

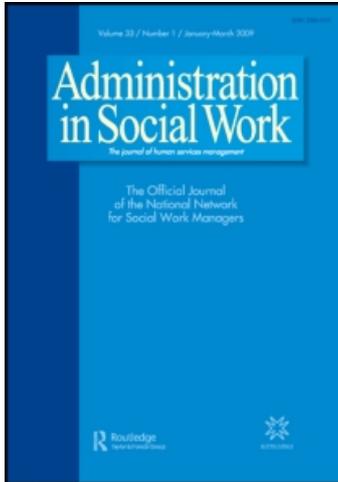
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Evidence-Based Management: Origins, Challenges, and Implications for Social Service Administration

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Evidence-based management is emerging in the helping professions in response to heightened demands for public accountability and organizational performance. This paper defines evidence-based management and reviews its origins in the health care and business sectors and its recent incorporation into the social work profession. A case study describes the efforts of one social service agency to use evidence-based management to improve the performance of its child welfare and mental health programs. Consideration is given to the similarities between the dominant models of evidence-based management and evidence-based practice, the challenges facing administrators seeking to incorporate evidence-based management processes into social service agencies, and the implications of evidence-based management for social service agency practice and social work management.

KEYWORDS *evidence-based management, evidence-based practice, decision making, organizational performance, public accountability*

“How many plans have been adopted on the assumption that certain procedures would bring desirable results! How few have been tested to see how far the assumptions on which they are based have been verified! This is perhaps the most important job before the social work profession

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at the present time: to undertake the measurement of effectiveness of social treatment and the study of causes of success and failure" (Claghorn, 1927, p. 181).

Over the past decade, social service agencies have increasingly adopted evidence-based practices and guidelines (Proctor, 2007). This trend of evidence-based practice, which can include the use of scientifically validated clinical interventions and the regular collection of client-level data, has been partly in response to funders' and legislators' demands for cost-effective social service programming and partly in response to requests for greater transparency in clinical decision making (Johnson & Austin, 2006). Evidence-based practice principles are now commonly used to organize service provision in the health, mental health, and substance abuse service sectors (Gray, 2001; Norcross, Beutler, & Levant, 2005).

While evidence-based practice over this time has been principally the province of clinicians and front-line workers, its central tenets have never been deemed inappropriate for use by social service administrators. There has recently been a sustained effort to apply the major components of evidence-based practice to management practice. In the health care, medical, and business sectors, increasing attention is being paid to evidence-based management (EBM) (Newhouse, 2006; Pfeffer & Sutton, 2006a, 2006b, 2006c; Walshe & Rundall, 2001; Woolston, 2005). While no comprehensive studies exist on the extent to which EBM is used in these sectors, anecdotal evidence suggests that "evidence-based management promises to increase the effectiveness of organizational leadership, while also catalyzing new research that addresses practical, relevant, and important questions" (Williams, 2006, p. 244).

These arguments for EBM have been premised partly upon the possibility that the performance of evidence-based practices may be affected by their organizational environment (Johnson & Austin, 2006). When empirically supported treatments are not implemented by staff given appropriate resources and training, then program effectiveness may be compromised (Biegel et al., 2003; Gold, Glynn, & Mueser, 2006). A growing literature speaks to social service agencies' difficulties in identifying appropriate evidence-based practices (for a review of this literature, see Fixsen, Naoom, Blase, Friedman, & Wallace, 2005); and, through its Roadmap for Medical Research, the National Institutes of Health have recently committed to identifying the factors that compromise the implementation of clinically validated treatments in agency- and community-based settings. Social service managers play a central role in organizing these processes of identifying researchable questions, gathering and reviewing evidence, and choosing and implementing appropriate interventions.

In principle, EBM offers social service managers a set of methods to clarify how they use information to make strategic decisions, and thus

provides a mechanism for improving the quality of managerial decision making and problem solving. Because of the novelty of EBM, however, no empirical studies have examined its benefits and challenges for social service agencies and managers. Resultantly, there is little guidance for managers seeking to fit various evidence-based programs within their organizational environments. What challenges face social service managers seeking to use EBM processes? What barriers limit the collection and use of different types of evidence in social service management?

