

TRaversing the MAZE OF 'EVIDENCE' AND 'BEST PRACTICE' IN DOMESTIC AND FAMILY VIOLENCE SERVICE PROVISION IN AUSTRALIA

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SUMMARY

This paper considers how 'evidence' is constructed and translated into 'best practice'. It contends that the experience and understanding of practitioners within domestic and family violence (DFV) services constitute important contributing knowledge for the evidence-base. However, practice wisdom alone is not sufficient, since other forms of knowledge also play an important role in optimising outcomes. Ultimately this paper promotes the engagement of DFV practitioners in formal research and evaluation, not only to substantially inform the evidence but also to critically examine the effects of their interventions against all manner of valid evidence, in a recursive process of knowledge translation. It is suggested that a critical, reflexive engagement with formal evidence is ultimately the defining feature of 'best practice' in the continuous drive towards an effective response to violence against women.

Key Points

- 'Evidence-based best practice' (EBP) is an important concept for the development of effective responses to all forms of violence against women, including domestic and family violence. However, what constitutes 'best practice' and 'best evidence' can be highly contested.

- The accepted 'evidence' ultimately influences practice by shaping policy, the service system, funding, intervention models and service evaluation.
- Traditionally, quantitative research methodologies grounded in the natural sciences (with the randomised control trial as the ideal model) have tended to dominate understandings of what is accepted as the 'best' or 'gold standard' evidence. However, criteria for gold standard evidence are not easily implemented in the complex arena of DFV practice and do not fully encompass the importance of the worker-client relationship.
- The diverse and trustworthy forms of knowledge that contribute to reliable evidence in DFV work, include not only quantitative findings but also qualitative studies, descriptions of lived experience and practice wisdom.
- In particular, practitioner knowledge and professional judgement can play a critical part in generating formal, valid evidence to underpin best practice.
- Rigorous evaluation, built in to program design and partnerships with researchers to investigate experience and test current evidence are critical to the ongoing development of best practice.

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INTRODUCTION

Domestic and family violence (DFV) service provision is a complex field within which victims' needs for safety, recovery and ongoing support are influenced by multiple, changing factors (Laing, Humphreys and Cavanagh 2013). An adequate response to these needs can often involve workers from a broad range of professional and occupational backgrounds informed by different values and disciplinary traditions. It can also require collaboration between a number of different sectors with different priorities and roles (Breckenridge and James 2013; Healy and Humphreys 2014). Policy and practice responses within DFV therefore demand skilful, nuanced interventions across multiple, integrated service systems and professional cultures. To successfully navigate this complexity, workers are commonly urged to deliver what has come to be known as 'good' or 'best' practice, informed by the 'evidence'. Australia's overarching policy framework, the National Plan to Reduce Violence against Women (VAW) and their Children (COAG 2012) strongly emphasises "evidence-based best practice" (18, 30) as a means to enhance the effectiveness of the overall response to VAW. This echoes earlier, important work emerging from the Australian Government's Partnerships Against Domestic Violence (PADV) program (Kirsner et al 2001) and builds upon many developments since. A range of best practice models, guides and standards are now widely promoted, serving to underline this notion.¹ While this paper focuses specifically on domestic and family violence, the questions and concerns about 'evidence' and 'best practice' can be raised in relation to other areas where women experience gendered violence including for example, sexual assault.

It is perhaps a basic professional expectation, not to say common sense, that DFV policy and service delivery should be based on reliable evidence that confirms particular interventions are necessary, appropriately sensitive to critical concerns and actually 'work' to keep women and children safe.

However, what specifically constitutes good or best practice; which evidence justifies this assessment; and by whose authority, can be highly contested (Lamont 2000; Larner 2004). The purpose of articulating and promoting certain approaches as 'best' practice is often not only to provide a beacon for continuous improvement but also as a means to regulate unproven or poor practice. Proponents can thereby optimise outcomes, allocate resources efficiently and actively prevent harm. It is argued here that what becomes accepted as 'evidence' significantly affects DFV practice through shaping policy, the service system and service evaluation and therefore its influence should be understood and critiqued. In a sophisticated service system that is committed to women's and children's safety and where resources are limited, it is important to examine the seemingly ubiquitous presence of 'evidence-based best practice' through a full understanding of how different types of evidence are used and gain status. It is also critical to ask how the accepted evidence actually translates into day to day 'best practice' through not only skill development but also regulatory processes such as outcome-based funding agreements and evaluations.

