



Moving Best Practice to Evidence-Based Practice in Child Welfare

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ABSTRACT

Increased emphasis is being placed on improving outcomes for abused and neglected children served by the child welfare system. To achieve this goal, the notion of “best practice” is widely embraced. Unfortunately, there is no consensus on its definition. Various interpretations include (a) practice wisdom, (b) emulating other systems, (c) expert consultants, (d) professional guidelines, and (e) evidence-based practice. In this article, the authors describe the advantages and disadvantages of each of these definitions. While all of them have a role to play in improving results of child welfare interventions, the authors argue that best practice is optimally defined as evidence-based practice. At the same time, there are many difficulties in employing this form of best practice, including a lack of evidence, the transfer of information, and the organizational culture in which the worker operates. Suggested solutions to these difficulties are discussed.

Since the early to mid 1980s, the field of child welfare has increasingly been held accountable for results of services and interventions provided to children and families. Weary of relying on faith in well-intentioned but often ineffective programs, society began asking child welfare workers to prove that their work is worth supporting by demonstrating the results or outcomes of services (Magura & Moses, 1986). During the 1990s, a political consensus developed on what should be the results of interventions or outcomes on behalf of victims of abuse or neglect. The Adoption and Safe Families Act of 1997 (ASFA; Public Law 105-89) codified this consensus by identifying the national goals or outcomes for children as being safety, permanency, and well-being.

Although concerns for accountability are at the center of the outcomes movement, the emphasis on defining and measuring results can draw attention away from practice.

Focusing on numbers and quotas can draw attention away from the practice that produces the result. For example, under the ASFA, if a state meets the adoption requirements for a given year, then they receive fiscal rewards. Yet, the quality of the relationships and commitments built through the adoption process may be ignored.

One mechanism for maintaining the proper focus on practice and outcomes is “best practice.” While child welfare¹ has embraced this idea, there is no single definition of the term. This article reviews the major definitions of best practice. While evidence-based practice (sometimes referred to as EBP) is presented as the most useful definition, there are many obstacles to child welfare accepting this approach. These obstacles are reviewed together with suggestions for overcoming them.

¹ In this article, the term *child welfare* refers to the response system for child abuse and neglect.

Defining Best Practice

The use of best practice is not restricted to child welfare. In an article in the *Chronicle of Higher Education*, Stanley Fish (2002) criticized the best practice movement, saying, “Best practices is itself a practice, an industry focused on itself and equipped with its own internal machinery including a version of the Academy Awards that allows practitioners to recognize and honor one another publicly.”

Fish also used words such as “empty,” “tautological,” and “fatuous” to describe best practice. While Fish has some appropriate warnings for, and observations of, the best practice movement, discarding the term may only result in a different and equally meaningless term coming into vogue. One way to reclaim the term *best practice* is to be clear on its meaning and work to maintain a common and useful definition.

In child welfare, best practices are contained in documents such as guidelines, manuals, or approaches to practice that are designated by a group as the optimum way to achieve positive results for children and families. There are several different ways that agencies, public and private, are defining best practices. The most common definitions of best practice follow:

1. Practice wisdom
2. Emulating similar systems
3. Use of expert advice
4. Professional guidelines
5. Evidence-based practice

Practice wisdom may be the most common definition of best practice in child welfare. To codify practice wisdom into manuals and training curriculum, experienced practitioners are asked to identify what they have found to be effective in their practice. When a new practice problem arises, this is often the only recourse. For example, a new recreational drug arrives in a community, and there is little or no knowledge of how to effectively respond. In situations like this, practitioners are expected to be pragmatic, self-reflective, and learn from their work with clients. The result is practice wisdom, or experientially and inductively derived knowledge.

However, while workers’ experiences are a valuable resource, practice wisdom is not always wise (Scott, 2001). Given the complexity of the world of child welfare, workers often err in trying to “make simple the complex,” and do not look for disconfirming evidence in their case situations (Munro, 1999). As a result, emotion and preconceived ideas rather than evidence of desired outcomes may direct a worker’s thinking about their practice.

Emulating similar systems—what is being done in other states, agencies, or systems—is another definition of best practice. There are national organizations such as the Child Welfare League of America (CWLA) and the American Humane Association (AHA) that exist to enhance public

and private child welfare systems by facilitating the process of sharing policies and practices and encouraging communication between agencies. For example, every year, the AHA convenes roundtables to “address cutting-edge issues in child welfare” such as outcome measures, risk assessment, and managed care in child welfare services (AHA, 2001).