This paper, which is organized into four sections, introduces the concept of EBM to the profession of social work. The first section surveys the origins of EBM and compares it with the dominant models of evidence-based practice. The second section identifies the principal challenges or tensions involved in incorporating EBM models in social service agencies. A case study is presented in section three that describes the efforts of a social service agency to use evidence to improve the performance of its child welfare and mental health programs. The paper concludes with a consideration of unresolved issues concerning EBM in the social service sector.

ORIGINS OF EBM AND CURRENT MODELS

Direct-care social workers and social service administrators have historically valued the use of various types of evidence to assess clients, inform decision making, and evaluate program effectiveness (Claghorn, 1927; Reid, 1994; Richmond, 1917). Evidence-based practice, however, has gained popularity in the past two decades in reaction to the adoption and diffusion of innovative developments in health and medical care (Eddy, 2005). The principles behind evidence-based practice have been promulgated by the National Institutes of Health; accrediting bodies including the Joint Commission and the Council on Accreditation; professional membership organizations such as the National Association of Social Workers and the American Psychological Association; and state and local governments. Resultantly, evidence-based practice now holds a gold standard of reputability in the arenas in which social service managers commonly operate, including mental health, child welfare, and substance abuse.

EBM, which arose in the health care and medical sectors around the turn of the millennium, can be defined as “the conscientious, explicit, and judicious use of current best reasoning and experience in making decisions about strategic interventions” (Kovner, Elton, & Billings, 2000, p. 10). The rise of EBM and evidence-based practice has been partly in response to political, financial, and accountability-related trends. Policymakers and public funders have, over the past 20 years, sought to demonstrate heightened accountability for public funds (Ingraham & Kneeder, 2000). Due to the increased emphasis on organizational performance, funders and social service

managers have sought new organizational models and management techniques to promote cost-effectiveness. Some local and state funders have requested that social service agencies use evidence-based practices and have required service providers to demonstrate the effectiveness of their service technologies. This performance-focused environment has rewarded social service agencies and managers who adopt evidence-based practices and use evidence to justify their strategies (Shortell, 2006).

While no empirical research on the effects of EBM exists to date, it is plausible to anticipate an increase in EBM-focused scholarship in the future. Organizational researchers are increasingly finding that managerial activities influence service effectiveness and client outcomes. Controlling for client-level covariates, studies have found that organizational factors (such as contracting environment, auspices, and culture and climate) affect child welfare service provision and outcomes (Wulczyn, Orlebeke, & Melamid, 2000; Yoo & Brooks, 2005); organizational culture and employee job satisfaction and behaviors (Glisson & James, 2002); substance abuse service provision (Durkin, 2002); and welfare recipients' employment outcomes (Bloom, Hill, & Riccio, 2001). Thus, support is increasing for research on the relationship between social service managers' use of evidence and various agency and program outcomes. (Institute of Medicine, 2001).

Two recent cases illustrate the role of the manager in the current EBM and evidence-based practice environment. In 2006, the Illinois legislature created child welfare error reduction teams in the hope of reducing the number of child fatalities in foster care. The agencies in which these teams are housed are mandated by law to use client-level data and other evidence as a basis for decision making, and to create a culture of learning and innovation (T.L. Rzepnicki, personal communication, June 15, 2007). In Oregon, Senate Bill 267 requires that specific state agencies devote increased funding to evidence-based programming. Under this legislation, state agencies ranging from the Department of Human Services to the Department of Corrections must ensure that, by 2010, at least 75% of their state-appropriated funding is used to support evidence-based programs. In each of these cases, social service managers will be called upon to gather evidence from within and outside their agencies to identify and implement evidence-based practices.

These cases reflect competing models of evidence-based practice: the evidence-based process model (Illinois) and the evidence-based program model (Oregon). The Illinois experience has been premised upon the original definition of evidence-based medicine (Newhouse, 2006; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). Under this formulation, which has been supported by social work educators (Gambrill, 2006; Gibbs, 2003; Rzepnicki & Briggs, 2004), practitioners are asked to integrate the best available evidence, client expectations, available resources, and their clinical expertise prior to making practice decisions. Information is gathered from

electronic literature reviews as well as quantitative and qualitative assessments of clients and agencies. Evidence-based practice thus refers to a problem-solving process in which the practitioner seeks to individualize care to the specific needs of the client as well as the agency.