- This paper explores 'evidence' and 'best practice' in domestic and family violence service provision in order to provide practitioners with:
- A definition and critique of evidence-based 'best' practice, including the political, economic and ideological appeal of knowing 'what works'
- An understanding of the contested nature of 'evidence' and the helpfulness of widening the evidence base to ensure that different types of evidence inform and construct effective responses to victims of DFV
- Reflections on the ways in which evidence may be accessed and translated into best practice responses and strategies
- Concluding thoughts as to how as a sector, DFV workers can contribute to the ongoing development of evidence-based best practice.

1 For example Government of Western Australia 2000, Queensland Government 2002, Grealy et al 2008, ADFVC 2011, New South Wales Government 2012.

DEFINING AND CRITIQUING EVIDENCE-BASED 'BEST' PRACTICE

Notwithstanding their popularity within the DFV literature, the terms 'good practice' and 'best practice' are frequently not well defined. Along with 'emerging practice', 'frameworks of excellence', 'practice standards' and other similar concepts their meanings tend to be assumed and the various terms employed interchangeably. In addition to this lack of clarity, some researchers and practitioners have taken issue with the word 'best', suggesting it implies a static end-point, inviting a 'one size fits all' approach, rather than a set of responsive interactions capable of evolving to meet the changing needs of individual women (Lamont 2000, Laing et al 2013, and Ife 2010) and advances in knowledge. Despite this criticism there are those who maintain that the concept of best practice can still be useful as an aspirational goal, provided it is not intended to suggest 'perfect' practice, without qualification or continuous review (Hill and Shaw 2011). In developing a best practice model as "a critical mechanism for promoting victim safety", Lamont (2000: 2) makes the point that the political, philosophical and methodological diversity of the DFV sector can lead to significant disagreement about what may be judged 'good' or 'poor' practice. She advises that without shared knowledge and ownership of the criteria used to assess this, there is unlikely to be any meaningful translation of what has been learnt, into direct service delivery. Moreover, while the intention to provide evidence-based best practice may be worthy, some authors caution that various incarnations may well be driven by particular ideological positions or economic agendas that are obscured by claims of objectivity (Rycroft-Malone et al 2004). In this paper we use 'best practice' as an umbrella term to refer to all attempts to apply formal research evidence to define, specify and direct DFV practice for optimum health and wellbeing, thus remaining consistent with 'The National Plan to Reduce Violence against Women and their Children 2010 – 2022' (the National Plan).² Through a discussion of the issues we invite questions about how evidence

2 The National Plan can be accessed at <http://www.dss.gov.au/our-responsibilities/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children>

for best practice is understood and translated into service delivery. Ultimately we urge a critical engagement with accepted evidence, including the generation of practice-led evidence through formal evaluation, to ensure that different types of knowledge inform and construct effective responses to DFV.

AN UNDERSTANDING OF THE CONTESTED NATURE OF 'EVIDENCE' AND THE HELPFULNESS OF WIDENING THE DFV EVIDENCE-BASE

According to Webb (2001) the idea that best practice can be achieved through following evidence derived from rigorous research methodologies is "deeply appealing to contemporary technocratic culture" (2001, 58). He articulates a concern that in many ways evidence-based practice is viewed as a panacea for intransigent (and costly) social issues and within the field of human services it has bypassed appropriate critique. Speaking from a UK social work perspective, Webb suggests there are hazards in relying too heavily on dominant forms of evidence that emerge mainly from the quantitative research models and experimental or randomised trial methods championed by medical science. He infers that a strong orientation towards these types of evidence can ignore the complex decision-making that occurs in social work contexts, through discretionary, professional deliberation and that this focus might actually hinder best practice. Thus, alternative forms of knowledge such as workers' practice wisdom and interpretive enquiry into lived experience can be sidelined or assessed as less credible. Webb's concern about the way in which a dominant quantitative orientation excludes or marginalises a broader range of evidence is echoed throughout the human services and in particular within the therapeutic and DFV literature (for example, Larner 2004; Bowen and Zwi 2005; Carson, Chung and Day 2009; and, Laing et al. 2013).