Learning from other systems can be helpful. States experiment with policies and practice models. Some states see desired changes in their system that are attributed to an innovation, and this is well worth sharing. For example, the Illinois Department of Children and Family Services developed an innovative performance-based contracting system that contributed to increases in children achieving permanency (Martin, 2002). Other states can clearly benefit from the lessons learned in designing and implementing such a system.

However, child welfare systems are political entities primarily defined at the state level. For example, there are as many definitions of child abuse and neglect as there are states and territories. With regional differences, it is important to recognize that what works in one state may not work in another. Urban areas may respond well to one type of program that would be ineffective in a rural area. The political climate of states and regions often determines what types of programs and services receive support. The political atmosphere may also require modifications in an effective program, and these changes may alter the effectiveness of the innovation. Finally, programs and services that are well funded in one state may be implemented without the required funding in another.

Use of expert advice is still another way that best practice is defined. National organizations such as the CWLA and the AHA frequently have experts on staff to consult with child welfare systems. The Child Welfare Institute (CWI) in Georgia is another example. Developed in 1984, CWI has been nationally recognized for providing consultation services to state and local child welfare agencies, human services agencies, and nonprofit organizations (CWI, 1999). Their mission is to “provide information, ideas and guidance,” and the focus of their organization is on “practice, and creating effective solutions that achieve measurable goals.” Another way of using expert advice is by convening an expert panel. A child welfare system might bring together a group of experts to review best practice documents or give advice on a topic of concern.

The use of experts in defining or reviewing best practices can be advantageous. Child welfare requires such a range of knowledge that no single person is able to possess all that is needed. Experts can fill gaps where the knowledge is missing. For example, if a child welfare agency was working to define best practices in investigating head injuries, then it would be helpful to have medical experts review the guidelines that child protection investigators use to identify head injuries related to child abuse. An agency’s credibility is enhanced when a group of experts reviews investigative guidelines and approves them.

However, there are problems with experts. For example, they may “overstate” their area of expertise. They may not be completely qualified for the area of practice in which they are reviewing or establishing guidelines. They may not stay current with the research in their area of expertise. They may have personal biases and beliefs that they promote. They may dismiss evidence that does not conform to their preferred mode of practice.

Professional guidelines, especially those developed by professional organizations, is another way that best practice is defined. Most national professional organizations such as the American Medical Association or the American Psychological Association establish practice guidelines on a variety of topics. The National Guideline Clearinghouse (NGC) includes lists of several hundred guidelines from various professional organizations (NGC, 2002). The guidelines undergo review that requires, among other criteria, “systematically developed statements,” “corroborating documentation ... that a systematic literature search and review of existing scientific evidence was performed,” and that information “was developed or reviewed, or revised within the last five years.”

Use of guidelines developed by a professional organization can save a child welfare agency substantial time and effort in reviewing a body of literature to arrive at best practices on a particular topic. For example, the literature on head trauma is extensive and technical and may be better reviewed by a group of physicians rather than by child protection investigators. The use of guidelines developed by the American Medical Association can also lend credibility to agencies’ practice guidelines.

However, sometimes professional organizations base guidelines on practice wisdom rather than on research. These professional organizations may use practice wisdom because there is a lack of an existing body of empirical literature on the subject. Another potential drawback of relying on guidelines from professional organizations is that some of these groups may want to advance an agenda to benefit themselves or their profession.

Evidence-based practice is still another definition of best practice. In simple terms, evidence-based practices are those that are shown to be effective through controlled experiments like those used to prove the effectiveness of medications. There is increasing discussion of evidence-based practice and its application to social work practice, with much of this focused on the ethical obligation to practice with tested interventions (Gambrill, 1999; Gibbs & Gambrill, 2002; Howard & Jenson, 1999; Thyer, 1995). The *Code of Ethics of the National Association of Social Workers* emphasizes that social workers have a responsibility to base practice on recognized knowledge including empirically based knowledge (National Association of Social Workers, 1999). As MacDonald (1998) stated, “when we intervene in the lives of others, we should do so on the basis of the best evidence available regarding the likely consequences of that intervention.” Like the other definitions of best practice,

there are advantages and disadvantages associated with the use of evidence-based practices. Since we argue for a move to evidence-based practice as a way to balance the pursuit of child welfare outcomes with concerns for practice, a more complete discussion of evidence-based practice follows.

The Use of Evidence-Based Practices

Sackett, Straus, and Richardson (1997) defined evidence-based practice as the conscientious, explicit, and judicious use of current best evidence in making decisions about individuals. Evidence-based practice requires

1. an individualized assessment,
2. a search for the best available external evidence related to the client’s concerns and an estimate of the extent to which this applies to a particular client, and
3. a consideration of the values and expectations of clients.