In contrast, the Oregon case exemplifies the evidence-based programming model. Here, evidence-based practice refers to a chosen intervention whose efficaciousness has been determined through two or more independent randomized clinical trials. Under this model—which has gained favor in the National Institutes of Health, accrediting bodies, and public and private funders—practitioners are asked to follow established treatment guidelines faithfully and avoid tailoring services to suit observed differences in client or agency conditions (for critical reviews of this model, see Aisenberg, *in press*; Gambrell, 2007; Gold et al., 2006). Practitioners are required to gather strictly positivist, quantitative data from clients. In summary, the evidence-based programming model leads the practitioner to the selection and implementation of a prepackaged intervention with strong quantitative support. In contrast, the evidence-based process model seeks to establish a culture of experimentation and inquiry in a team- or agency-based setting and allows for the use of many types of evidence.

Current EBM Models

To date, EBM has been more influenced by the evidence-based process model than the evidence-based programming approach. Three general models of EBM have been proposed in the business, nursing, and health care management literature. The first EBM model uses the following five-step process to guide managerial decision making:

- Identify a researchable question pertaining to an agency problem or issue. For example, what factors lead to improved worker retention?
- Gather independent, relevant evidence on the question using literature reviews and electronic search engines. In clinical EBP settings, a piece of research is relevant if it matches the clinician's query in terms of its client problem, client characteristics, intervention, clinician type, and agency environment (Johnson & Austin, 2006). In EBM settings, a piece of research is relevant to a manager's query if it has face validity and is judged to be potentially helpful to address the management dilemma under study.
- Assess the scientific rigor of each individual piece of evidence and the logical consistency across the accumulated evidence.
- Summarize and organize the evidence so as to establish some preferential order to the alternatives for intervention.
- Ensure that agency leaders integrate the lessons learned from the research process into the decision-making process (Kovner & Rundall, 2006).

The second EBM model elaborates upon the above five-step process. This decision-making model entails: “(1) identification of a problem, (2) identification of a decision, (3) allocation of weights to criteria, (4) development of alternatives, (5) analysis of alternatives, (6) selection of an alternative, (7) implementation of the alternative, and (8) evaluation of decision effectiveness” (Kovner & Rundall, 2006, p. 7). This decision-making model helps managers identify the cause(s) of problems and alternatives for developing and implementing solutions, and involves continuous monitoring and evaluation activities (Robbins & DeCenzo, 2004).

The third EBM model includes a four-stage program that resembles some total quality management models. This model involves the following actions: (1) *Do*—make organizational changes on a small scale; (2) *study*—observe the effects of the managerial changes; (3) *act*—identify what was learned; and (4) *plan*—study the process (Kovner & Rundall, 2006, p. 8). The data derived from this approach can be compared with research data from other organizations.

Despite the models’ differences in number of steps and specificity of tasks, three major similarities exist across these EBM models. First, the models emphasize skepticism, empiricism, and critical thinking, and require the agency manager to role model the process of gathering and using evidence to make strategic decisions. Thus, EBM may be viewed as a rejection of the anti-critical and non-scientific manner in which managerial decisions are sometimes made (Kovner & Rundall, 2006; Pfeffer & Sutton, 2006b, 2006c; Shortell, 2006). Pfeffer & Sutton (2006a) argue,

Many management decisions aren’t based on sound ideas, established theory, or solid evidence. In fact, many management actions are based on copying what appears to be successful for others, repeating what seems to have worked in the past, believing what people think to be true, and buying into the latest fads written up in the business press (p. 43).

The EBM process seeks to develop managers’ abilities in the areas of skepticism and empiricism by teaching managers to avoid following the established practice wisdom, expert opinion, or colleagues and competitors (Fine, 2006). For any proposed solution to a managerial dilemma, the manager is asked to gather and evaluate evidence concerning the appropriateness of the proposed solution.

