 4 | 5 |
| Sheffield Hallam | | | | 2 | 3b | 3a |
| Southampton | 3 | 3a | 3a | | | 5 |
| South Bank | | | | 3 | 4 | 4 |
| Staffordshire | - | 2 | 3b | | | |
| Sunderland | | | | 2 | 2 | 3a |
| Sussex | | | | 2 | 3a | - |
| Thames Valley | | | | 2 | 3b | 3a |
| Warwick | 3 | 5 | 5 | | | |
| Westminster | | | | | | 3a |
| York | 3 | 5 | 5 | 5 | 5 | 5 |
| Dundee | 3 | 3a | 4 | | | |
| Edinburgh | 3 | 4 | - | 3 | 4 | 4 |
| Glasgow | | | | | 4 | 4 |
| Glasgow Caledonian | | | | - | 2 | |
| Paisley | | | | - | - | 3a |
| Stirling | 5 | 5* | 5 | | | |
| Glamorgan | | | | - | 3b | 3a |

The role of a national institute in developing knowledge and practice in social care

| | | | | | | |
|--------------------|---|----|----|---|----|----|
| Bangor/UCNW | | | | 3 | 4 | 3a |
| NE Wales Institute | - | 2 | 2 | | | |
| Wales, Newport | | | | - | 1 | |
| Swansea/UCS | 2 | 4 | 5 | | | 3a |
| Queen's Belfast | 2 | 3a | 4 | - | 3b | |
| Ulster | - | 3b | 3b | 4 | 4 | 4 |

(Source: HEFCs)

8

Promoting evidence based practice in a child care charity: The Barnardo's experience

Tony Newman and Di McNeish

Pity the poor social worker trapped between a post-modernist blizzard of narratives, discursive space and heurism, and an empirical swamp of randomised controlled trials, systematic reviews, critical appraisal and Bayesian statistics. On one side, an ideology that apparently questions the existence of any objective reality and locates personal experience at the centre of the evidential universe. On the other, one which seemingly proposes that the infinite complexity of humanity can be subjected to natural law, and believes that the unmeasurable can be measured. As an observer in a recent debate between protagonists of both perspectives commented in a conference feedback form:

There appears to be an academic in-fight going on which wasn't clearly outlined. Interesting, but a bit removed from practitioners' concerns.

Whatever the respective merits of these academic disputes, the view from the shop floor is clear - the people who actually deliver services are asking for practical tools, not complex discussions on epistemology.

What works?

Why 'what works?'. When the authors of this paper, along with other colleagues both within and outside Barnardo's,

began an initiative in 1994 to promote evidence-based practice in social care, the term seemed both fresh and challenging. It subsequently became the title of a popular series of 'best evidence' reviews, the first of which was published in 1995 (Macdonald and Roberts, 1995). We asked the question:

Experts have a duty not to intervene in people's lives on the basis of whim and intuition. But people at the receiving end of interventions are frequently vulnerable and powerless. How certain can they be that the services offered to them have been properly evaluated, that one service is better than another, or that any service is likely to be of greater benefit than no service at all? (Oakley and Roberts, 1996, p.1).

While no credit (or blame) is due to us for the growth in popularity of this phrase, the term has entered public and professional discourse, and is asked routinely by politicians when reviewing the possible range of welfare investment options. While inevitably suffering from over-familiarity, asking the question 'what works?' has led to other important questions being posed. What works for whom? Who decides what works? What do we mean by 'works'? And, given the immense richness and complexity of humanity, how realistic is it to seek to compile such a body of knowledge in social care services?

Interventions in social care, health or education, do not work well for all people, in all contexts, all of the time. Even if they did, it is unlikely that they would remain the intervention of choice indefinitely, as policies, practice and people's expectations change over time. In many cases, there may be little to choose from between different types of interventions, or the difference between intervening and just doing nothing may be minimal. In some cases, positive shifts at an individual level may need to be aggregated to detect any overall benefits at a population level, and this may only be visible when the experience of hundreds or thousands of people are analysed. This may be compelling evidence for an epidemiologist, but less persuasive to the average UK parent whose main interest is the welfare of the 1.7 children in her family.

What matters?

There is no single best way of helping a child affected by behavioural problems, no single best treatment for attention deficit disorders and no single best method of preventing youth crime. The chosen intervention will be driven by a wide range of factors; empirical evidence certainly, but also the views of children and families, the ecology of their environment, professional experience, the skills available and any resource constraints. However, by a conscious attention to the evidence base, we can increase the odds that a more, rather than a less effective intervention will result. Evidence-based practice cannot deliver certainties, just increase probabilities, and this is the most that any approach claiming to be 'evidence-based' can hope to achieve. We also need to remember that much of what *matters* to children cannot be provided by professional organisations, however richly resourced. No professional has a magic wand that can make children attractive to their peers, repair their parents' broken marriages or help them pass all their exams. However, some of the things that practitioners and policy makers do can make a difference, even in these areas. Being realistic about what we cannot do, will leave us more time and resources to devote to what we can do successfully.

Meeting the information needs of practitioners

The delivery of effective services, and the generation of a knowledge base that can underpin this is what, we would suggest, the public have a right to expect from any human service profession. However, while the ethical qualities of services have historically been stressed by both the UK and American professional social work associations, concern as to their actual *effectiveness* has been less prominent (Myers and Thyer, 1997). It is only recently that this dimension - that is, the extent to which the activities of social care agencies bring about the changes intended - has moved centre stage in

the policy arena. Social work research in the UK, and indeed the USA, has been largely pre-occupied - judged, at least, by publication volume - by theory, political discussion and descriptive studies. These are, of course, vital aspects of any dynamic profession. In the USA, publications which examine what social workers *do*, and the corresponding effects on service users of their doing it account, according to a recent review, for only 14 per cent of articles in social work journals (Rosen *et al.*, 1999). In the UK, of the 356 articles appearing in the British Journal of Social Work during the 1990s, only five were outcome studies (Sheldon and Macdonald, 1999). Academic social work, unlike medicine, remains curiously unwilling, or unable, to meet the information needs of its core user group - the ones who actually deliver services. This is surely not a satisfactory situation for a profession whose *raison d'être* is intervention, not observation.

