



# DRUM BEATS: FACT SHEETS

## One Way of Knowing Is Not Always the Best Way: Introduction to Evidence Based Practice for AIVRS Programs

The central goal of vocational rehabilitation (VR) is to assist people with disabilities to attain and sustain gainful employment. A common model for accomplishing this is called evidence-based practice (EBP). Sadly, EBP is poorly understood in general, but its application to American Indian Vocational Rehabilitation Services (AIVRS) is even more confusing and, in some cases, its appropriateness has been questioned. For this reason, the American Indian Vocational Rehabilitation Training and Technical Assistance Center (AIVRTTAC) has adopted a broader perspective of EBP to guide training and technical assistance to AIVRS programs. Our perspective is different. We think this broad perspective of EBP is a better cultural match to AIVRS programs and that this framework will help programs build capacity toward more effective service to tribal members with disabilities. Ultimately, effective decisions made by VR counselors in partnership with clients (based on the EBP framework described below) will enhance employment outcomes of American Indians with disabilities. EBP can be a useful framework for AIVRS programs, but before it can be, EBP has to be properly understood. This document briefly describes common definitions and uses of the phrase “evidence-based practice” and reveals some aspects of EBP that are less known, but very relevant to AIVRS programs.

In its truest sense, EBP is a decision-making process that involves the integration of three things: a) the best available evidence, b) clinical expertise, and c) client values, preferences, and context. This definition suggests “practice” is something a



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### About the Institute

*The Institute for Human Development is a research and training program located on Northern Arizona University. Our program is part of a national network of University Centers for Excellence in Developmental Disabilities (UCEDD). In Arizona, we are designated as one of two Arizona University Centers on Disabilities (AzUCD).*



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practitioner does. If so, it conflicts with the everyday use of the phrase “evidence-based practice” to refer to a specific intervention, treatment, program, strategy, curriculum, approach, procedure, or method that has met a specified criterion based on the amount and quality of relevant research (i.e., “What are evidence-based practices for vocational rehabilitation?”). We think this use is problematic and should be avoided. In most all papers written about EBP, authors define “evidence-based practice” as a decision-making process but then use the same phrase when talking about a specific treatment or intervention. This is the root of mass confusion around EBP.

While EBP as decision making process has received surface-level attention, a proliferation of lists and databases of interventions has occurred. A more suitable name for interventions with a substantial research base is “empirically supported interventions.” The distinction is important because identifying empirically supported interventions aligns only to the first source of influence on decision-making—best available evidence. However, application of off-the-shelf interventions without consideration of clinical expertise and client values, preferences, and context is incompatible with the spirit of EBP as a decision making process. For AIVRS programs, implementing an intervention before considering the other two components of EBP could have significant detrimental consequences.

A narrow focus on the best available evidence component has led to a hierarchy model of “best” evidence based on the rigor of the design used to evaluate the intervention. For example, a popular model describes five levels of evidence with a systematic review of multiple randomized control trials topping the list of “best” and opinions from respected authorities at the bottom. Although these levels can be helpful in determining the “best” evidence with respect to study design, it is not the only way evidence can be “best.” It has been suggested that “best” also describes the relevance of the evidence. Many rigorous studies document the positive effects of rehabilitation counseling, but studies that included American Indians and Alaska Natives as participants would be more relevant to AIVRS programs than those that didn’t and thus better for making decisions about rehabilitation counseling with American Indian and Alaskan Native clients. In some cases, evidence that is most relevant may not be the most rigorous. When there are different types of “best” evidence available, clinical expertise and client values, preferences, and context are needed to arrive at a clear recommendation.

Evidence, as used in the best available evidence, typically refers to research evidence. In reality, other sources of information can also be evidence such as information gathered from focused groups, surveys, and case reviews. Monitoring of individual client outcomes (e.g., sustained employment) is an essential part of EBP because it allows for confirmation of the intervention’s effectiveness with a specific client in a specific situation. Contextualized demonstrations of effects are often referred to as practice-based evidence. The need for a variety of evidences is apparent when the following question is asked, “What should I do when there is no research available on a specific intervention, with a specific population, or for a specific situation?” Practitioners cannot simply stop practicing. Instead, they need to search for other types of evidence that are available. Evidence doesn’t count if it isn’t available and practitioners cannot wait until mounds of high quality research evidence are available. Importantly, evidence-based practice can occur whether or not the desired amount or type of evidence is available.