The widespread use of the term 'evidence-based practice' can be traced to the formation of the 'Cochrane Collaboration' established in Britain in

1993.³ Continuing today and wielding significant influence, the Cochrane Collaboration focuses specifically on health and medical research, featuring systematic reviews of treatment interventions as well as promoting the search for 'gold standard' evidence, based on the implementation of clinical trials. The subsequent Campbell Collaboration, founded in 2000, transposed this model with minimal adaptation, to focus on the social sciences.⁴ Understanding the influence of Cochrane and Campbell is important for DFV practice because they provide a context for the ways in which academic and public debates about 'evidence' have developed. In particular, they frame contemporary perceptions of what more generally has constituted credible and robust evidence.

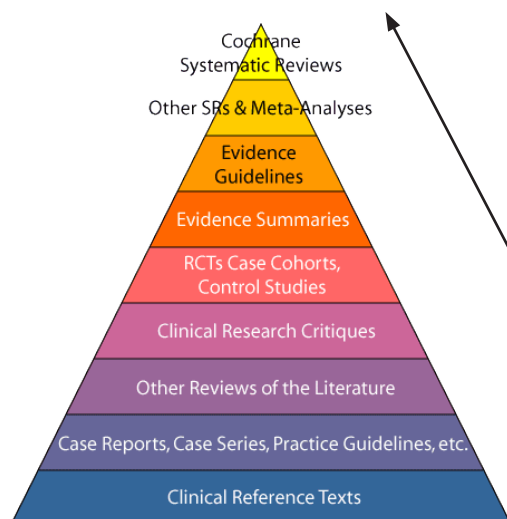
The Cochrane Pyramid in Diagram 1 is one of many visual depictions of the Cochrane taxonomy. The pyramid demonstrates a hierarchy of evidence from 'gold standard' at the top of the pyramid, privileging quantitative methodology and research processes such as systematic reviews, meta-analyses, evidence guidelines and summaries and randomised control trials (RCTs), cascading down to the base of the pyramid where qualitative and

clinical literature is noted as also constituting a form of evidence, albeit less 'scientific'.⁵

In the glossary of Cochrane reviews, 'gold standard' evidence is recognised as "the method, procedure, or measurement that is widely accepted as being the best available, against which new developments should be compared" (Cochrane Collaboration www.cochrane.org/cochrane-reviews accessed 20 January 2014). This definition could conceivably include a wide range of evidence, but in reality reflects Cochrane's assumption that the 'best available' evidence is only able to be assessed by rigorous quantitative research methodology. Greeno (2002) suggests that within a hierarchy of possible quantitative research designs, the randomised control trial (RCT) is the most rigorous approach and therefore more likely to be reliable in producing the best evidence to underpin treatment choices. In strict scientific terms an RCT conforms to a 'classical experimental research design' where there is a 'treatment' group and a control group. Participants are randomly assigned to either group (referred to as double blind allocation).⁶ A 'treatment' or intervention outcome must be defined and measured both before treatment commences and after treatment is completed, so that change

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- 3 "Cochrane is an international network of more than 31,000 people from over 120 countries, working to help healthcare practitioners, policy-makers, patients, their advocates and carers, make well-informed decisions about health care, by preparing, updating, and promoting the accessibility of Cochrane Reviews - published online in the Cochrane Database of Systematic Reviews, part of The Cochrane Library". Text taken from About Us - <http://www.cochrane.org/> accessed 15th January 2014
- 4 www.campbellcollaboration.org/www.cochrane.org/cochrane-reviews.

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- 5 The Evidence Base Pyramid is taken from Health Services Library – University of Washington <http://libguides.hsl.washington.edu/ebptools> accessed 15th January 2014.
- 6 Double blind treatment refers to patients or a client being randomly allocated to one of two groups – one which receives the treatment in question and the other group known as a 'control group' receives no treatment. The patient or client does not know (is 'blind' to) which group they are allocated to. Obviously this research design is used extensively in medicine and particularly drug trials to prevent a placebo effect.



Credibility of evidence increases up to the pinnacle of 'gold standard'.

Diagram 1

Source: Health Services Library – University of Washington <http://libguides.hsl.washington.edu/ebptools>

can be measured over time (Greeno 2002). This method has assumed pre-eminence, as the most trusted means to produce gold standard evidence (Rycroft-Malone et al 2004).

To establish evidence as 'gold standard' however, requires more than a single randomised control trial. Within the Cochrane and Campbell field of thought a more complex process of verification is required, involving systematic reviews and meta-analyses. Larner (2004) suggests there are three defining requirements of 'gold standard' evidence:

(1) The approach has been shown to work using double-blind treatment and control groups with replication by at least two independent studies

(2) The approach has been translated into a 'treatment manual' allowing other practitioners to follow guidelines or frameworks which standardise interventions into recognisable and replicable steps

(3) The treatment has been applied with particular client populations and problems, and both specific and universally agreed outcomes have been named for the treatment or intervention (Larner 2004, 18).