Social care services, in common with health, the probation service and increasingly education, have been directed to base practice on 'the best evidence of what works' (Department of Health, 1998, p.93). Investments in child care programmes, including Sure Start, the Children's Fund and Connexions, have been accompanied by an expectation that strategies adopted will be evidence-based. Interventions that have been validated by research methods featuring 'before' and 'after' measurements and comparison groups (for example, Sure Start, 1999), are especially commended. A growing range of consortia, for example Research in Practice (www.rip.org.uk) Making Research Count (www.uea.ac.uk/swk/research/mrc/welcome.htm) and the Centre for Evidence Based Social Services (www.ex.ac.uk/cebbs), are promoting evidence based practice and disseminating robust research summaries to an increasingly broad range of practitioners. Excellent material relevant to social care, as well as guidelines for finding and using research are also available from a range of websites, including Southampton University (www.soton.ac.uk/rminded), the Wales Office of Research and Development (www.dialspace.dial.pipex.com/word), the Scottish Executive (www.scotland.gov.uk/edru/edrupub.asp), the Home Office (www.homeoffice.gov.uk/rds/horspubs1.html) and, especially in relation to disability issues, the Social Policy

Research Unit website at York University (www.york.ac.uk/inst/spru/pubs/researchwks.htm). On the international front, the Campbell Collaboration (Petrosino *et al.*, 2001, www.campbell.gse.upenn.edu), an analogue of the Cochrane Collaboration (www.cochrane.org) in health care, has been established to review and disseminate evidence in the fields of educational, criminological and psychosocial interventions. The establishment by the Department of Health of the Social Care Institute for Excellence (SCIE) is a clear recognition that the conscious use of evidence is central to a professional social work service. The information technology revolution has enabled any social worker with a PC to access on-line data bases which cover the full range of social work practice, such as the excellent electronic library of social care (eLSC) maintained by NISW, recently transferred to SCIE (www.scie.org.uk), and now available without subscription. The next generation of data bases will, as has already occurred in medicine, contain abstracts which have screened for methodological quality and are regularly updated, rather than simply being a list of published articles. These developments are already taking place. Barnardo's is helping the Centre for Evidence Based Social Services (CEBSS) at the University of Exeter develop an on-line resource of critically appraised social work studies, which will go live in 2003 (www.be-evidenced-based.com). As the only non-academic institution participating in the ESRC Evidence Network (www.evidencenetwork.org), Barnardo's is working with City and York Universities to develop dissemination and implementation programmes for projects in Yorkshire developed under the auspices of the Children's Fund.

Why evidence based practice?

While a degree of controversy surrounds the applicability of evidence-based practice to social work, with some concern that this will over value technocratic solutions to human problems, the empowering potential for users and practitioners in having interventions based on sound evidence

is substantial. Whatever one's perspective, an understanding of the issue has become crucial to practitioners and child welfare organisations. So what do we mean by evidence-based practice? Drawing on a number of other sources (Sackett *et al.*, 1996; Sheldon and Chilvers, 2000), we suggest that evidence-based child care practice may be defined as '*the process of systematically locating, critically reviewing and using research findings as the basis for decisions in child care practice*'.

Promoting evidence-based models of practice in child care organisations is frequently a controversial activity. Social workers are often unhappy with empirically based approaches and raise typical - and often justified - issues.

- Why should we value one kind of knowledge more than others?
- Where do the views of users fit in?
- Who gets to decide which evidence is the 'best'?
- Evidence based practice seems to be about counting and measuring everything - not everything that counts can be counted.
- Human problems are much too complex to be managed on this basis.
- Evidence-based practice will discourage radical ideas by imposing conformity on practitioners.

These points-deserve answers. Evidence-based practice in social care has indeed been closely associated with empirical models of investigation and cognitive-behavioural methods of intervention. It has been argued that this approach results in other types of knowledge being under-valued (Lewis, 1998), in procedure driving out creativity (Trinder, 1996; Webb, 2001), in process being sacrificed on the altar of outcomes (Sinclair, 1998) and the day to day experience of practitioners being diminished (Shaw and Shaw, 1997). A more worrying objection suggests that evidence-based practice oppresses users by failing to give equal - or paramount - status to their views and experiences (Everitt and Hardiker, 1996). No single form of discourse, it is argued, has the right to claim precedence over another (Witkin, 1999).

These views have some common features. Firstly, they are sceptical that the principles of natural science can be successfully applied to social care practice, give the intrinsic 'messiness' of human relationships and the impossibility of standardising interventions. This, however, tends to exaggerate the extent to which 'evidence' alone is ever the sole criterion justifying a social care intervention, and underestimates the 'messiness' of health service interventions. What, for example, is the 'best' treatment for depression? Open or log onto the current volume of 'Clinical Evidence' (subscription only, www.clinicalevidence.org) - a regularly updated summary of evidence from randomised controlled trials in medicine distributed to all GP's - and look it up. The answer? There isn't one. A wide range of treatments, pharmacological, herbal, behavioural, electrical and psychotherapeutic are discussed, so is exercise, be-friending and bibliotherapy. Depending on the severity of the condition, there is evidence for the effectiveness of all these approaches, compared to doing nothing. Some of the evidence is stronger, some is weaker, with some the jury is still at least partially out. Even at the cutting edge of evidence based medicine, the most that can usually be achieved is that a patient is fully appraised of the range of treatment options, their respective pros and cons, and is able to make an informed choice about what's best for them.

Secondly, there is a perception that evidence-based practice devalues the narratives of the powerless and privileges the good and the great. On the contrary, we would argue that what devalues the powerless is being subject to unsubstantiated claims of authority. These may be based on expert knowledge (the 'I have more letters after my name than you' approach), a long career (the 'I have nothing left to learn' approach), practice wisdom (the 'I have arrived at the right answers by a process which transcends analysis' approach), membership of an oppressed group (the 'our history of suffering renders us immune from criticism' approach) or personal experience (the 'I have walked through the valley of the shadow of death and you haven't' approach). All these sources of authority are legitimate and indispensable; however, they are also not enough. Those who believe that

their chosen approach - whether based on 'knowledge', 'experience', 'intuition', 'practice wisdom', or simply an ideological conviction - is sufficient justification for their actions are adopting authoritarian positions (Chalmers, 1983), and these positions are no less authoritarian when they come dressed in anti-oppressive rhetoric. As well as individuals, organisations and special interest groups with territory to defend - and yes, Barnardo's falls into this category - may react fiercely to criticism if their well-intentioned actions are found to be unsupported by a robust evidence base. Recent examples of this are systematic reviews that have suggested that screening for breast cancer does not save women's lives (Olsen and Gotzsche, 2001), and that programmes run by the Driving Standards Agency in schools may result in more rather than fewer accidents (Achara *et al.*, 2001).