Second, each EBM model provides a framework to help managers clarify the central issue, problem, or question facing the agency, and gather reputable evidence on this topic. The process of EBM generally parallels the evidence-based social work practice process (Gambrill, 2007; Gibbs, 2003) and the evidence-based medicine process (Guyatt & Rennie, 2002; Hamilton, 2005; Straus, Richardson, Glasziou, & Hayes, 2005) in that all three processes help practitioners identify and answer researchable questions. Thus, one similarity

TABLE 1 EBM Electronic Search Engines in Health Care Management

Sponsoring organization	Location
National Health Service (NHS) Service Delivery and Organization Programme	www.sdo.lshtm.ac.uk/
U.K. National Library for Health	www.library.nhs.uk/
NHS Health Management Online Resource	www.healthmanagementonline.co.uk/
Canadian Health Services Research Foundation	www.chsrf.ca/
Agency for Healthcare Research and Quality	www.ahrq.gov/research
Cochrane Effective Practice and Organisation of Care Group	www.epoc.cochrane.org
Consumers and Communication Review Group	www.latrobe.edu.au/cochrane/
Center for Health Management Research	www.hret.org/hret/programs/chmr/
PubMed	www.ncbi.nlm.nih.gov/pubmed
Medline	http://medline.cos.com/
Google Scholar	http://scholar.google.com

Note: Source data from Kovner & Rundall (2006).

between the three EBM models is the emphasis on assessment through the collection and critical appraisal of external evidence, often gathered through electronic search engines such as those identified in Table 1. A corollary of this is that each model pushes managers away from relying solely upon data from within the agency or from the manager's own personal experience. Instead, internal data are to be compared to information gathered through electronic web searches.

Finally, each model is hypothesized to lead to improved decision making via the increased use of research, collection of information, and identification and consideration of alternative managerial strategies for resolving a specific agency dilemma. Through the collection and critical review of the best available evidence as well as the systematic consideration of plausible options, managers are thought to make less biased, better informed, and more transparent decisions than their peers (Newhouse, 2006; Rynes, Colberet, & Brown, 2002). At the agency level, managers' use of evidence may improve organizational performance by creating a culture that is driven by questioning and organizational learning (Kovner & Rundall, 2006; Pfeffer & Sutton, 2006c; Williams, 2006).

TENSIONS IN ADOPTING EBM

Managers seeking to introduce EBM into social service agencies may face numerous tensions in marshalling organizational resources, training personnel and creating an evidence-based organizational culture, and broadening the agency's collection and use of various types of evidence (as opposed to only positivist, quantitative data). Each of these areas brings challenges to social service agencies and administrators.

Resource Requirements

The growing emphasis on electronic performance reporting to fiduciaries and the development of integrated client databases have increased the information and technology competencies needed by social service managers (Oster, 1995). EBM may further increase managers' information-related needs by requiring that managers access electronic search engines and locate evidence in support of their proposed solution(s) to a strategic problem. Some managers may believe that they are already overloaded with information and may thus view EBM as adding unnecessarily to their professional responsibilities. Additionally, gaining access to available research may be difficult in competitive marketplaces: Research may be conducted in proprietary settings in which agency executives may not want or be able to share their findings publicly (Finkler & Ward, 2003).

Because of the time it takes to locate and appraise studies, reports, and other evidence generated from electronic literature searches, EBM decision making may take more time than non-EBM decision making. Many practitioners report not having enough time to assess evidence in practice (Edmond, Megivern, Williams, Rochman, & Howard, 2006; Williams, 2006). Engaging in EBM-related information gathering may further decrease the amount of time managers may need to devote to assigned duties and responsibilities.

Finally, the financial costs of implementing EBM are unknown. Due to the absence of external funding to support research, large-scale organizational research rarely occurs in the human services. In general, there are few incentives for funders to conduct management research on cost-effectiveness in organizational practice (Sauerland, 1999).

Personnel and Organizational Issues

Several personnel-related factors may influence managers' use of EBM. Chief among these is the research-related competence demanded of social service managers in EBM settings. Empirical studies suggest that clinical and administrative practitioners do not always have access to or use available research (Kovner & Rundall, 2006; Rosen, Proctor, Morrow-Howell, & Staudt, 1995). Rynes, Colberet, and Brown (2002) surveyed human resource directors about their beliefs about their field as compared to the current research findings in human resources. Respondents generally did not remain current by reading relevant research and practice journals, were unaware of major research findings, and in some instances did not believe published, peer-reviewed research results. In place of using research evidence, managers sought the opinions of their colleagues and paid attention to political, social, and environmental considerations.

The process of EBM requires that social service managers be trained and mentored in posing researchable questions, using electronic search

engines, and conducting critical appraisals of evidence (Fanning & Oakes, 2006; Newhouse, 2006). Administrators may need to ensure that managers of key programs are trained and supervised, and that staff faithfully adopt administrative decisions arrived at via the EBM process. This is particularly the case in decentralized social service agencies in which program units operate relatively autonomously.