These stringent criteria underscore that 'evidence' is not only concerned with what we know but also in large part, how we know it and by whose authority. This has implications for what is ultimately deemed 'best practice' and how the success of individual practices and service responses are measured, sometimes becoming circulated as benchmarks and tools for learning.

While a reliance on quantitative methods, including randomised control trials, systematic review, and longitudinal studies clearly offers important insight into a range of issues, it can also present a somewhat narrow and limiting perspective on the diversity of experience and practice, most particularly in the DFV sector (Glasby et al 2007). Researchers frequently note that quantitative methods provide answers to very particular questions such as 'how many' and 'how much' but may fail to capture the 'how' and 'why' of intervention (Bryman, 2008; and Sprenkle and Piercy, 2005). Questions regarding the extent of a 'problem' and demonstrations of measureable change over time as determined by outcome studies, can certainly contribute

to our understanding of what 'works' and for whom. However Carson et al (2009) argue that to solely rely on or privilege quantitatively informed methodological approaches does not accurately capture and reflect the lived experience of women experiencing DFV, or do justice to the complexity and skill of the practitioner response. While these latter studies are preferred by many DFV researchers for the philosophical reasons just stated, arguably the credibility awarded to the evidence they produce positions their findings at the margins of knowledge. The gold standard criteria on the other hand, reflect a positivist approach (Campbell 2002) meaning they explicitly claim to confirm 'facts' and causal relationships through the 'objective', value-free testing of observable phenomena.⁷ While this approach is less concerned with complex, 'how' and 'why' questions related to the social sphere (Larner 2004), it remains centrally located as the basis of credible, 'scientific' knowledge.

A number of authors agree that identifying and discerning what constitutes valid and reliable evidence in domestic and family violence service provision can be problematic (Laing et al 2013; Ferguson 2003; Jones et al 2008; UN 2008). Implementing RCTs and meeting the limited criteria required to establish gold standard evidence is extremely hard for most DFV services or DFV researchers (Larner 2004; Bowen and Zwi 2005; and, Carson, Chung and Day 2009). As with many welfare and therapeutically-oriented services, responses to DFV do not always lend themselves easily to quantitative inquiries. In particular:

- DFV interventions in a real world environment do not translate easily into a step-by-step fixed process or procedure that can be tested and repeatedly applied by different practitioners in exactly the same way. 'Manualising' DFV intervention is difficult because an effective response frequently requires spontaneous action and collaboration between various services at different points in time.

7 In sociology 'positivism' is based on the philosophical assumption that observation of social life can establish reliable, valid knowledge about how it works. Methodologically, social theories are built in a rigidly structured and linear way to best establish a base of verifiable 'fact'. See Larner (2004, 30) for further discussion of what he terms the imposition of 'an unrealistic positivist-science model' on practice.

- Randomized control trials (RCTs) are more suitable for medical interventions where a specific drug or treatment outcome can be isolated and pre-determined. RCTs standardize the intervention, allowing for little if any, negotiation of what might be considered a uniquely successful outcome between practitioner and client.
- Variables within DV circumstances and interventions often intersect and change over time making it difficult to specify a precise range of desired outcomes prior to the client's engagement with a service. Moreover, to do so would be inconsistent with facilitating women's sense of agency and control over their life choices which many DFV workers consider to be 'best' practice with their clients.
- Related to the above, the role of on-going perpetrator violence and harassment even after women have left a violent relationship frequently influences 'treatment outcomes' for women independently of or despite potentially 'best practice' interventions.
- There are ethical problems with implementing the 'double blind' treatment approach in that not providing an available treatment can place women and children in significant danger. Greeno (2002) addresses this concern by suggesting that instead of 'no treatment' control groups, clients may be allocated to a 'treatment as usual' group. However, providing a potentially less than optimum 'usual' treatment without the client being aware of the alternative, still raises ethical concerns.
- Overall, an important research focus for DFV is to ask why and how certain practices are effective rather than merely which intervention causes what outcome. These are interpretive investigations requiring a qualitative research approach.