Evidence based practice is thus not, as is frequently alleged, a search for 'certainty' in either medicine or social work (Taylor and White, 2001). It is rather a genuine attempt to give vulnerable people a better chance of having good, rather than bad things happen to them, by a continuous process of improvement. As the physicist turned philosopher Piet Hein remarked:

*The road to wisdom?
Well, it's plain and simple to express
Err and err and err again
But less and less and less*

The Barnardo's approach

While the collision between empiricism and intuition is hardly new (William Blake was picking a fight with Newton two centuries ago), the dispute is more than a tedious argument between academics and their pet methodologies. Important issues concerning the welfare of vulnerable people are at stake. Will those who utilise empirical methods of investigation be inoculated against outrage at poverty and

disadvantage? Can social justice really be promoted through randomised controlled trials? The subject matter of 'books that have changed my life' tends to feature spirituality, biography or fiction. No-one, to the best of our knowledge, has ever claimed that their life was changed by the Handbook of Empirical Social Work Practice (yes, it exists; in two volumes). However, a recent analysis of twelve months of queries to the 'Advice Shop' of the leading social work journal 'Community Care' by Katherine Curtis at City University revealed rather more prosaic concerns. The majority of practitioners wanted practical information on how to work more effectively with (in order of frequency) disabled people, looked after children and service users from ethnic minorities. Questions about epistemology were thin on the ground.

Promoting social change through appeals to both reason and emotion was well known to Thomas Barnardo. While basing much of his early success on photographic images of children's misery, it was also important for him to establish a reputation as a serious social scientist. Addressing a social science convention in 1879, he provided an early example of a cost benefit analysis. He suggested that we could choose between expenditure:

...in the shape of rates and taxes for the support of police, magistrates, justices, houses of detention, convict prisons ... or in the form of donations to institutions like ours ... every convict costs England upwards of £80 per head per annum. Every boy or girl taken from the streets costs but £16 per year (Night and Day, September 1879).

That early investment can reap handsome social rewards was reiterated over a century later. The longitudinal study of the Perry Pre-School programme noted that, 'over the lifetime of the participants, the pre-school program returns to the public an estimated \$7.16 for every dollar spent.' (Schweinhart *et al.* 1993, p.xviii). Then, as now, the crucial factor driving public investment was hard data on social gains combined with narratives arising from personal encounters with disadvantaged children. There is little doubt, for example, that the initial £550M investment in the national

Sure Start programme would not have taken place without compelling evidence from US and UK early intervention programmes of the positive long term impacts on child well-being of pre-school support (Macdonald and Roberts, 1995; Zoritch and Roberts, 1997).

Introducing an evidence based model

Barnardo's has made a commitment to work towards basing all its child care practice on the best current evidence of effectiveness. Barnardo's is fortunate in having a well resourced research and development team with six permanent staff and a number of others employed on a temporary basis. This team has, with the support of policy and training officers, operational child care staff and colleagues in our Marketing and Communications divisions, led the evidence based practice strategy. This, in itself, is an important factor which the literature on organisational change stresses - the need for product champions of sufficient seniority with access to change levers.

Our primary concern has been to focus on the outcomes most wanted by children and families, and to make judgements about what information we need to assure ourselves that our efforts are making these outcomes happen. To this end, Barnardo's has commissioned a range of reports, the *What Works?* series, which address important areas of child care practice. Each report summarises the best current evidence in its particular field, highlighting, where possible, evidence from controlled trials and systematic reviews. Volumes published to date include reviews of early years interventions, services for families with disabled children, leaving care services, youth justice, inclusive education, child protection, parent education, stability in care, support for parents with learning disabilities, the education of looked after children and community development, among others. A programme of seminars designed for Barnardo's staff and led by the report authors has been delivered. To complement these volumes, a series of shorter 'key message' fact sheets

have been prepared are available to Barnardo's staff through the organisation's intranet. Dissemination and implementation are crucial dimensions of any evidence based approach. Barnardo's R&D staff recently completed a commission for the Joseph Rowntree Foundation reviewing the most effective ways of making the leap from theoretical to applied knowledge, and have cascading the results to our national child care regions (Barnardo's R&D team, 2000). As members of Research in Practice, research officers are currently piloting the REAL (Reflection on Evidence for Action and Learning) team working pack with a number of Barnardo's projects, which helps staff identify key practice issues, research the literature, formulate a change strategy and implement the results.

Listening to the voices of children is a key element in our programme of research. A range of studies drawing directly on children's views have been completed, the most recent being a major review of children's participation for a London Health Action Zone (McNeish *et al.*, 2000). This process has been greatly assisted by Barnardo's R&D intern programme, which offers one and two year contracts to young graduates, and is financed by external commissions and awards. Barnardo's library provides a crucial support service to staff seeking specific information, either on the shelves, on CD-Roms or on-line. In collaboration with R&D staff, reviews of effective interventions are carried out in response to requests from services that are being set up or re-focused. Recent examples are reviews of sensory integration therapy for a pre-school service working with autistic children and a summary of what we know of the effectiveness of community based support services for bereaved children. It is our long term intention that all Barnardo's services are based on such reviews, and that new services will be designed around what is currently known to be the most effective service structure or intervention.

Examining and synthesising previously published material is cheaper and, in many cases, more productive than undertaking original research. In the near future, all Barnardo's staff will have access to on-line data bases and will know how to use them. A series of workshops designed to

assist staff locate and download relevant evidence based material has been piloted. This will involve help staff discriminate between poor quality information and material that is more credible.

Conclusion

What evidence is there that Barnardo's child care practice, and more importantly, outcomes for children have changed as a result of these strategies? While it is early days yet, there are encouraging signs of change. Requests for evidence based reviews from services are increasing. The 'What Works?' series is widely consulted. The use of the Barnardo's library and information service by practitioners has improved. The proposition that *not* seeking to base one's work on best evidence of effectiveness is an ethically indefensible position has penetrated the powerful moral universe of social work. None of this yet constitutes any paradigm shift in service delivery and is certainly no indication of whether children have benefited. However, it has become clear that there is in Barnardo's - and undoubtedly in other child care organisations in both the voluntary and statutory sectors - a hunger for robust, well crafted evidence based research that has utility for day to day practice. We have moved through the phase of stimulating need, and now have to provide the product, which will undoubtedly be a more difficult but highly invigorating task.

