Volume
3

COMPREHENSIVE HANDBOOK OF SOCIAL WORK AND SOCIAL WELFARE

SOCIAL WORK PRACTICE

Volume Editors
William Rowe **Lisa A. Rapp-Paglicci**

Editors-in-Chief
Karen M. Sowers **Catherine N. Dulmus**

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Our lives are rich tapestries woven with relationships and experiences. The thread begins with our parents—relationships that color the work of art that we become. For this reason, and many more, I would like to dedicate this volume to my mother, Charlotte (Kitty) Rowe (1924–2007).

William Rowe

There are people who touch our lives, help to shape and inspire us and then there are others who make a profound impact on us. There are those, whose spirits are so potent that their imprint remains with us even when they are no longer here. I would like to dedicate this volume to my husband, one of those intense spirits whose impact cannot be measured nor forgotten, David Paglicci (1963–2006).

Lisa A. Rapp-Paglicci

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Handbook Preface

The profession of social work spans more than 100 years. Over this period, the profession has changed in scope and depth. Despite the varied functions and methods of our profession, it has always been committed to social justice and the promotion of well-being for all. The profession has made great strides and is experiencing a resurgence of energy, commitment, and advancement as we face new global realities and challenges and embrace new and innovative technologies.

In considering how the field of social work has evolved over the past century with the resulting explosion of new knowledge and technologies, it seemed imperative to create a resource (*Comprehensive Handbook of Social Work and Social Welfare*) that provides a manageable format of information for researchers, clinicians, educators, and students. Our editors at John Wiley & Sons, the volume editors (Ira Colby, William Rowe, Lisa Rapp-Paglicci, Bruce Thyer, and Barbara W. White) and we as editors-in-chief, developed this four-volume handbook to serve as a resource to the profession.

The *Comprehensive Handbook of Social Work and Social Welfare* includes four volumes (*The Profession of Social Work, Human Behavior in the Social Environment, Social Work Practice,* and *Social Policy and Policy Practice*). Each volume editor did an outstanding job of assembling the top social work scholars from around the globe to contribute chapters in their respective areas of expertise. We are enormously grateful to the chapter authors who have contributed their expert knowledge to this work. Each volume includes a Preface written by the respective volume editor(s) that provides a general overview to the volume. In developing the *Comprehensive Handbook,* we attempted to focus on evidence supporting our theoretical underpinnings and our practice interventions across multiple systems. Content was designed to explore areas critically and to present the best available knowledge impacting the well-being of social systems, organizations, individuals, families, groups, and communities. The content is contemporaneous and is reflective of demographic, social, political, and economic current and emerging trends. Authors have paid close attention to contextual factors that shape the profession and will have a future impact on practice. Our profession strives to understand the dimensions of human difference that we value and engage to ensure excellence in practice. These dimensions of diversity are multiple and include factors such as disability, religion, race, culture, sexual orientation, social class, and gender. Each of the volumes addresses how difference characterizes and shapes our profession and our daily practice. New knowledge, technology, and ideas that may have a bearing on contemporary and future social work practice are infused throughout each of the volumes.

We challenged the chapter authors to not only provide an overview of specific content, but to feel free to raise controversial issues and debates within the profession. In the interest of intellectual freedom, many of our chapter authors have done just that in ways that are intriguing and thought provoking. It was our objective to be comprehensive but not encyclopedic. Readers wishing to obtain even greater specificity are encouraged to access works listed in the references for each chapter.

The *Handbook*'s focus on evidence should assist the reader with identifying opportunities to strengthen their own understanding of the amount of science that does or does not support our social work theory and practice. Social work researchers must expand the scientific evidence that supports social work theory and practice as well as informing policy, and enhance their functional scope to overcome the more than 10-year lag between research and practice. We are rightfully proud of our social work history, and its future will be driven by our success in demonstrating that as a profession we can achieve credible and verifiable outcomes across the spectrum of services that utilize our skills. As a profession, we must assure we value science so that even the most vulnerable populations receive the best available services.

We hope that you find this *Handbook* useful. We have endeavored to provide you, the reader and user, with a comprehensive work that will serve as a guide for your own work in this wonderful profession. We welcome your comments and suggestions.

Karen M. Sowers
Catherine N. Dulmus

Acknowledgments

An endeavor of this magnitude required the efforts of many people, and we are indebted to their unique and valuable contributions. First, we would like to thank Tracey Belmont, our initial editor at John Wiley & Sons, for recognizing the importance of this project to the profession of social work and for her commitment to making it a reality. It was Tracey's vision that allowed this project to get off the ground, and we are grateful to her. A special thanks to Lisa Gebo, our current editor at John Wiley & Sons, who provided us with expert guidance and technical support to see this project to fruition. Others to thank at John Wiley & Sons include Isabel Pratt and Sweta Gupta who assisted us with all aspects of the contractual and prepublication processes. They were invaluable in assisting with a project of this size, and we are grateful to them.