Simply put, the means by which we gain the 'best evidence' to guide 'best practice' derive from a mainly medical model underpinned by a positivist philosophy and methodological preference for quantitative research, that does not readily match the reality of DFV sector experience. In spite of this mismatch, this model of 'best evidence' has arguably been positioned as the most valid approach to firstly defining what 'works' in DFV and secondly measuring the success of policies, services and specific interventions. Webb's comments (mentioned earlier) about the appeal of such evidence to government and funding bodies are

salient here (2001). The requirement to measure what is effective in terms of cost and successful outcomes is now built into funding agreements and outcome evaluation is a contractual expectation at both the organisational and program level. There is no doubt that quantitative evidence of effectiveness and successful outcomes can helpfully contribute to our understanding of 'what works'. It is important to recognise however that the service system and individual responses are then shaped by this particular type of evidence that can be used as a benchmark and source of evaluative criteria for policy-making and funding. While it is necessary and valuable to assess the effectiveness of what services do and scrutinise claims of credible evidence derived from research, this potential preoccupation with quantitative methodologies can exclude or marginalise other forms of qualitative knowing. It can also overlook the role of professional judgement in the moment of practice (Plath 2006).

Rycroft-Malone et al. (2004) describe and distinguish between the two types of knowledge derived from evidence that are equally important to professional practice:

(1) Propositional or codified knowledge - formal, explicit and derived from research utilising particular methodologies and concerned with generalizability.

(2) Non-propositional knowledge which is implicit, informal and derived from an individual's practice experience and may be referred to as practice wisdom, craft or art.

Until recently and in alignment with Cochrane, propositional knowledge appears to have achieved higher status through the evidence-based debate. However, in real-world service delivery, research evidence interacts with clinical experience, contextual and organisational factors, the lived experience of the client and the practitioner/client working relationship. The ways in which these particular elements contribute to outcomes in DFV can be overlooked. With this in mind, Bowen and Zwi (2005) propose 'evidence-informed' or 'evidence-influenced' as terms that more aptly capture a process which is context sensitive and considers the use of all of the best available evidence - including practice wisdom. The use of these terms acknowledges that every situation/context in the social world is in certain respects essentially unique and requires intelligent

assessment to craft a new targeted response to a specified real world problem, with awareness of evidence from other contexts.

Plath has argued (2006) that in the 'evidence-based' approach, research findings are often rigidly translated into practice through mechanistic systems that are unhelpfully generalised across all clients. In this case, flexible and tailored responses become harder to achieve. She attempts to address these concerns by allocating greater agency in the process to the practitioner which accords with an 'evidence-informed', less deterministic approach. Synthesising a range of definitions from the literature she describes evidence-based practice as:

“[T]he conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare or care of individuals, service users, clients and/or carers” (Plath 2006, 58).

Plath's definition recognises 'current best evidence' as an important element within a broader process of deciding what and how to deliver services. In other words the evidence is taken into account as the major (but not only) factor in the translation of knowledge into 'best practice'. This requires practitioners to apply judgement, as they respond to clients within their particular service context. It is within this critical exchange between client and worker that 'what works' is constructed and this consideration extends the concept of evidence, positioning client experience and workers' practice wisdom as important sources of knowledge. Writing about therapeutic interventions, Lerner argues that this change of focus is necessary to move away from what he terms 'evidence-obsessed' to a more scientifically 'open' approach that is appropriate for clinical work (2004, 28).

Broadening the evidence-base to incorporate the importance of the client-worker relationship and to include practice wisdom in this way, requires acknowledgement that evidence is a social as well as scientific process, emerging in complex human interactions that occur through practice. This type of evidence has been referred to in the literature as 'practice-informed evidence' or 'practice-informed research' underscoring a recursive relationship between practice and evidence (for example, 'What is practice-informed research?' <http://promising.futureswithoutviolence.org/advancing-the-field/research-informed-strategies/>; Lueger, 2002; Bowen

and Zwi 2005). These ways of thinking thus challenge the dominant position of quantitative research as the only credible, 'objective' knowledge and allow for evidence to be derived from a variety of sources (Rycroft-Malone et al. 2004).

