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The Concept of "Best Practice": A brief overview of its meanings, scope, uses, and shortcomings

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"Best practice" has multiple meanings and particular connotations. We examine the origin of the term "best practice" and related terms and concepts and provide some examples of its use in disability fields. We identify some reasons why its use should be more judicious, if not curtailed altogether. We also suggest two complementary options to address our concerns.

Keywords: actualisation; best practice; concepts; definitions; drawbacks; examples; option; usage

Introduction

"Best practice" is a currently very popular term in the English-speaking world, used pervasively in a vast array of disciplines, ranging from humanoid robotics to human services. However, there are many problems with the term "best practice". It has become an elastic catch-phrase that has been overused and misused. This is not to say that what is proclaimed by some people to be a "best practice" may not, in fact, actually merit that designation. However, people tend to use or apply the term in diverse ways. In this article, we argue for a conservative approach to the use of the concept and the discourse about it.

Six Important but Often Conflated Distinctions Regarding "Best Practice"

In looking at both the term and concept of "best practice", we distinguish between six interrelated elements that are often conflated. They are: the abstract concept represented by the term, in this case the idea that there is or should be a best particular way of doing something; the term (i.e., "best practice") as a way of communicating this notion; the definition(s) and description(s) of what the concept and term ("best practice") mean; the term's usage in social discourse (i.e., the way(s) "best practice" is employed in the literature, media, and common parlance); the explication of the concept's action implications (i.e., spelling out the processes necessary to carry out the concept "best practice"); and the actualisation of the concept (i.e., concrete action implementing whatever practice is considered best). When "best practice" discourse is adopted without any clarity provided about these distinctions, then whatever utility the formulation may have is undermined.

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"Best Practice" as Abstract Concept

While human beings for generations have probably held notions about the best way to do whatever needed doing, it was not until the turn of the twentieth century that individuals began to systematically study and enunciate "the best way". In the United States this was done originally by F. W. Taylor, a management consultant who sought the "one best way" of improving efficiency of production in industrial settings (Kanigel, 1997; Taylor, 1911). His efforts led to practical applications of efficiency research, such as time and motion studies, the development of specialised machinery, tools, and other manufacturing equipment, and the establishment of production quotas. Many of these efficiency applications were initially controversial and resisted, but today are "bedrock" management principles of industry.

There is little or no literature on what exactly brought about the adoption and spread of "best practice" in disability and other human service fields. It seems mainly to have crossed-over from the commercial and industrial sectors where the early adoption of the "best practice" approach was motivated by a quest for financial profit. However, that impulse would have been much less prominent in the human service sector in that most such services are structured as public service or "not-for-profit" entities. In reporting on "best practice" in special education, Peters and Heron commented that "historical accounts of best practice usage in the special education literature are not easily traced" (1993, p. 372). Thus, there does not appear to have been a strong conceptualisation of what constituted best practice in this field.

"Best Practice" as a Term

Although industrial and manufacturing interests were systematically applying the concept of a best way to achieve desired results in the early 1900s, the term "best practice" was not coined until much later. The earliest written references to it that the authors could find are from the 1960s in the business and financial management fields (see Campfield, 1960; Smith, 1966), and from the 1970s in manufacturing (see Gregory & James, 1973), although discourse in those fields probably employed the term before it was used in written form. Thus, while industry pioneered the idea of the "one best way", it may or may not have been the first to use the term "best practice". Today it continues to be used in many fields such as accounting, medicine, and transportation.

The term has also taken hold in human service fields such as mental illness, substance abuse, aging, and child welfare. In the field of intellectual disability, its use expanded rapidly during the 1980s, starting most probably in "special education". For example, in the authors' experience at that time, talk about "best practice" became very prominent within TASH (formerly known as "The Association for the Severely Handicapped"). The term "best practice" has appeared often in TASH and other publications associated with intellectual disability over the years (e.g., Horner & Loman, 2008; Meyer, 2003; Peters & Heron, 1993; Snell & Lorhmann, 2007; TASH, 2007; Trader, 2007).

Other terms have also been used to convey the same concept as "best practice". Such variants include "evidence-based practice", "science-based practice", "leading practice", "better practice", and "effective practices". We will comment later on the proliferation of such terms, but for now we note that "best practice" is the general term most often used.

"Best Practice" Definitions and Descriptions

Efforts to delineate and communicate what one means by "best practice" are desirable. However, the authors have documented definitions and descriptions in more than 50 different fields or areas of endeavour. These are highly variable in their comprehensibility and utility. "Best practice" definitions and descriptions can be classified in three ways: broad generic definitions meant to apply expansively across the boundaries of fields, disciplines, and countries; field-specific definitions and descriptions (e.g., in the field of disability, or to specialised aspects of such fields, such as physical or intellectual disability); and technique-specific definitions (i.e., circumscribed specifications of "best practices" in narrow areas of applied practice). Examples in each of these categories that are related to disability are provided below.