An individualized assessment requires that the worker engage with the client to determine what specific issues are causing difficulties in family functioning. The worker and the client collectively determine the stressors and work to define a treatment path. Critical to this stage is an understanding on the part of the worker that an underlying condition/risk factor present within one family system may act out differently than the same factor in another family system. For example, two families may have the presenting problem of mental illness. However, the effect of the mentally ill family member on the family system impacts each system and member differently. Severity of the illness, who is diagnosed with the illness (i.e., parent or child), families’ cultural background, and which areas of functioning (i.e., school, work, or home) are compromised impact the clinical service pathway selected by the worker and family.

The Best Available Evidence

Evidence-based practice that links interventions to outcomes is based on a body of research that comprises controlled experiments. Randomized controlled trials are the “gold standard,” allowing researchers to control for the factors, known and unknown, that may account for the outcome of an intervention. The best evidence is then brought together in meta-analysis and systematic reviews. Systematic reviews are the synthesis of research studies in which the researchers outline their methodology and sources of biases. Meta-analyses use statistical analysis to quantify the degree of effect that can be expected from the intervention.

Unfortunately, there are a limited number of randomized controlled trials in the child welfare literature. Barbara Thomlison (2003) reviewed this literature in regard to child maltreatment interventions and found just three that are supported by at least two randomized clinical trials. In the absence of meta-analyses and randomized controlled trials, evidence-based practice suggests that social workers

use the best available evidence. Consequently, social workers need to know what evidence is available to them and the strengths and limitations of the methodologies that are employed. Studies using secondary data analysis and statistical analyses such as causal modeling are not as powerful for providing evidence on effectiveness, but these methodologies answer important questions that may not be testable by randomized controlled trials. Also, qualitative studies can provide a wealth of information concerning the clients' perspective. These are critical to understanding clients' thoughts, emotions, and experiences with their situations as well as planned interventions.

However, there are important opportunities to conduct controlled studies with present child welfare populations. Under Section 1130 of the Social Security Act, as amended by Public Law 105-89 (ASFA, 1997), Child Welfare Demonstration Projects are allowed for and waive certain requirements of Titles IV-B and IV-E (U. S. Department of Health and Human Services, 2001). These demonstration projects provide an opportunity for child welfare to greatly increase the number of randomized controlled trials in the knowledge base. Preference is given to approving projects that include an evaluation based on randomized controlled trials. These waivers provide a way to develop creative approaches to dismantling the many barriers that exist between children waiting in foster care and permanency, enhancing the number and quality of randomized controlled trials and the scope of knowledge about the effectiveness of interventions, thereby helping to define quality practice.

The diversity of the child welfare population also raises an important question about the nature of the evidence. There is always the danger that an intervention tested on one group may not fit the cultural framework of others. Women and African American families are overrepresented in the child welfare system (Morton, 1999; U. S. Department of Health and Human Services, 1999). Conducting rigorous research with the present child welfare population through Title IV-E, waivers can alleviate this problem.

Values and Expectations of Clients

Client involvement in making decisions regarding services that they receive and programs in which they will participate is a key element of evidence-based practice (Gambrill, 1999). This is also an important part of practicing under the *NASW Code of Ethics*, in which self-determination and informed consent are core responsibilities to clients (NASW, 1999). According to Gambrill, social workers need to seek

out practice-related research regarding important practice decisions and share the results of their search with clients. The social worker talks with the client to assure that she or he understands the benefits and deficits of the proposed interventions and the extent to which the research applies to his or her individual situation. The client needs to understand that the intervention presented as optimal is more likely to be effective than other interventions but is not guaranteed to work, especially since it depends on individual factors that may not have been controlled for in the research trials. The client's input is essential to ensure the best use of present evidence because it will help the social worker and the client to combine research results and these individual factors to reach an intervention that is more likely to be successful.

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Implementing Gambrill's (1999) suggestion of presenting clients the research evidence and having them make the treatment decision is difficult in child welfare. Working with involuntary clients and the balance between individual choice and social control presents significant challenges to this effort. Research in the United Kingdom indicates that although parents are involved in child protection conferences, they can feel outnumbered by professionals, uncomfortable talking in formal settings (Farmer & Owen, 1995;

Hall & Slembrouck, 2001), and can find it difficult to dispute errors social workers present as fact (Corby, Millar, & Young, 1996; Hall & Slembrouck, 2001). Also, the need to "be seen as cooperative" (p.145) resulted in parents saying little unless directly addressed (Corby et al., 1996; Hall & Slembrouck, 2001).