THE WAYS IN WHICH EVIDENCE MAY BE ACCESSED AND TRANSLATED INTO BEST PRACTICE

Exploring the process through which evidence is translated into practice draws attention to forms of knowledge other than gold standard evidence or findings derived from mainly quantitative inquiries. In this process the many and varied ways in which we come to understand what 'works' in DFV practice emerge more clearly into view. Bowen and Zwi (2005, 0600) propose that conceptualising an 'evidence-informed' (rather than rigidly evidence-based) approach can help researchers, policy makers and presumably practitioners better navigate the use of a broader range of evidence. To achieve this they developed an evidence-informed pathway termed 'framework for action', in which they emphasise practitioner reflection and responsiveness to both policy and practice context as key elements for understanding and deciding how best evidence should be acted upon in each unique circumstance. The authors identify the importance of practitioner decision-making and contextual factors in the evidence-informed pathway by developing a process which has been termed "adopt, adapt, and act" (2005, 0600). Taking this thinking into account it can be assumed that both 'practice-informed evidence' and 'evidence-informed practice' have a part to play in the translation of knowledge, to achieve best practice.

Bowen and Zwi's emphasis on practice reflection resonates with other literature proposing a critical reflexive approach as intrinsic to evidence translation. In this context, reflexivity requires DFV practitioners to continually review the effects of their day to day interventions upon clients and the effective adaptation of these to best meet individual needs (for example, Laing et al 2013). A critical reflexive approach is therefore an ongoing process by which practitioners consider the use of all forms of evidence. This process requires active self-questioning and the review

of current accepted models of intervention in the light of new formal evidence and individual client circumstances. These types of strategies can be enabled through supervision, specialist consultation, peer review and professional development forums, all of which underscore the need for leadership and organisational cultures that promote learning and analysis. DFV workplaces can, and frequently do, support reflexivity and a learning culture by creating a context for service evaluation, promoting an interest in all forms of formal evidence and facilitating the consideration of practice wisdom alongside (but not in the place of) other evidence (Healy and Humphreys 2014). Moreover, there is a demonstrable recognition by DFV workers of the value of external sources of knowledge such as reports, newsletters and other grey literature which can encourage this critical reflexive disposition as indicated by their extensive use of the Australian Domestic and Family Violence Clearinghouse amongst other knowledge hubs.

Humphreys (2002) suggests there is a significant challenge in translating good intentions into 'good' or 'best' practice in DFV. In Australia and internationally, DFV policy and research literature provide a plethora of models, frameworks, principles, standards and guides to instruct and in some cases regulate workers in an attempt to standardise or 'fix' operational definitions and the application of evidence-based best practice.⁸ A key purpose of these tools is to maximise accountability in service provision (Lamont 2000). Here, principles, standards and approaches are introduced as a list of specific, desired responses to victims' needs and used as criteria for judging and enforcing a minimum acceptable response. Perhaps the clearest illustrations of this 'standards' approach are the formal units of competency that constitute part of nationally recognised vocational qualifications,⁹ or minimum standards for men's behaviour change programs, enforced across various states and jurisdictions (for example NSW Government 2012). These standards are sometimes used to direct funding and for the official accreditation of individuals, qualifications or

programs. Thus, they regulate what is funded and what type of practice is permissible within certain occupational and professional roles.

Some researchers suggest that when used well, standards, principles and guidelines may function to help structure interventions and assist workers to consider how and why they might intervene (Breckenridge and Ralfs 2006). Their explicit purpose is to reduce or prevent otherwise harmful interventions and potentially support more thoughtful and transparent collaborations with other service providers in the DFV sector. When used poorly however, they can be implemented in rigid 'utilitarian' manner and applied as a definitive measure of the efficacy and success of workers' professional actions and behaviours (Watters & Ingleby 2003, Hill & Shaw 2011, Jones et al 2008). Laing et al (2013) suggest that over-reliance on strict guidelines can sometimes lead to simplification of the complex and fluid nature of DFV service provision. This perspective is echoed by White et al (2009), Munro (2011) and Jones et al (2008) who suggest that rather than strengthening practice, adherence to overly strict (and possibly simplistic) guidelines can in fact lead to poorer practice, undermining the importance of professional judgement in the provision of support. The suggestion being that total and possibly uncritical adherence may reduce practice to a series of instructions, rather than encourage a critical responsiveness to the evolving needs of clients. When used in this way, these tools have the potential to obscure the importance of the worker/client relationship and ignore the context-specific circumstances within which workers engage with victims of DFV, leading to less than optimal results.