Finally, EBM may fit some organizational settings and cultures better than others. Due to the lack of research on EBM, the organizational conditions that are needed to accommodate the transition to EBM are unknown (Damore, 2006). Yet it is likely that agencies with strong research cultures transition more smoothly to EBM than non-research based agencies (Fanning & Oakes, 2006). Agencies with strong research cultures might be characterized as being committed to the process of learning through inquiry and empiricism. These organizations are often willing to invest substantial resources into recruiting and retaining well-trained staff with prior research experience; to track and analyze client data as well as staff perspectives regularly; to use population-based studies based in epidemiological and public health research to compare and contrast the agency's client population with local, state, and national trends; to subscribe to professional journals regarding core client populations; to use pilot programs to test new service delivery approaches; and to engage in reflective, transparent decision making that incorporates the perspectives of multiple stakeholders as opposed to only key elites (Johnson & Austin, 2006; Williams, 2006).

Epistemological Tensions

A final set of tensions involved in situating EBM into social service agencies concerns its epistemological framework of positivism and rationality. Under this framework, agency and managerial behavior can be organized according to deductive logic and cause-and-effect relationships. These principles are thought to be necessary for managers to collect evidence and weigh the relative merits of various managerial interventions. Webb (2001) argues, "Evidence-based practice assumes that rational agents draw the obvious logical consequences of evidence-based findings, to apply fundamental logical principles about the likelihood of action achieving certain ends that respect the axioms of a behavioral probability calculus" (p. 63).

The rational-positivist perspective of EBM fits well with some managerial theories and behaviors. Scientific management sought to apply the scientific method to management as a basis to increase production, revenue, and profits (Netting & O'Connor, 2003). In this positivist context, managerial decision making is based upon an orderly process of objective measurement, testing, and empirical analysis. All aspects of program management as well as staff behaviors are included in supervisory checklists, which are used to monitor the progress of managerial activities. External literature is

combined with local data to inform decisions and assist staff in mastery of activities and outcomes. In this quantitatively oriented environment, a hierarchy of evidence exists that values evidence from randomized clinical trials more than other forms of knowing (Johnson & Austin, 2006; Williams, 2006).

Yet the suggestion that social service agencies are rational and that managerial behaviors are reducible to a positivist calculus may lead to certain epistemological tensions in managers' conceptions of their roles and responsibilities. For some social workers, especially those performing direct practice and middle management functions, organizations can be miasmas, enclaves, and irrational systems. Numerous case studies describe the nonlinear nature of the spread of organizational innovations (MacNulty & Ferlie, 2004; Van de Ven & Lostrom, 1997). Many studies have suggested that formal and informal organizational politics, human relationships, and group behavior often shape the design, implementation, and performance of organizational initiatives (Berwick, 2003; Krackhardt & Hanson, 1993). Cultivating these social and political networks may constitute a great deal of what social service managers do (Menefee, 1998; Preston, 2004; Zunz, 1995).

More generally, the reliance upon positivist evidence in managerial decision making may preclude more in-depth study of what Netting and O'Connor (2003) term the morphogenic, factional, and catastrophe aspects of organizations. Morphogenic factors are "dynamic social systems that thrive on transactions, exchanges, which can be messy and oppressive or orderly and hostile or friendly" (Netting & O'Connor, 2003, p. 146). Factional organizational tendencies include arguments and disagreements over "goals, priorities, resources, and strategies" (Netting & O'Connor, 2003, p. 147). Catastrophic organizational tendencies are defined as environments in need of change encompassing qualities of fragmentation and chaos that are pervasive to organizational context requiring conflict and reorganization as remedies for change.

Managers and scholars who subscribe to these interpretivist perspectives may find the linear and rational aspects of EBM to be contrary to their conceptions of how administrative decisions are made in practice. Basing decision making wholly or primarily upon an assessment of positivist evidence may preclude a deeper consideration of important contextual factors, including personal beliefs, funding dilemmas, politics, important precedents and commitments, public opinion, and the wishes of key stakeholders, communities, and/or client populations (Williams, 2006; Wuenschel, 2006).