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9

Towards a more reflexive research aware practice: The influence and potential of professional and team culture

John Lawler and Andy Bilson

Introduction

Evidence-based practice (EBP) is a fashionable idea in social work. Whether it develops into a more enduring aspect of social work will only become clear with the passage of time. Despite some of the reservations about the use of evidence in this and other contexts, it is important to highlight the benefits of building awareness of evidence into practice. Without this, it is unlikely that evidence-based practice will develop beyond the transience of fashion. This will involve considering some aspects of social work practice with fresh eyes, but will also utilise other more familiar processes of support, communication and development. This article reviews the current debates including those outlined in the recent special edition of this journal on the nature of evidence, as well as the possibilities for evidence-based practice in social work. We will consider how to encourage a more reflexive, research aware practice in social work. We conclude that the focus for attempted reforms needs to be widened from the current primary focus on individual professionals and their education to a broader perspective that can enable development of new practices in social work teams and organisations. Our focus is predominantly that of culture and knowledge in social work teams.

Evidence in Social Work

There are many different views on the causes of problems that result in social work intervention and therefore on appropriate ways of responding to them. To that extent, the issue of evidence-based practice in social work will always be problematic (see Newman and McNeish, 2002). A key challenge to the implementation of evidence-based practice is how to deal with the tacit and socio-politically based knowledge which informs social work practice (see Frost, 2002; Taylor and White, 2002; Smith, 2002). There is a continuing need to explore this knowledge base and the development of 'received wisdom' in social work. In many ways there is a clear parallel with the development of received wisdom in management, again in part a strongly, socially-orientated area of work with much tacit operational knowledge. Whilst some areas of management, e.g. production management, have powerful rationalist, explicit traditions, areas of management such as human resource management and organisational change are much less so and propose more emergent, more interpretive approaches. This similarity between the disciplines of management and social work, noted by Booth *et al.* (2003), is of particular relevance in an era of increasing managerialism in social work. They cite Stewart's definition of evidence-based practice, (itself a paraphrase of that by Sackett *et al.*, 1996), that it is the:

explicit and judicious use of current best evidence in making decisions
[Stewart 2002, p.6] (Booth *et al.*, 2003, p.192)

and argue that the source of this definition is managerial:

The management origin of this pragmatic definition signals similarities between social care and management as disciplines where there is apparent under-utilization of research evidence (Booth *et al.*, 2003, p.192).

One interpretation of evidence-based practice in general, is that, in common with many management practices, it is an attempt to limit uncertainty in decision-making in individual

cases and as such, is a characteristic of the growing rationalist focus within social work organisation and delivery of services (see Taylor and White, 2002). The rationalist approach to certain aspects of management is well documented in management texts (e.g. Mullins 2003; Darwin *et al.*, 2002) and can be seen today within the health and social care contexts as discussed by Moullin (2002, p.100). Writers such as Bilson and Ross (1999), Webb (2001), Harlow (2003) and Harris (2003) point to the development of techno-rationalist, managerial models pervading social work, which is manifest in a 'performance-driven' culture (see also Frost, 2002). The emphasis on the use of evidence to inform practice reinforces this, with its particular ontological position and its assumptions of near universal (and as yet undiscovered) answers to particular problems. Social work practice does not sit happily with this. It is an 'invisible trade' (Pithouse, 1987) and as such its processes present particular challenges for research and evaluation. Its practice is reconstituted through re-telling in different contexts. It is also open to different interpretations by professional and user and its 'outcomes' are complicated and often long term, if they can be regarded as outcomes at all. Additionally, but not exclusively to social work, its interventions are crucially dependent for (intended) effect (or effectiveness) on the collaboration and commitment of the user. The techno-rationalist approach relies on a 'scientific' basis of evidence in social work practice, which Webb (2001) questions. He highlights a fundamental point about social work defining or realising its position within an 'aporia', which is unrecognised by policy makers and, through emphasis on certain aspects of policy, is disregarded by managers.

An alternative view is that the use of evidence is an acknowledgement of the inherent uncertainty in social work and a means of highlighting this. Despite the potential problems, Gibbs and Gambrill (2002) argue the benefits of evidence-based practice in social work. According to them it

is a process (not a collection of truths) in which the uncertainty in making decisions is highlighted, efforts to decrease it are made, and clients are involved as informed participants. (p.473)

The process in practice involves several fundamental elements, according to Bilsker and Goldner (2000)

questioning of unfounded beliefs, rigorous scrutiny of methodology, critical appraisal of proposed treatments. (p.665)

The move towards evidence-based practice constitutes a shift in both form and content of knowledge, according to Newman and Nutley (2003), away from the current tacit knowledge base to the more explicit. This in turn implies a major, longer-term change in professional knowledge and therefore in training.

Culture and evidence-based practice

The potential barriers to the adoption of evidence-based practice are several, as noted by Sheldon and Chilvers (2002). Issues such as professional identity and status; established values and practice; and professional training can all be seen as aspects of 'professional culture'. If certain aspects of professional culture themselves present a barrier to EBP, other objections to the introduction of EBP might be reinforced by it. McKenna *et al.* (2004) point to the conflicting nature of research conclusions as being a barrier to the introduction of evidence-based practice in primary care. Any potential conflict in results, it is argued, causes confusion amongst practitioners. Furthermore, the conflict is likely to be emphasised as a means of resisting any change in practice. Bilsker and Goldner (2000) stress the need to convince both practitioners and users of the value and feasibility of evidence-based practice as a precursor to any plans to develop it. However, these views imply that social workers consider research conclusions as a matter of course, an issue challenged by the research carried out by Sheldon and Chilvers (2002). Similarly Gibbs and Gambrill note that

research suggests that few social workers draw on practice-related research findings. (p.452)

The reasons for this may vary, but include professional practice and the time practitioners might or might not have to access research information. Gira *et al.* (2004) make a similar point:

The daily pressure to see more clients makes it extremely difficult for social workers to find time to read research literature even if they were inclined to do so. Social work as a profession has not found ways to help practitioners identify and use the latest research evidence in their practice. (p.69)

Professional culture may be challenged by the concept of EBP. Newman and Nutley (2003) argue that EBP, within the context of probation for their discussion, is perceived as a threat to professional practice, status and identity, as exemplified by a research participant:

a shift in the definition of what constitutes professional knowledge was not easy to accomplish. The old status and identity of probation officers had been based on a tacit pool of knowledge.... This tacit, experiential knowledge was perceived to be being devalued in the search for more explicit, research-based knowledge. The autonomy of individual probation officers was also being curtailed (they) perceived themselves as 'ticking boxes' rather than using their judgement and discretion. (p.551)

Tacit knowledge forms an important part of such an operating culture and relies on experience and verbal transmission. Barratt notes that:

[there] is an oral, rather than a knowledge-based, culture within social services which results in staff valuing direct practice experience over, and often to the exclusion of, other forms of learning [Sheldon & Chilvers, 1995] (2003, p.145).