Not all practice is wise

Ignoring or minimising the value of knowledge informed by the experience and wisdom of practitioners and clients is at best a lost opportunity (Glasby & Beresford 2006, Glasby et al 2007). More worryingly, if it means that flexible, responsive practice is forfeited due to the narrow implementation of 'gold standard' evidence, it is possible that significant risks could arise for client wellbeing. With this in mind, a wide range of disciplines and service contexts now accept practice wisdom, craft or art as offering valid and critical contributions to the development of evidence-based practice (Plath 2006). However,

8 See for example Domestic Violence Victoria 2006; Grealy et al 2008; Family Court of Australia 2013; Ganley & Hobart 2010; Healey et al 2013; Humphreys & Stanley 2006; and, Legal Aid 2012.

9 For example CHCDFV816B - 'Safety planning with people who have been subjected to family and domestic violence' or CHCDFV812B - 'Assist user of violence to accept responsibility for their family and domestic violence and abuse', accessed online at <http://training.gov.au> January 31st 2014

advocacy for practitioner-led evidence does not seek to position this as superior knowledge, nor presume an 'either-or' choice between practice-based and research-based evidence. It would be manifestly irresponsible to assume that all practice is by definition 'wise', or necessarily keeps pace with changing lived experience and understandings of human behaviour. Practice should therefore be open to rigorous evaluation of its qualitative effects, outcomes, cost-benefit considerations and capacity to adapt in the face of new findings. The methodological device of 'triangulation' (Denzin 2009, Bryman 2008) is particularly important in research and evaluation, to enhance the trustworthiness of findings, thus supporting the production of robust evidence and strengthening the evidence-base overall.¹⁰ It is therefore the active and intelligent use of evidence, informed by different knowledge bases, derived and validated through different methodologies and then interpreted and applied in the particular moment of intervention, that can produce 'best practice'. This recursive relationship and iterative process are arguably at the heart of finding and successfully implementing what 'works'.

The production of credible evidence, even when it reliably incorporates practice wisdom, still does not guarantee effective translation into best practice. Knowledge transfer can be a challenge occurring only through significant, directed effort within an ongoing process that builds over time, influencing thinking and behaviour in a continuous cycle. This involves active sifting and assessment of current evidence, vigilant implementation and conscious practice reflection. The integration of formal evaluation strategies within program design provides helpful tools for practice reflection, supporting knowledge transfer and the generation of practice-informed evidence. However, a range of issues such as the technical and scientific complexity of much research, seemingly contradictory evidence, feeling unsure of how to assess the validity of knowledge claims and the practical obstacles caused by lack of time and financial resources, can impede or interrupt this process for many practitioners. Consequently, despite the reservations outlined above, research syntheses, grey literature, guides, tools and

10 Simply put, in research (including evaluation) triangulation is where more than one research methodology and/or data source are used, to check 'findings' and create a more complete picture of a particular phenomenon.

frameworks and a host of other dissemination strategies now form a critical interface with 'the evidence' as it is produced.

CONCLUDING THOUGHTS – A CYCLE OF EVIDENCE PRODUCTION AND REFLEXIVE PRACTICE

Domestic and family violence is a complex field with the potential for serious harm or death to occur if risk is overlooked or mismanaged. Best practice policy and service responses based on the best possible evidence are critical to the prevention and minimisation of this harm. While formal evidence is crucial, there has arguably been a bias towards 'gold standard' criteria that dictate what particular kind of evidence is accepted as credible and therefore helpful. In reality, the 'gold standard' does not always fit the DFV practice context and more diverse forms of knowledge are necessary to create robust evidence, capable of underpinning a relevant and flexible response.

The DFV service sector has a strong, demonstrable commitment to practice development, which privileges the lived experience of women and children affected by DFV (Breckenridge 1999; Humphreys and Stanley 2006; Laing et. al 2013). Alongside this advocacy and innovation, a range of structured programs have focussed on translating formal research evidence into best practice tools and guides.¹¹ These best practice tools support an effective response, providing accountability measures that in many cases mitigate poor practice and direct funding.

However, best practice tools and guides do not in and of themselves ensure best practice. A process of knowledge translation and review is necessary to make the evidence 'work'. A continuous recursive cycle of practice-informed evidence leading to evidence-informed practice is therefore vital. Ultimately, a critical reflexive approach that involves the meaningful participation of practitioners in professional development, formal evaluation and research partnerships will ensure

11 These include large scale programs such as the previously mentioned PADV program, the Commonwealth funded DFV and sexual assault clearinghouses and the Family Court 2009 (updated 2013) but also include smaller State-based projects such as NSW Government AGD 2012.

continuing 'evidence-based' innovation in the DFV field.

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