EBM IN PRACTICE

Despite these tensions, some social service agencies have begun to use EBM processes to improve their services to disadvantaged communities and

client outcomes. This section presents a case study of one social service agency that used EBM to undertake significant organizational changes. While not all of the aforementioned EBM-related tensions were present, and while the generalizability of the case is necessarily limited, this section illuminates the processes, challenges, and benefits experienced by one agency using EBM.

The Agency Context

Community Support Inc. (CSI) is a nonprofit social service agency serving low-income African American individuals and families across the lifespan in a major Midwestern city. (A pseudonym is used to protect the agency.) Over its 15-year history, CSI had grown into a multiservice organization providing educational, case management, mental health, substance abuse, and employment services. Its primary client population included individuals with barriers to functional independence and community adjustment. Clients lived either in the community, group homes, or in foster care placements operated by the agency.

In the five years preceding its use of EBM, CSI experienced various structural and cultural dilemmas. Its seven service divisions (employing roughly 100 full-time staff) operated relatively autonomously, with little comprehension of or interaction with one other. There were no agency management meetings, and staff affiliated principally with the division director as opposed to the executive director.

CSI's reputation and relationships with its principal funding sources had also declined substantially over this time. Funders were growing concerned with the performance of its two largest service divisions, child welfare and mental health. The state public child welfare agency had noted CSI's high staff turnover, poor performance in case and service reviews, and poor staff preparation for court appearances. And the state mental health agency had refused to license CSI's new group home for adults with developmental disabilities because CSI had neither fully staffed the group home nor prepared a full policy and procedures manual, including detailed information on program operations, staff development, and client habilitation programming.

The first author entered the agency as an organizational consultant with an initial charge of developing and implementing empirically supported treatments in the child welfare and developmental disabilities divisions. Within a few months, however, he was asked by CSI's executive director to become the agency's chief operating officer (COO) with a goal of facilitating the agency's transition to a client-centered, learning organization through the use of best practices and staff and client empowerment strategies. In particular, the EBM process was to be used to reshape CSI's mental health and child welfare divisions.

The EBM Process

The key management dilemma facing the mental health division was obtaining state licensure for its group home. The COO used the eight-stage decision-making approach (Kovner & Rundall, 2006) to identify organizational strategies for bringing the group home into compliance with state requirements. A search of the academic literature identified case studies of accountable, evidence-driven group homes and provided information concerning the necessary responsibilities of group home administrators, program staff, and clients. Further literature searches were employed to identify empirically supported strategies for sustaining family involvement in service provision and preparing clients for independent living.

This external information was combined with data from an internal survey of division staff as well as direct observations of program supervisor activities. The COO then implemented a process of using client choice in service planning and developing social leisure programs. Checklists were designed with staff involvement to use for data collection, assessment, and decision making. Group home managers, supervisors, and line staff were taught to use behavior modification and other evidence-based strategies to define expected performance and change and reinforce behaviors. To sustain program improvement, a performance monitoring system was set up that incorporated data from applying the eight-step process in individual supervision with the residential division director and group home program supervisors.

In contrast, the child welfare division required improvements in staff retention as well as staff performance with children, families, and court officials. Division staff were failing to complete records on clients, few understood case management, none had received training in evidence-based approaches to parent training or brief therapy, and no regular supervision or quality control was occurring. The COO terminated the employment of the division director and then began a series of programmatic changes. Reviews of various literatures suggested that effective case management, task-centered child welfare practice, permanency planning, and parent training were appropriate methods for improving staff performance.

Expert trainers in these areas were then employed to teach front-line caseworkers strategies for returning children home or preparing them for adoption by foster parents. Because staff lacked clinical supervision concerning foster parent-child dynamics, clinical consultation on all foster care placements was arranged to support the overall therapeutic gains being established between the foster child and significant others. Finally, executive staff began to make random, unannounced field audits in which they would gather foster parents' input concerning the frequency of staff contact, services provided by agency caseworkers, and how care could be improved. The results of these field visits were incorporated into a staff performance monitoring system.

Tensions and Benefits from the EBM Process

Significant tensions arose within CSI's mental health and child welfare divisions as a result of the EBM-related changes. Through the staff hiring, retention, and performance monitoring process, numerous personnel changes were made. Literature reviews suggested that group home staff should be able to coach disabled individuals to complete basic, daily tasks, manage a household, and manage complex caseloads; and that child welfare case managers should set up regular parent-child visitation schedules, link parents to community-based services, and document parent and child progress toward case goals. These criteria were built into position descriptions, used to hire new staff, and incorporated into staff performance monitoring. Staff that underperformed on performance criteria had their contracts terminated, while staff that excelled in these areas received performance bonuses.