Client expectations about treatment play an important role in their decisions and may make it more or less difficult for practitioners to use evidence-based practice. If evidence-based practice indicates a certain intervention that is unknown to the general public, and quite different from what people think is the standard intervention in their case, then clients may be resistant to that intervention. Clients may also try to influence practitioners to use certain interventions because they think that it is what they need. If evidence-based practice indicates that this intervention is not effective, then it may be difficult for the practitioner to convince the client of this fact. Attention-deficit/hyperactivity disorder (ADHD) and the general public's perception about this disorder is a good example. Many parents believe they can "solve" their children's behaviors by getting them medication for ADHD. Few parents know the difference between this very real disorder and normal children's behaviors. This misunderstanding gets many children

misdiagnosed and overmedicated, and it may also prevent some children who do have this disorder from having access to medication that would be beneficial because their parents “don’t believe in ADHD.” Practitioners may have difficulty convincing a parent with a strong opinion about ADHD that their child needs more structure and would benefit from a behavioral intervention rather than medication, or that their child would benefit from medication in combination with a behavioral plan.

There is much to be learned about how to involve child welfare clients in evidence-based practice. This is a line of research that needs a great deal of attention. At the same time, more can be done to train workers in engaging families in discussions of interventions and the potential risks and benefits of clients’ choices. Worker training is shown to be most effective when the training event includes practice and feedback (Gregoire, Propp, & Poertner, 1998). Training of this type coupled with supervisory feedback from direct observation may enhance the worker–client relationship and therefore engage and empower families.

Organizational Challenges to Utilizing an Evidence-Based Practice Model

It is a nontrivial exercise to make research-based practice guidelines available to workers and to influence them to change their practice to incorporate new ideas (Gira, Kessler, & Poertner, 2004). There are a variety of constraints to employing evidence-based practice from lack of quality evidence to the management of information to the organizational culture in which the worker operates. We highlight some of the challenges and suggest ways to move best practice toward evidence-based practice.

Social workers know about the influence of the reciprocal interactions that occur between people and their cultures on individuals and families. This also applies to organizations and the range of worker behaviors that are encouraged or discouraged. On one hand, public child welfare agencies have “established ways of doing business” and are less likely to embrace new practices. On the other hand, workers in organizations where the culture indicates a value for innovation and demonstrating outcomes for clients are more likely to be open to new approaches.

An example of an attempt to change the organizational culture to practitioner use of research is a recent effort by the Illinois Department of Children and Family Services. The director created a Practice Advancement Committee as an attempt to integrate research into policy, practice, and training. The director of the agency, top staff, and researchers attend all meetings. This group’s task is to examine the research basis for all policy, training curricula, and practice guides. Questions about the research base for a proposal to change a policy, practice, or training are asked, and short research summaries on current topics of interest are presented at each meeting.

The Gap Between Research and Practice

In order to move best practice toward a model of evidence-based practice, child welfare systems need to integrate research knowledge into their practice guidelines. However, in addition to the paucity of tested interventions, a communications gap exists between social work researchers and practitioners (Gira et al., 2004). Researchers seldom take the implications of their research to the level of practice behaviors. Practitioners for their part seldom have time to read and critically evaluate research (Gambrell, 1999).

Mechanisms are needed to better communicate research findings and translate them into practice. One solution to this problem was developed within an agency that created a committee responsible for the translation of research into practice. Researchers were asked to present their research and implications. A group of practitioners then wrote practice behaviors and asked the researcher if these behaviors were consistent with the findings. The result was a collection of practice guides that identified worker behavior derived directly from research findings.

In addition, schools of social work are making research and evidence a more important part of BSW and MSW curriculums. This effort will help produce a group of graduates, and hence practitioners, who are more likely to use research evidence in practice. As such, schools of social work are an important training ground for evidence-based practice, and will help close the gap between research and practice.

Information Management

Getting evidence-based practice information to workers when and where they need it is another challenge. Child welfare workers deal with a great variety of situations, ranging from individual problems to issues involving a whole community or even the society. No single worker can know all of what needs to be included in best practice. A related challenge is keeping research-based practice guidelines updated.