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In VR, the client (also called consumer) is typically an individual with a physical or mental disability that makes it challenging for the individual to be employed. Clients have unique strengths and limitations surrounding their disability, but they also have individual values and preferences that are tied to their culture, religious beliefs, or history. Evidence-based practice celebrates the diversity among clients, families, and communities and a holistic understanding of an individual is at the heart of making effective rehabilitation decisions. Informed choice in the rehabilitation process is an important cornerstone of both EBP and VR counseling. As self-determiners, clients should be involved in every decision. Based on their values and preferences and in collaboration with a VR counselor, clients establish specific goals of rehabilitation, select the interventions and avenues to achieve the goals, and determine when successful employment has been achieved. To ensure rehabilitation services are a contextual fit for a client, the integration of the client’s values, preferences, and strengths is critical.

Clinical expertise refers to a range of skills the practitioner uses to consider the best available evidence with respect to the values, preferences, and context of a specific client. Practitioners need to assess important problems, identify underlying processes, judge the “bestness” of evidence, select interventions, adapt interventions, implement interventions, and monitor and evaluate outcomes. Extensive training, supervised practice, and on-going professional development are necessary to help practitioners develop clinical expertise. Practitioners have an ethical responsibility to provide and recommend interventions with the best chance of being effective. The extent to which rehabilitation professionals can do this depends on the expertise they have developed.

Evidence-based practice in VR promises to increase employment and enhance self-determination of people with disabilities, but its successful application to AIVRS programs requires a more sophisticated characterization. At this point in time, the typical levels of evidence are largely irrelevant to AIVRS programs because few (if any) empirical studies have investigated the effect of rehabilitation services and interventions with American Indians with disabilities. That is not to say that research evidence, as a whole is irrelevant. Research evidence that is available and partially relevant may be useful, with some modification based on an American Indian/Alaska Native or individual context. For example, an assessment tool that has been shown to be effective in state VR programs could be effective in AIVRS programs with some specific adaptations. Although not precisely relevant to the needs of AIVR programs, evidence generated from research studies may serve as a starting place for learning what will work with American Indians with disabilities.

The nuances of the EBP model described here may serve as a viable framework for the AIVRS programs. This broader EBP approach relies more heavily on clients’ values, preference, and context and available types of evidence to make effective decisions. Relevance of evidence is a key factor in identifying the best available evidence and sources of practice-based evidence are acceptable. The most important point is that AIVRS programs can implement EBP even though there is limited research to support VR interventions with American Indians with disabilities. EBP is not just about selecting an intervention with research support. It’s really about making effective decisions with whatever evidence is available. Many of the resources developed by AIVRTTAC will integrate relevant research, but because we have this broader perspective of evidence we will also offer guidance for practice even when there is no research evidence.

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## Glossary of Terms

**Best** – how helpful a piece of evidence is to inform effective decisions. Evidence can be judged as best according to: a) the rigor of research design that produced the evidence, b) the amount of evidence, and c) the relevance of evidence to specific client and context.

**Best available evidence** – information used to help make decisions, often considered research of the highest quality and rigor. However, research of great relevance can also be considered best.

**Clinical expertise** – skills practitioners need to integrate the best available evidence and client values, preferences, and context.

**Client values, preferences, and context** – factors, unique to clients, that influence decisions about what rehabilitation services and interventions are selected and how they are implemented.

**Empirical research** – a type of research that relies on objective observation of the phenomenon of interest to generate knowledge.

**Empirically supported intervention** – an intervention that has a substantial research base documenting it as effective.

**Evidence** – information used to help make decisions.

**Evidence-based practice** – a decision making process that integrates the best available evidence, clinical expertise, and client values, preferences, and context.

**Intervention** – a specific procedure or set of procedures used to impact a specific outcome, also called treatment, approach, strategy, curriculum, program, or method.

**Practice** – what a practitioner does, including making many clinical decisions every day.

**Practice based evidence** – information about the effectiveness of an intervention derived from its specific application with a client or context.

**Randomized controlled trial** – a study design that involves the random assignment of participants to a group that receives the treatment of interest (experimental group) or to a group that does not receive the treatment of interest (control group).

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## Disclaimer

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