Personnel-related tensions began after the firing of the child welfare division director and other underperforming staff. Staff expressed allegiance to the prior child welfare director and to the status quo methods of providing mental health and child welfare services. Additionally, because staff training increased, staff initially worked longer hours. Furthermore, staff initially did not accept the validity of the evidence from the literature reviews, deeming them unrealistic and inappropriate for use with the client population.

Despite their initial resistance, support increased once staff began to see improvements in client outcomes. Caseworkers began to increase their attention to timely, effective service provision. Supervisors began to provide literature that caseworkers could use to manage foster parents and provide brief therapy to youth and birth families, as well as group training and individualized consultation on case interventions. As supervisory procedures and routines were established for time management, quality control, and staff training, staff became more invested in the process of using internal data to make programmatic decisions and to support salary increases and promotions. The focus on EBM was further strengthened through the institution of quarterly agency-wide meetings, which were used to highlight successful, evidence-based programs and share information across divisions. Throughout, program performance data were shared in order to identify trends in service provision, client outcomes, and programmatic and administrative needs.

The supervision, personal time management, and program quality assurance functions required the collection of local data by supervisors and division directors. These data were incorporated into the agency management information system and reviewed by the COO. Due to the increased production of information and data, two program directors and a personnel director were hired to assist the COO. In this manner, the COO could attend to sustaining the evidence-based innovations that had been started and to monitoring program improvement processes.

The EBM process resulted in CSI growing from 100 to 300 employees and from \$1.2 million to \$13 million in annual revenue over a six-year period. CSI's group home was licensed, its child welfare contracts were renewed and expanded, and its mental health and child welfare divisions bid successfully to provide new publicly funded programs. While front-line staff turnover decreased at CSI, the agency's improved performance led many of its program managers and supervisors to leave for other agencies that sought to adopt CSI's evidence-based service strategies. CSI is now well known regionally for its social service programming, training, and research with low-income, urban African American populations.

DISCUSSION

At this early stage of its development, EBM is being touted as a mechanism leading to increased agency performance and transparency in decision making. Given rising performance expectations for social service agencies and increased incentives for social work managers to support their practice decisions with research, EBM enters the social work profession with some promise. Yet because the utility of various EBM models for social service agencies and their staff and clients has not been determined, critical questions require scholarly attention.

What Types of Evidence and Decisions are Appropriate for EBM?

Evidence is a broad construct that includes positivist and non-positivist paradigms, each with distinctive strengths and weaknesses. Given its roots in evidence-based practice, EBM is predisposed toward the use of positivist, quantitative data. The hierarchy of evidence used in evidence-based practice implies that managers adopting EBM models may prefer quantitative, experimentally derived data above other forms of knowing. Such a position might appear *prima facie* incompatible with interpretivist approaches to organizational decision making (e.g., critical and postmodern perspectives concerning relational conflict and cooperation, power, and sensemaking) (Aldag & Fuller, 1993; Alvesson & Deetz, 1996; Weick, 1995), as well as impractical in that few controlled studies of managerial innovations exist (Hewison, 2004).

There are many reasons why managers may use non-positivist types of evidence. In clinical evidence-based practice settings, social workers typically rely upon positivist data to make decisions. The context surrounding a specific managerial decision, however, may not be fully captured through positivist, quantitative evidence (Williams, 2006). Many managerial decisions require consideration of the positions of multiple internal and external stakeholders. Additionally, managers may not be

able to rely upon quantitative information exclusively in making strategic decisions, either because the agency must comply with precedent, funders, or elite stakeholders, or because it may incur reputational costs if it appears to deviate significantly from the status quo or its competitors' actions. These complex relationships, tensions, and demands may be factored into managers' decision-making calculus as much as scientific evidence, and may therefore limit managers' use of positivist evidence and EBM.