Gira *et al.* (2004) point to the difficulty presented by a different culture of practice within social work as opposed to the medical culture, where the introduction of evidence-based practice has arguably been more successful. A further aspect of organisational culture is also highlighted by Barratt who notes

the perception of social workers that they operate within a 'blame culture', with the attendant difficulties this presents for changing practice. The social work workforce is also seen as being relatively poorly qualified, unqualified to some extent, having little in its culture which promotes critical appraisal and little time to read and reflect. This is aptly summarised by Booth *et al.* (2003):

A literature review reveals a workforce, poorly equipped by professional education, relying heavily on personal communication and 'gut instinct' to deliver packages of care. A workplace culture of action, not reflection, and the absence of information, resources and skills, make social care practitioners less likely to consult research to improve their practice. (p.191)

The current system of professional training needs revision if evidence-based practice is to be fundamental to the culture of professional practice in the future according to Howard *et al.* (2003). They argue that qualifying students, despite having access to a greater wealth of information than previous generations of students and practitioners, do not develop the skills through their training to be able to access and analyse critically the research which might inform practice.

The rationalist approach of reliance on disseminating published information alone is very unlikely to have any significant impact in the development of EBP. Combinations of approaches appear most likely to have an effect on changing practitioner behaviour (Gira *et al.*, 2004) and offer a greater likelihood of influencing professional culture. Gira *et al.* conclude that:

The literature from health care suggests that disseminating information alone is insufficient. Many interventions have been designed to improve practitioners' adherence to EBP guidance and are differentially effective. To date no intervention has demonstrated powerful effects. (2004, p.77)

The majority of the approaches reviewed above, reflect a growing technocratic rationality. This presents a set of institutional reactions to the perceived need to change which are largely rationalist in their analysis and bureaucratic in their

responses. Whilst this may be apt in the bio-medical context, in the socio-medical and social work contexts such responses have limitations. Such limitations are compounded when considering the intangibility of professional culture and the difficulties of trying to change it (Ormrod, 2003).

Developing an evidence informed social work culture

Whilst bearing these limitations in mind, we will argue the need to develop a way forward which, we believe, is more fitting to social work than the techno-rationalist approach evident in much of the implementation in medicine and which addresses the issue of professional culture. To reiterate: the aim of EBP is to develop practice so that the most convincing information is used fully to inform the delivery of social work interventions for the most positive outcomes, from the perspectives both of service deliverer and user.

The development of EBP constitutes a considerable change to the tradition of social work practice. It is important here to acknowledge the considerable and developing literature of organisational change, but it is not our intention to review that here. The change management literature in general has a concern with looking for universal solutions to the problems of 'change management' (Sturdy and Grey, 2003) and can be very prescriptive. Some of the more recent change literature, which offers most utility for developments in the social work context, is that which acknowledges the complications and unpredictabilities of professional service interventions and delivery and the role of discourse in studying change. The importance of culture in organisational change is a recurrent theme. It is important to note that the literature on organisational culture is itself characterised by debate. In simple terms this revolves around the issue of whether culture is something an organisation/profession *has* and which it can change relatively easily, or whether it is something the organisation/profession *is*, that is, a manifestation of the values, experiences and perspectives which inform its practice

(Ormrod, 2003). The former perspective implies a managerialist, rationalist approach to change, whilst the latter highlights the role of personal and professional values and implies the need for a reflective, discursive approach to change. It is this second approach that we feel has value in the development of evidence and evidence-based practice in social work.

Culture and tacit knowledge

The need to recognise and alter the particular culture within both health (Pettigrew *et al.*, 1992) and within social work (MacDonald, 1999) is acknowledged in the literature. Any focus on changing individual practice without taking due note of the operational culture is unlikely to lead to sustained change. MacDonald recognises the particular need to change 'culture and practices of (social work) organisations' (p.31) if effective EBP is to be introduced. Mullen (2002) similarly notes the culture of social work as paying little attention to research findings and argues the reasons for this:

the place of systematic reviews of effectiveness research has grown in importance, such as seen in the Cochrane and Campbell Collaborations. Systematic reviews provide an important means to accumulate and assess the cumulative results of research pertaining to outcomes of health, education and social interventions. However, systematic reviews do not provide a direct linkage to practice prescriptions. This is because practice decisions need to be made on the basis of knowledge derived from not only scientific investigations, but also experience, values, preferences, and other considerations deliberated by providers, users, and carers within the constraints of available resources. (p.10)

The point on the nature of practice decisions is key here. It demonstrates the need to acknowledge the role of tacit knowledge - built up through experience and incorporating professional knowledge - to be used in delivering a service in a manner which is sensitive to the specific needs of the vulnerable

individual, that is, caring for human sensibilities.

The literature on knowledge conversion (from tacit to explicit to tacit) is useful in relation to this. Nonaka and Takeuchi (1995) outline a 'knowledge spiral' within the context, for their purposes, of organisational innovation. This approach recognises that tacit knowledge is developed through practice and through socialisation with colleagues and that it is informed by aspects of explicit knowledge, internalised by practitioners. Similarly, aspects of tacit, practitioner knowledge are made explicit, externalised to others, through more formal rather than verbal means, a process which de-contextualises the knowledge to some extent. Explicit knowledge from various sources is then combined and adapted by individual practitioners to meet specific circumstances, which in time becomes integral to the tacit knowledge that informs their practice and thus the spiral continues. Elements of this process, which are crucial for practitioners, are reflection, both with colleagues and users, on effective practice; ready access to external explicit information; and the support for individual reflection in order to combine and apply evidence appropriately.

Professional teams

The role of teams in developing professional culture, in socialising new members and in developing tacit knowledge is important (Pithouse, 1987; Hall, 1997; White, 1998; Bilson and Barker, 1998). The change literature is too often concerned with the individual 'change agent' to the neglect of the role of the team itself as an instigator and supporter of change. This may be an important factor implied rather than explicit in some models of change. For example, Rogers' (1995) approach to the diffusion of innovations highlights the key role of the 'critical mass' in the adoption and sustenance of innovation. His model follows a process of dissemination, adoption, implementation and maintenance. The role of dissemination in the traditional sense has its limitations in the social work context, as already discussed. However at the team level dissemination can take a different turn, involving the sharing of learning, - dissemination of experience from research and practice - to other team

members, the stage of combination in Nonaka and Takeuchi's spiral, noted above. Such a process model of change provides a more complete systematic approach than many other models, highlighting as it does, the maintenance or institutionalisation of new practice. Our view is that the team can be very influential at each stage of Rogers' model. Shared experience, shared values and tacit knowledge characterise the professional team. These teams have an important support function and themselves provide a forum for discussions which share information (e.g. on both evidence and on local context; tacit and explicit), share experience (e.g. on effective practice), and which provide the opportunity to develop evidence to share with and beyond the team.