The advantages of the information technology revolution need to be blended with child welfare workers agency and community context to get workers the information that they need when they need it. One solution is the development of a Web site where workers can access all of the laws, agency policies, best practice guides, and the latest research. One of the authors of this article was involved in such an effort, and this Web site contains the equivalent of thousands of pages of material that a worker can access by major topic or by conducting a keyword search. The more than 5 linear feet (2 m) of paper guides and manuals that workers had to search for answers is now available via a computer search and is updated weekly.

Two other examples of efforts to organize information in an easily accessible way and make evidence available to professionals are the Cochrane and Campbell collaborations. The Cochrane Collaboration is an international organization that coordinates the efforts of health care professionals and researchers around the world to prepare, maintain, and

disseminate systematic reviews of health care research (Robinson, 1995). The collaboration is divided into groups that are coordinated by an editorial team that compiles modules from the reviews produced for electronic dissemination.

In the social sciences, the Campbell Collaboration, formally established at the University of Pennsylvania in February 2000, is striving to emulate the Cochrane Collaboration. In fact, a linkage of the two groups was created to “stimulate the empirical methodological research required to improve the validity, relevance and precision of systematic reviews and the randomized and nonrandomized trials on which they are based.”²

Decision-Making Processes

The complex environment of decision making in child welfare needs to be recognized if child welfare practice is to become evidence-based practice. This includes not only workers’ decision-making skills but also environmental constraints. Practitioners are not always free to choose whatever intervention would be best for their client, regardless of costs. In some cases, final authority

for decision making rests with a judge and not the child welfare worker. This is an instance in which child welfare administrators need to maintain contact with and educate judges about best practices.

Research on decision making in social psychology also demonstrates that people tend to use certain reasoning strategies regardless of the evidence (Nisbett & Ross, 1980; Tibrewal & Poertner, 2000). For example, people frequently make quick decisions on the basis of little evidence and then have great confidence in these decisions. This tendency can be dangerous when used for decisions that may have a low failure rate but high negative consequences. For example, the substantiation of a report of abuse or neglect in substitute care is typically 2% (U. S. Department of Health and Human Services, 2000). This means that workers are correct 98% of the time. This high rate can increase workers’ confidence in these types of decisions when it is not warranted. However, the consequence of a rare but mistaken decision for the child that is re-abused may be devastating.

Child welfare has largely ignored the decision-making research and seldom trains workers in making decisions. This clearly needs to become a standard element of worker training. The basic decision-making principle of looking for evidence that might disconfirm a position as well as evidence that supports the decision is important for workers

to practice whether it be for decision making or for critically evaluating research. Supervisors play an important role in checking workers’ decisions and can simply remind workers of the need for examining evidence on both sides of a question before a final decision is made.

Also related to decision making, Webb (2001) suggested that oftentimes “it is the social workers’ conception of how things are, rather than the evidential facts per se which determine actions” (p. 67). Webb pointed out that “social workers make decisions not only because of the ways things

are but because of the way they would like things to be.... Social problems, to a very considerable extent depend on what social workers think they are” (p. 67). For example, research may point to a cognitive-behavioral intervention to help a client facing emotional problems derived from his or her workplace. This assumes that the origin of the client’s problem is his or her cognition and coping mechanisms. However, a social worker may want to focus on the social issue constituted by a history of discrimination in the workplace and try to solve this problem as

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an environmental stressor that can and should be removed from the client’s life. This indicates that the agency, usually the worker’s supervisor, needs to consciously address the question of the level of intervention to be attempted. This advocacy aspect of social work has been important to the field’s culture and could easily get lost if not specifically addressed in evidence-based practice models.

Conclusion

Best practice in child welfare is used in a variety of ways. Best practice is being defined as (a) practice wisdom, (b) emulating other systems, (c) expert advice, (d) professional guidelines, and (e) evidence-based practice. Each of these definitions has advantages and disadvantages and a role to play in child welfare practice. There is also a need to increasingly include research evidence in practice. By using research evidence in the definition of a best practice guideline, child welfare moves the field in the direction of using evidence-based practice. The stakes are high for children and families. Workers need to know that the interventions they use to assist families are helping. Research evidence can inform practitioners about the methods they are using. On the basis of the evidence, child welfare workers can change and enhance their practice to better meet the needs of children and families.

At the same time, there is a substantial set of barriers to implementing evidence-based practice in child welfare.

² The full mission statement may be viewed at <http://campbell.gse.upenn.edu/about.htm>

The field is complex, protective, and bureaucratic, with little research-based knowledge. However, there are promising efforts being made to influence the field to become evidence based. As the considerable challenges to implementing research-based practice are addressed and lessons are learned, the desired link between practice and desired child and family outcomes is more likely to occur.

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