Broad Generic Definitions

These are definitions that, because of their broad nature, are relevant, but not exclusive, to disability. For example, the United Nations Educational, Scientific, and Cultural Organization (n.d.) defines best practices as: "successful initiatives ... that impact on improving people's quality of life; are the result of effective partnerships between the public, private and civic sectors of society; and are socially, culturally, economically and environmentally sustainable". This definition is a mix of concerns and outcomes; specifically, it refers to success and effectiveness as concerns and quality of life and sustainability as outcomes.

Field-specific Definitions

Definitions and descriptions of "best practice" in this category range from being stated broadly to relatively narrowly. An example of the former, in the disability field of rehabilitation psychiatry, is from Farkas and Anthony, who note that: "best practices are empirically-based practices that have impacted recovery outcome variables" and "also are value-based practices that have recovery values ... [that] should be able to be described and measured" (2006, p. 87). A much broader field-specific definition comes from the Alberta Association for Supported Employment (n.d., p. 1) which pointed out that many assume "best practices" are "the most ethically sound, progressive and inclusive with regard to employment supports for persons with disabilities". These two definitions are characteristic of other field-specific definitions that place importance on the particular context in which one practice occurs. "... What is a 'best practice' depends on the context ... and could be considered the use of 'good practice' in a specific context" (Commonwealth of Learning, 2004).

Technique-specific Definitions

This category comprises "best practice" specifications in narrow areas that purport to provide detailed instructions or guidance for carrying out a procedure, applying a treatment, conducting an activity, or establishing a desired scenario. For example, there are "best practice kits" such as the Americans with Disabilities Act Best Practices Tool Kit for State and Local Governments (Department of Justice, 2007). We have also located technique-specific "best practices" in many fields, including: adult basic education for people who are blind and illiterate (American Foundation for the Blind, n.d.); determining the social security eligibility of persons with an intellectual disability in the United

States (Reschly, Myers, & Hartel, 2002); educating students with severe impairments (Williams, Fox, Thousand, & Fox, 1990); helping "high-need" schools include children with disabilities (Farrell, 2007); identifying autism (Autism Identification, 2009); promoting self-determination for students with disabilities (Wehmeyer, 2002); supporting employment of persons with disabilities (Stevens & Ibanez, 2002); teaching persons with an intellectual disability to read (Ministry of Education and Training, 1998); treating obsessive-compulsive disorder (DeAngelis, 2008); pet-centred therapy (Fine, 2006); and using restraints in mental health settings (Commonwealth of Pennsylvania, Department of Public Welfare/Office of Mental Health and Substance Abuse Services, 2002).

Often, the "best practices" for doing a certain thing are spelled out in the absence of any claim that the thing itself is a "best practice". Further, technique-specific "best practices" may be identified for certain human service approaches that are themselves questionable, stigmatising, or otherwise undignified. For example, there are (as noted in the above examples) "best practices" for the application of restraints and for pet-centred therapy (e.g., using monkeys, donkeys, fish). One main difficulty with these technique-specific definitions has to do with the power of unconscious learning by association. If "best practices" are promulgated for doing a certain thing, say providing disabled people with chimpanzee companions, then people may form a belief, at least unconsciously, that having a chimpanzee as a companion for a disabled person is the "best practice" for them. Another concern is the implication that it is appropriate to do harm as long as those things are done according to the "best practices" for doing them. For example, in several US states, governors have ordered investigations into "best practices" for administering lethal injections (see Tennessee Department of Corrections, 2007).

"Best Practice" Use and Misuse

Despite elusive origins and meanings, once the "best practice" term was coined, its use quickly became widespread. We believe there are three major factors that influenced the popularity of the term in the human services. First, and probably foremost, "best practice" is an elegantly simple and appealing phrase. In addition, it appears to have applicability to many human service endeavours. A second and somewhat related factor is that a claim to be doing "best practice" is nearly irresistible to many individual and organisational human service providers motivated to present themselves in the best possible light. A third factor is that coming to consensus on a "best practice" might satisfy people's avidity for wanting nothing short of that. Thus, having a certain practice identified as best out of many alternatives would have a strong appeal.