The research into teams in social care (e.g., Pithouse, 1987; Hall, 1997; White, 1998), medicine (e.g., Bloor, 1976) and nursing (e.g., Latimer, 2000) show how cultures are locally accomplished and reproduced and can sustain the tacit practices of occupations, organizations and teams and indeed may be used to resist the sort of approaches to policy and practice change usually associated with rational approaches to implementing evidence-based practice. A key problem in cases where practice is framed in a strong local culture that supports the resisting behaviour, is recognising that this presents a problem at all. This is because these cultures and the practice that is supported by them are based on tacitly held assumptions that are difficult to challenge as they are taken for granted as truths.

Armstrong (1982), in a similar vein, states:

The rational approach is rational only for the change agent. For the changee, change seems irrational. Should we change important beliefs each time someone thrusts disconfirming evidence on us? It is not surprising that 'people are resistant to change.' The rational approach implies that the target of the change is irrational. (Armstrong, 1982, p.463)

An example of how an attempt to implement an evidence-based approach can falter because it is unable to challenge strong team cultures, can be seen in social work practice regarding contact between parents and their children in care

(Bilson and Barker, 1994, 1995, 1998). This area of child care has a well developed research base that stresses the importance of regular contact for the well-being of children (Lawder *et al.*, 1986; Millham *et al.*, 1986; Bullock *et al.*, 1990). Following the 1989 Children Act in England, serious attempts were made to implement evidence-based practice in this area through extensive training programmes, regulations and rules, publishing research reviews and good practice guides. Research by one of the authors into how this evidenced informed practice was undertaken and demonstrated that levels of contact varied widely within and between local authorities. It was also found that large variations between teams within local authorities could not be explained by the factors usually linked to differing levels of contact. Evidence that team culture played a crucial part in these differences came from feedback from the teams. Some teams had a local culture of low levels of parental contact, acting on premises related to rescuing children from their parents whilst other teams had high levels of contact (dealing with similar problems in the same authority) from a culture of cooperation with parents. Following research seminars using the principles outlined below four from five authorities achieved high levels of contact in a follow up study.

Our point here is that human agents easily develop routinized patterns of thought, action and interaction in relation to their activities. These aspects are supported by, and become the local cultures of teams and organisations. They tend to be relatively invisible to those within the culture and thus are also extremely durable. They are vitally important in understanding reasoning and action, as Varela notes:

... my main point is that most of our mental and active life is of the immediate coping variety, which is transparent, stable, and grounded in our personal histories. Because it is so immediate, not only do we not see it, we do not see that we do not see it, and this is why so few people have paid any attention to it ... (Varela, 1992, p.19)

Varela goes on to question how we can apply this distinction between 'coping behaviours and abstract judgement' to making judgements which are moral and ethical. This point is central to the judgements of social workers. The evidence cited so far

leads to the conclusion that many social work judgements are of the immediate coping variety. We will suggest that to develop a response to decision making in this context, it is important both to have an analytic approach to ordinary activity - a way of reflecting on what is taken for granted - and an emotional and ethical engagement with the moral nature of social work decision making.

This tacit dimension of practice often seems very difficult to extract and articulate. However, its nature is essentially social, and it cannot therefore be located entirely in the social worker's internal thinking. It must from time to time be visible, accessible and reportable - this will be particularly evident in the way that novices are inducted into team practices or 'deviant' behaviour is punished. We therefore argue that, if we are to develop the capacity of social workers to evaluate whether they want to make changes to tacit foundations of their practice and base decisions on available evidence, we need techniques to help them reflect on their tacit assumptions (Taylor and White, 2000; White and Stancombe, 2003).

The support function of the team can be crucial here. The team provides an important opportunity to reflect on and to discuss practice generally. Thus a forum is presented which permits members to discuss the emotional aspects of their work; a dimension recognised as important within social work, but one which receives less attention in the 'evidence' and change literatures. Bilson and White (2004), Gira *et al.* (2004) and Webb (2001) all note the potential impact on professional workers of emotional engagement in evidence, for example using case studies to exemplify practice rather than relying on the less engaging material from more traditional research summaries. The potential of team discussions that engage individuals using direct case information may be an important part of the development and dissemination of practice evidence. Allowing an emotional aspect in the development of evidence-based practice is important as is recognition that the relationship between new knowledge and change in professional practice is not a direct causal link. Changing professional practice might involve questioning basic practice assumptions and this can cause considerable concern, threat or discomfort for the individual. Certain models of change acknowledge this, such as

the 'transition model' described, for example, in both Hayes (2002) and Hopson *et al.* (1992).

Two further aspects of social work culture are important for consideration here. The first is the historical collective culture of social work practice; generic social work is particularly team based and relies on team discussion and support. Whilst there may be significant individualization in many aspects of society, this collective aspect of social culture appears to continue and provides an opportunity as a facilitator to EBP. The second aspect of social work culture and practice is the holistic nature of the social work perspective. Mirroring the evidence-based approach in medicine would present social work practice as a fragmented set of activities, with each aspect subject to investigation of its own evidence base, but the need is to see it as a systemic whole. The change literature generally notes the need to acknowledge the factors which might promote or hinder particular change initiatives and to utilise the former in promoting change. Change such as implementing EBP involves challenging long held assumptions and altering established patterns of behaviour. As we have said, the professional team provides the forum for both these as it presents an opportunity to develop reflexive discussion and to support, encourage and reinforce changing practice, which might be more difficult as an unsupported individual initiative. Mullen (2002) notes this opportunity:

supervisors, consultants, and teams [our emphasis] seem to be the most promising conduit for knowledge dissemination in organizations, ... regarding practice guides and other forms of evidence-based practice for social workers. (p.9).

The evidence of using groups as a means of implementing evidence-based practice is particularly light and we believe an under-regarded aspect of EBP, both in its possibilities to assist and to resist EBP. However, it is not totally disregarded. Gabbay *et al.* (2003) consider the potential of 'communities of practice' in implementing evidence-based policy. Whilst their study considered multi-disciplinary teams, the points they make in relation to groups of professionals using and considering evidence are important. They note the value of collective sense-

making and the ways in which evidence can be explored and interrogated in the collective context. Whilst their study reveals the ways in which evidence might be mediated, and its translation to practice might be deferred as well as encouraged, they present important findings which highlight how such communities of practice can be supported to examine evidence and its implications in a useful manner.