It is also possible that managers draw upon various types of knowledge simultaneously to provide for the delivery of effective, empowering social service programs. That is, managers may seek to weave together different types of positivist and non-positivist knowledge, including:

- Technical knowledge, which is positivist in nature and is derived from the application of the scientific method (Briggs, 1996, 1994; Grimshaw, Baron, Mike, & Edwards, 2006).
- Social and political knowledge, which concerns social interactions, an understanding of power dynamics, sensemaking, and a comprehension of the social meaning and values of key elites (Bolman & Deal, 1997; Weick, 1995).
- Self-knowledge, which is gathered through continuous critical thinking and self-assessment (Goleman, 1998; Kondrat, 1999).

There may be certain advantages to combining positivist and non-positivist data to make managerial decisions. For example, while reliance upon positivist EBM perspectives may lead social service managers to deemphasize issues concerning race, class, and sociopolitical context, solely drawing evidence from the post-positivist paradigm may ignore the broader performance-based, quantitatively oriented environment surrounding many social service agencies. This triangulation of different evidence bases may bolster the limitations of each type of knowledge.

These considerations suggest two topics for future research on EBM and the use of evidence in social service managerial decision making. First, it is important to understand the varieties of evidence in use and the conditions under which positivist or non-positivist knowledge is employed. Additionally, the synthesis of various types of evidence also merits study. When and why do managers use multiple types of evidence, and are certain types of knowledge combined regularly? Second, the utility of various EBM strategies is unknown. Under what conditions does the use of positivist and/or non-positivist knowledge lead to positive agency outcomes (as measured by agency performance and/or client outcomes)? Identifying which evidence-generating paradigm best resolves a particular managerial dilemma will require that social service managers access and consider the relative merits of different types of data.

How Should Managers Integrate EBM and Client-Centered Decision-Making Approaches?

In client-centered social service programming models, service recipients are formally and/or informally involved in governing the programs in which they are enrolled (Linhorst, Eckert, & Hamilton, 2005). These models elevate client needs and interests by giving clients influence over managerial decisions or, more indirectly, by asking social service managers to serve as faithful stewards of client perspectives. Thus, these models seek to make administrative and line-staff decision making more responsive to the perspectives of clients (often called “consumers”) as opposed to other key stakeholders such as funders or public officials, and allow for provider-consumer partnership (Gowdy, Rapp, & Poertner, 1993; Segal, Silverman, & Temkin, 1993).

The place of client knowledge, interests, and perspectives in EBM and evidence-based practice is uncertain. None of the three EBM models specifically attends to client values or wishes, although nothing in these models prevents managers from incorporating client-based participation in the EBM process. Evidence-based programming models, however, do not generally include client preferences in clinical decision making, as they reserve for the practitioner the responsibility for defining researchable questions and searching for appropriate treatment options (Straus et al., 2005; Webb, 2001). Nor do these models easily allow for culturally specific adaptations to empirically supported treatments. In contrast, some evidence-based process models specifically incorporate client preferences and knowledge (Gambrill, 2006; Gibbs, 2003). For example, Walker, Briggs, Koroloff, and Friesen (2007) recommend that evidence-based processes begin by assessing client preferences.

This client-centered perspective may be crucial for the development of EBM within the social service sector and the profession of social work. The ethical foundation of social work—with its emphasis on social justice, client self-determination, and empowerment—obliges social service administrators to integrate client preferences within existing strategic decision-making processes, including EBM. Carefully attending to clients allows managers to learn what is important to clients and what they deem to be barriers and obstacles to achieving their desired goals. How managers integrate EBM with client- and culturally sensitive governance models, and what effect such integration has on client outcomes and agency performance, are therefore topics that merit future attention from scholars and practitioners.

CONCLUSION

Evidence-based practice and its administrative derivative, EBM, have diffused from the health and medical sectors into the profession of social work and

the social service sector based at least partly upon their promise of heightened accountability, performance, and transparency in decision making. This paper introduces the concept and core models of EBM to social work and social service administrators. Because little empirical research on EBM has been conducted, numerous questions exist concerning its short- and long-term benefits for agencies, managers, and clients. Early evidence suggests that agencies seeking to use evidence to improve strategic decision making may transition to EBM more easily if they have the necessary staff and financial resources to access internal and external information, train key staff, and have an organizational culture characterized by skepticism, empiricism, and experimentation. Finally, two possible tensions between EBM and standard social service management practice are identified, namely how managers use various types of evidence and how agencies integrate EBM models with client-centered decision-making approaches.

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