In addition, referring to something as a "best practice" can be factually incorrect. Simply saying that something is "best practice" does not mean that it is, in reality, the best practice, or even a good one. Further, labelling something a "best practice" can be conceptually misleading. Perhaps worse is that the circumstance where the "best practice" label presents a "stamp of approval" that has the effect of preventing the analysis of the pros and cons of a practice. We argue that neither the validity, nor effectiveness, nor the "best-ness" of an action or idea or policy is assured simply because it is purported to be a "best practice". Similarly, the potential excellence of an idea or action is not nullified because it has not been endowed with the "best practice" soubriquet—although lacking the designation may very well cause it to be rendered suspect, accorded lesser status, or go unnoticed or unused by some.

Initially, "best practice" use in the human services was tied to the notion of evidence that supported the claims made. That is, something would only be considered

and accepted as a "best practice" if a solid body of evidence (not just a single study, or experiment, or experience) demonstrated that the practice ranked at, or near, the top of effective measures. Although this notion of "best practice" still exists, it is no longer the only or even prevalent one. For example, the appellation of "best practice" is ascribed to some approaches that have nothing to do with "evidence" of their worth. In fact, the "best practice" may be contrary to evidence. A "best practice" assertion may also be made based on a certain ideology. For instance, within the special education and self-advocacy ideologies, the promotion of self-determination is hailed as a "best practice" (Wehmeyer, 2002). Within the facilitated communication ideology (Biklen & Duchan, 1994), the touch of a person's hand or arm while the person sat before a communications device or keyboard became a "best practice". Evidence was not considered relevant.

Another usage pattern is a retroactive or "grandfathering" attribution whereby whatever people are doing is declared to be a "best practice". For instance, at a conference, there might be a symposium entitled "best practices" that cover topics that might have been covered under any number of other headings in other conferences. In the authors' view this is the case for the Young Adult Institute symposium on healthcare entitled "Best Practices Autism Spectrum Disorders" (see YAI/National Institute for People with Disabilities Network, 2008). The titles of the four contributions were not distinguishable from the titles of presentations about practices presented in comparable conferences. There was no indication why the contents of the listed contributions were considered to be "best practices". We would argue that this criticism can also be applied to other publications that provide lists of "best practices" (e.g., Robinson, Patton, Followay, & Sargeant, 1989).

"Best Practice" Action Implications

The actions that a "best practice" calls for should always be made clear and explicit to those interested in knowing about or becoming involved in carrying out the practice. If this is not done people will be left to make their own judgments about how the best practice is enacted. Individuals, even within a specific field, may evoke multiple applications of "best practice". This happened on occasion, when the ideas of "normalisation" were enacted in the human services field of (what was then called) mental retardation. Specifically, in the case of normalisation some people assumed that it meant "making people normal", or "what I do is normal, so I must be doing normalisation" (Lemay, 1995; Wolfensberger, 1980, 1999).

"Best Practice" Actualisation

Actualising a "best practice" means to carry it out or perform it. Assessing the actualisation of a "best practice" can only be done in regard to the specific "best practice". We make four major points in regard to evaluating the implementation of a specific "best practice".

First, the application of a "best practice" strongly implies concerns about, and safeguards to, its actualisers' proficiency, quality of implementation, effectiveness, and outcomes. A "best practice", even one that is valid, well-conceptualised, properly used, and fully explicated, may do no true good—and perhaps much harm—if these concerns and safeguards are lacking in its actualisation. For example, in the field of intellectual disability, "inclusion" has been called "best practice" (Alvarez, 2008; Farrell, 2007;

Nolan, 2005), but the actuality of many inclusion implementations is the unwanted presence and social isolation of the "included" individual. Or, similarly, the "best practice" of "independent living" leaves many individuals to lead very lonely lives, a situation that is substantively the same now as it was 30 years ago (Amado, 1993; Chadsey-Rusch, DeStefano, O'Reilly, Gonzales, & Collet-Klingenberg, 1992; Specht & Nagy, 1986; Stancliffe et al., 2007).

Second, there are high-level principles and strategies that apply to virtually all types of human services, including those in the disability fields as well as in aging, education, rehabilitation, recreation, and corrections. There is a danger in particularising as this obscures high-order principles such as a positive relationship of the server to the served, holding and conveying positive high expectations of the party served, and countering negative stereotypes to which the party may be vulnerable. These desiderata are embedded in Program Analysis of Service Systems' Implementation of Normal Goals (PASSING) (Wolfensberger & Thomas, 1983, 2007), the Social Role Valorization (SRV)-based service assessment tool that has been applied to services in all of the above-mentioned fields.