*The rationalist, linear model of evidence-based practice is not reflected by the experience of these communities of practice. Nevertheless, with a clearer understanding of the processes of collective sense making, it may still be possible to encourage the more systematic use of relevant knowledge in collective decision making (Gabbay *et al.*, 2003, 328).*

In the rationalist, linear model 'evidence' is used to prescribe practice in a top-down manner. We would suggest the need for a different approach starting from the idea that actions to create a more reflexive practice should come from practitioners and managers in local teams and similar groups and should be realised through using research to reflect on their own understandings of what is good practice.

Implications for research and use of evidence

Our approach then, stresses the need to engage participants in reflecting on their assumptions. So what are the implications of this approach?

Research into the tacit

First, there is a need for data that falls outside the usual research approaches valued in traditional approaches to EBP. This requires us to find ways to collect data on the way that social workers create and maintain their culture and tacit knowledge and on its content. We have already outlined the way that data on patterns of practice, such as that found in

parental contact, can give indicators of how culture affects practice. We would also suggest that there is a need to research local cultures themselves. This can be achieved, for example though studying inter-professional talk and interaction in everyday settings (Taylor and White, 2000; White and Stancombe, 2003). This is because cultures must necessarily reinforce themselves and this making and remaking of occupational or team cultures takes place most visibly in interaction and talk between professionals. Research into local culture may also differ in terms of data collection and analysis of artefacts such as written records, statistical data, transcripts of talk. These need to be read, not in order to evaluate or prescribe practice, but for what they can tell us about the tacit presuppositions which order professional activity. For example, it is recognised that files represent 'a potential resource for vindicating practice' (Pithouse, 1987, p. 34). However it is the very way in which professionals attempt to vindicate their practice, which gives important information about their view of the official definitions within which they operate. Thus the aim is not to find more about the 'reality' of the lives of users, or to evaluate the adequacy of recording against some normative template, but to consider what presuppositions or world-views inform the social work decisions being made.

The following case closure summary from an audit of older people's services (Bilson and Thorpe, 2004) illustrates the use of files in this way. The case concerned a bedfast woman whose husband was worried about his continuing ability to care for his spouse, exacerbated by living in a third floor apartment with restricted access:

Mrs. Y is a very poorly lady all of her needs are met by her husband (he will not accept help). ... issues raised were around housing issues. Mr. and Mrs. Y have been waiting for ground floor accommodation for a long time. I have liaised with housing re my concerns.

The extract shows what the researchers saw as the tacit assumption of the worker and the manager who closed the case: that their role was to provide packages of physical care and that social aspects of the problem, such as inappropriate housing,

were not part of the team's responsibility. Note the bold statement that 'he will not accept help' and that 'the issues raised were around housing'. Once data of this kind has been generated, the assumptions underpinning such statements and the process of professional 'sense-making' can be examined through professional reflection.

Reflexive conversations

A second issue relates to the use made of findings. In the scientific-bureaucratic model 'evidence' is used to prescribe practice in a top-down manner. Our approach is similar to a 'knowledge spiral' (Nonaka and Takeuchi, 1995) described above. It starts from the idea that any actions that need to follow data collection should come from social workers and managers themselves and should be realised through reflection on their own understandings of what is good practice. To achieve this is not simple and we suggest the need to develop what have been termed 'reflexive conversations' (Bilson, 1997; Bilson and White 2004). These seek to focus attention on the tacit assumptions that shape practice.

Atkinson and Heath's suggestion that a reflexive approach to research needs to encourage the consumers of research 'to be more open to the research process' (Atkinson and Heath, 1987, p.15) stresses the need not only to give direct access to the research 'data', but also to demonstrate how the researcher constructed the results from them and the researcher's own premises. 'Consumers of research' in our context refers to practitioners. Thus this approach does not make truth claims about the findings or value the research 'evidence' above the wisdom of practitioners. Rather it accepts its own groundlessness and seeks to demonstrate how the distinctions made by the researchers lead to a particular moral view of the data. Rather than hiding the processing of the data into the 'findings' this process is exposed to share the possibility of constructing a view and the distinctions used to create it. The researcher thus demonstrates reflexivity and then encourages practitioners to reflect on their own assumptions.

Thus, for example, one of the authors had studied reports

for the children's hearing system (the Scottish equivalent of a juvenile court) and found them to be full of negative comments about the children and their parents, and yet the social workers and their team leaders believed that they acted only in the best interests of children. Rather than simply present the results to them in the hope that they would accept the researcher's 'more objective' position, a seminar was held for team leaders in the organisation. This involved: presentations of the theoretical model which informed seminar leaders' practice with young offenders; exploring participants' views about the causes of offending and the premises upon which reports were written; encouraging dialogue and critical and emotional review of these premises by practitioners through a reappraisal of actual cases and their outcomes. It quickly became clear that the staff used many different tacit models of the causes of crime, from the social through to the psychological. From further work and discussions amongst practitioners, the lack of information about the strengths of the children and the overwhelmingly negative focus of the descriptions of their lives (which stemmed from their premises about the causes of delinquency), became clear to those involved.

This reflexive conversation helped to make participants aware of the consequences of their views of delinquency for the lives of those they were supposed to help. Proposals for change were developed to include: a new structure for reports; a plan for repeating the seminar for the range of staff in the department who were responsible for children; and a proposal for quality assurance of reports. This approach led to significant drops in the numbers of children entering care and an increase in the provision of services in the community (for a more detailed account of this work and its theoretical background see Bilson and Ross, 1999).

Conclusion

In this article we started by reviewing the developments in evidence-based practice and stated our preference for a reflexive approach to the use of research. Above all we are concerned that if social work uncritically embraces the rhetoric of evidence-based practice there is a danger that, in the current political climate of increasing central control and managerialism, it may increasingly lead to a prescriptive, one-size fits all approach to interventions with a consequence for individual users of services. At the same time we are concerned that social workers need to reflect on the tacit assumptions on which they make decisions about their everyday practice. We argued that these tacit assumptions are principally created and maintained in the day-to-day interactions in the teams, practice groups and organizations within which social work practice is organized. Research can play an important part in creating 'News of Difference' to enable teams to create a more reflexive stance in which the hidden assumptions become more open to critical reflection by practitioners and their managers. This will require research to be presented in new ways and social workers and their teams to be given time and space to consider the outcomes of their practice.

In taking this approach we are aware that we are asking for major changes in the way research is usually seen and used. We are asking managers, social workers and researchers alike to develop ways to have reflexive conversations. We are proposing an alternative and complementary approach to the research process and its products, designed to encourage reflection. Cultures in teams and organisations have the capacity to sustain forms of reasoning which function as taken for granted truisms about what works. This reasoning has the tendency to close down debate. Our intention has been to outline ways in which social workers can participate in dissolving these forms of folk wisdom if they so choose. We are suggesting that research and other evidence can play a part to provide social workers themselves with a means to examine and reappraise what they have previously taken as 'common sense' truths and make any changes that they wish.

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Summaries

A pre-post empirical study of obstacles to, and opportunities for, evidence-based practice in social care

Brian Sheldon, Rupatharshini Chilvers, Annemarie Ellis, Alice Moseley and Stephanie Tierney

This chapter reports a summary of results from the largest and arguably the most representative study (a) of the attitudes of professional-grade social care staff to the idea of evidence-based practice; (b) of the facilities to encourage this which are available to them (or not); and (c) of their reading habits and levels of knowledge of basic research matters. It makes suggestions for improvement but also raises some concerns regarding the current content of professional training in our field

Evidence based social work practice: A reachable goal?

Frank Ainsworth and Patricia Hansen

In New South Wales the heads of Departments of Social Work in Teaching Hospitals support evidence based practice. Likewise, in 2002 the Association of Children's Welfare Agencies bi-annual Sydney conference will have the theme 'What-works? Evidence based practice in child and family services'.

There are debates about what constitutes evidence and how evidence should shape practice interventions. Some community-focused services are able to prosper through advocacy of a cause, issue or social problem. This is not enough in health care and child and family service settings where other

disciplines have developed evidence about their effectiveness. Social work must do the same.

Social workers need to put aside old maxims and favourite theories. They need to develop a readiness to examine research evidence and to modify direct practice. The challenge is how to build a stronger research orientation into professional education and social work practice.

Reframing an evidence-based approach to practice

Stephanie Tierney

The positive aspects of evidence-based practice have often been overlooked in arguments about the appropriateness of such an approach to social and personal problems. This chapter, by illustrating such aspects, hopes to further the debate and reframe understanding and (mis) perceptions of evidence-based practice, highlighting the essential component it has to play in contemporary social care.

What works about what works? Fashion, fad and EBP

Carolyn Taylor and Susan White

This chapter considers some key debates about evidence-based practice. It is intended to be a contribution to the process of appraisal of this key contemporary initiative. The paper begins by briefly outlining the key premises of EBP and its underlying assumptions, before considering what are its limits and how it may usefully be supplemented by other approaches. In particular, I argue for a more methodologically inclusive reframing of what is meant by EBP.

The limits of positivism revisited

David Smith

The title alludes to a paper (Smith, 1987) in the *British Journal of Social Work* called 'The limits of positivism in social work research'. At the time it was written, it was not unusual to hear academic

colleagues argue that there was something inherently conservative about positivist approaches to social research, and that such approaches inevitably served the interests of the powerful and maintained the *status quo*. I was never clear about the stages involved in this argument and remained unpersuaded by it, and this was not the line followed in the article (though I might be more readily persuaded now, for reasons discussed in this chapter). Instead, the 1987 article was mainly taken up with a critique of the work of Brian Sheldon, as the leading advocate over the previous ten years – and, as it turned out, over the next fifteen – of what would now be called ‘evidence-based practice’.

A problematic relationship? Evidence and practice in the workplace

Nick Frost

This chapter examines the emergence of the evidence-led school of thought in social work and related professions. The basic tenets and influence of this movement are explored. The author develops a critique of the movement which explores four fundamental challenges: the problem of evidence; the problem of applying evidence to practice; the relationship between evidence and values; and the relationship between providers and service users. I argue that the evidence school is vulnerable in these four areas. The chapter concludes by briefly exploring a possible alternative model of policy and practice development.

The Social Care Institute for Excellence: The role of a national institute in developing knowledge and practice in social care

Mike Fisher

The English Department of Health is instituting a new framework for regulating social care, and a key part of this is a new *Social Care Institute for Excellence* (SCIE). SCIE will have the job of developing the knowledge base for social care, extracting messages for practice from research reviews and from existing best practice, and developing knowledge resources

that social care practitioners can freely access.

This chapter explores the epistemological implications of this development for social work and social care, and the role that national bodies can play in developing excellence.

The development of SCIE includes key assumptions about the nature of knowledge underpinning social work and social care. It implies that

- there is a coherent supply of knowledge of which SCIE can be an ‘intelligent customer’;
- existing sources and modes of production deliver knowledge relevant to practice;
- it is possible to identify relevant knowledge, particularly through reviews;
- the state of the knowledge base is sufficient to develop guidelines for practice;
- it possible to develop a common framework for rating the quality of different types of knowledge, including the experiential knowledge of service users, so that practitioners may have confidence in what is made available; and that
- the dissemination of knowledge can be linked to excellence in practice.

This chapter examines these assumptions in the light of existing research evidence, and in the light of the debate about the nature of evidence-based practice. I conclude that, while national institutes such as SCIE can significantly enhance the coherence of the social care knowledge base, it will be critical to avoid narrow definitions of the nature of knowledge and to avoid ossifying the relationship between knowledge and practice.

Promoting evidence based practice in a child care charity: The Barnardo's experience

Tony Newman and Di McNeish

Barnardo's, the UK's largest child care charity, has a long standing interest in, and commitment to evidence based practice

(EBP) in social care. This chapter discusses some of the dilemmas, both ideological and practical, that challenge social care organisations trying to implement EBP, defends EBP on grounds of both morality and utility, and describes how Barnardo's has sought to translate theory into practice.

Towards a more reflexive research aware practice: The influence and potential of professional and team culture

John Lawler and Andy Bilson

This chapter reflects on the debates about Evidence Based Practice and suggests a new approach to implementing a more reflexive and research aware social work practice in professional teams. We show that there has been a substantial focus on the responsibility of individual professionals for using best evidence to guide their practice and on the organisation to provide an environment and policies suited to EBP. We argue that there is a need to balance this by an increased focus on the professional and team culture in which social work takes place. We draw on the literature on organisational change and social work research to suggest a new direction for encouraging greater reflexivity and developing a more open participative approach to the use of evidence to shape new practices in social work at the local level.

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