Third, in many fields that claim a set of "best practices", there is no clear performance test that has to be passed in order to verify the claim. In contrast, in other fields of human endeavour, the claim that something is the best is demonstrated via performance. The field of athletics is an example. Only teams or individuals that prove they are the best (e.g., by establishing a new record of performance) can claim to be the best. The "best practice" claim in human services is often untested as there is an absence of genuine assessment of the quality of service design or performance, based on objective criteria, applied by unbiased evaluators, and tested by proven empirical methods. Indeed, a number of organisations that serve people with cognitive and physical impairments profess adherence to SRV, yet few of these submit themselves to rigorous external evaluation by means of a recognised SRV-based service evaluation tool, such as PASSING (Wolfensberger & Thomas, 1983, 2007). We argue that scepticism is the only appropriate stance in regard to rhetoric about "best practices" from individuals and services that do not submit themselves to scrutiny.

Fourth, and most important, actualisation of a "best practice" involves three "parties": the practiced-upon, the practitioner, and the practice. However, assessment of the actualisation of "best practices" (if any occurs) seldom focuses on the first party. In human services, the focus of both the actualisation and the assessment of a "best practice" should be on the purported recipient. Confirmation of "best-ness" is not found in the practice nor in the practitioners. Fidelity to an approach and proficiency in the practice are important considerations, but the best "proof" is the outcome for the first party. Ironically, it is the first party who is often overlooked.

In reality, most effort with respect to best practice refers to the third party. The disability field (and human services systems in general) seem especially prone to standardising, codifying, and mandating "best practices". In the United States and Canada, this has happened with such "best practices" as "people-first language", "self-advocacy", "person-centred planning", and the right of self-determination or "choice" (Caruso & Osburn, in press; Lemay, 2011; O'Brien & O'Brien, 2002). We raise concerns about this for three reasons: the process may result in bureaucratisation, objectification, depersonalisation, and entropy of the codified practice; it delimits both science and clinical practice; and codified practice is often resistant to change (Lemay, 2011).

Practices that are "evidence-based" are also not exempt from this problem. For example, in the area of psychological disabilities, Barlow (2010) argued that even the

best "evidenced" evidence-based practices do not help everybody and in some cases may do more harm than good. He calls for a "single case experimental design for studying behavior change" (Barlow, 2010, p. 15) based on the notion that a practice needs to be "proved" every time it is actualised. We remind the reader that such "proof" cannot be established in the absence of clear evidence of benefit to the recipient.

Some Suggestions for Moving Forward

Others, too, have recognised at least some of the above problems related to the use of the term "best practice" and become engaged with the need for applied strategies or practices to have an empirical basis. This has meant that many writers are using such terms as "evidence-based practice" and "science-based practice" (Bond et al., 2001; Horner et al., 2005). We argue this change may be a correction to the many shortcomings of the use of the term "best practice". However, while other terms and concepts may seem to improve upon "best practice" by having more apparent precision and support, they still do not escape the shortcomings that inhere in the "best practice" terminology.

What options are available to address our concerns? One option is to do away with the "best practice" concept. This would mean that the self-correcting nature of science will "sort out" what to do about whatever it is we do and how we talk about it. This would mean the use of practices that are supported by respectable research or other empirical bases, such as cross-validation and replicability, and are associated with highly desired outcomes.

Another approach that deserves consideration is to adopt an "if this ... then that" approach (Wolfensberger, 1995). This approach is particularly relevant to human services, including the field of disability. It can be stated in this way: "If we want X to occur, then we must do Y, or we must avoid Z; or, if we do not want X, then we must not do Y, and/or we must avoid Z". The X that we want could be any desired outcome (e.g., symptom reduction, valued societal participation). The unwanted X could be any negative outcome (e.g., worsening symptoms, being segregated or excluded from valued society).

The "if this ... then that" formulation is based on the premise that one can reasonably ascertain "wanted outcomes" and how they are most likely to be attained. We posit that such outcomes are knowable. In fact, these outcomes are identified in the SRV literature. One could say that SRV identifies a set of positive, near-ideal "thises" and provides a framework for actualising the "thats" that lead to them (Wolfensberger, 1998; Wolfensberger & Thomas, 2007). Ascertaining the achievement of the "this" confirms the validity of the "that". The goal of SRV is to increase the likelihood that disabled people and others who are devalued by society will experience "the good things in life" (Wolfensberger, Thomas, & Caruso, 1996). Indeed, the desired outcomes may have little meaning unless they lead to valued participation in community life and enjoyment in the benefits of such participation.

Conclusion

In our view, claims of "best practice" should be discontinued. We have suggested two ways to address our concerns. The first focuses on using empirical evidence, possibly from a broad range of sources to guide practice. The second is to use the "if this ... than that" formulation with its strong focus on outcomes.

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The authors have elected to use the term "disabled people" (Editor).

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