Most important, we would like to thank the volume editors and contributors who made this *Handbook* a reality. The volume editors did an excellent job of developing their respective volumes. We particularly thank them for their thoughtful selection and recruitment of chapter contributors. The contributor lists for each volume read like a "Who's Who" of social work scholars. We are pleased that each contributor recognized the importance of a seminal piece such as this *Handbook* for the profession of social work and willingly contributed their time and knowledge. We extend a special debt of gratitude to these eminent contributors from around the globe who so graciously and willingly shared their expertise with us. It is the work of these scholars that continues to move our profession forward.

K. M. S.
C. N. D.

Preface

The field of social work has made dramatic changes since its inception. Trends and fads in practice have come in and out of vogue, some lasting a decade or so and others only a blink of an eye. These movements did not persist long in the field because they were not based in solid theory, did not have empirical verification and were not bound to a core ethical standard of the field. Evidence-based practice however is different. It is not simply a practice technique, rather it is a philosophical, theoretical, ethical, and practice approach, and its inception has changed the field of social work in a profound manner.

Evidence-based practice (EBP) has affected social workers from caseworkers to clinicians, modifying their practice skills and more importantly transforming their thinking about problems, planning, and intervention. EBP has also clarified the ethical principle requiring social workers to practice using effective interventions. These are the qualities of a movement that inform us that evidence-based practice is no whim.

Evidence-based practice was not openly welcomed at first in the field. However, over time it has become well understood and acknowledged and is revolutionary to the field. But the increased speed by which clinicians are bombarded with information and the sheer volume of information can make practitioners' tasks of rapidly identifying high-quality studies seem overwhelming. Ironically, clinicians previously had little or no evidence-based guidelines to work from, now the formidable number of studies and information often leads to the same result: A continued difficulty in application of evidence-based practice.

This volume addresses this concern by compiling an enormous amount of state-of-the-art information on EBP utilizing renowned international experts throughout the world. Its use for practitioners, researchers, educators, and students is incalculable, yet it is practically written for manageable access. It includes two sections: the first comprising information about basic social work skills such as interviewing, planning, advocacy, and termination and the second encompassing assessment and intervention for various populations like children, adolescents, elderly, families, groups, and communities. The chapters summarize EBP in a large variety of domains and populations and are extremely efficient to use. This volume is also a frontrunner in providing information about EBP in assessment and in providing outstanding chapters from social work authorities around the world.

Evidence-based practice has been accepted by a vast number of social workers and will continue to transform the field of social work if sustained. In this time of rapid information and technological change, this volume is immediately invaluable by its comprehensiveness, ease of use, and distinctiveness in the field of social work.

William Rowe
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Section I

ASSESSMENT AND INTERVENTION OVERVIEW

Chapter 1

EVIDENCE-INFORMED PRACTICE

Eileen Gambrill

Evidence-based practice (EBP) describes a philosophy and process designed to forward effective use of professional judgment in integrating information regarding each client's unique circumstances and characteristics, including their preferences and actions, and external research findings. It involves the "integration of best research evidence with clinical expertise and [client] values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 1):

> Without clinical expertise, practice risks becoming tyrannized by external evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best external evidence, practice risks becoming rapidly out of date, to the detriment of patients. (Sackett, Richardson, Rosenberg, & Haynes, 1997, p. 2)

Evidence-informed practice is a guide for thinking about how decisions should be made (Haynes, Devereaux, & Guyatt, 2002). It requires the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual [clients]" (Sackett et al., 1997, p. 2). It is a process for handling the uncertainty surrounding decisions that must be made in real life, in real time. Sources of uncertainty include limitations in current knowledge, lack of familiarity with what knowledge is available, and difficulties in distinguishing between personal ignorance and lack of competence and actual limitations of knowledge (Fox & Swazy, 1974). Uncertainties may be related to lack of information about problem-related causes, clients' ambivalence about pursuit of certain goals, and whether resources are available to help clients. A willingness to acknowledge that "I don't know," combined with taking steps to see if needed information is available, increases the likelihood that important uncertainties can be decreased or identified (Chalmers, 2004). This helps us to honor ethical obligations to involve clients as informed participants.

Evidence-informed practice involves a shift in paradigms. Intuition and unsystematic clinical expertise are considered insufficient grounds on which to make decisions. On the other hand, the "value-laden nature of clinical decisions" (Guyatt & Rennie, 2002, p. 4) implies that we cannot rely on evidence alone:

> Thus, knowing the tools of evidence-based practice is necessary but not sufficient for delivering the highest quality of [client] care. In addition to clinical expertise, the clinician requires compassion, sensitive listening skills, and broad perspectives from the humanities and social sciences. These attributes allow understanding of [clients' concerns] in the context of their experience, personalities, and cultures. (p. 9)

> . . . any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the [client's] clinical state, predicament, and preferences and thus whether it should be applied. (Sackett et al., 1997, p. 2)

The philosophy of evidence-based practice encourages practitioners to be effective advocates for their clients: "physicians concerned about the health of their patients as a group, or about the health of the community, should consider how they might contribute to reducing poverty" (Guyatt & Rennie, 2002, p. 9). The National Association of Social Workers (NASW) encourages social workers to "Stand up for others" (*NASW News*, 2006, p. 11). Service is the first value described in NASW's Code of Ethics (1999). A key characteristic of EBP is breaking down the division between research and practice, for example, highlighting the importance of clinicians critically appraising research reviews and developing a technology to help them do so: "the leading figures in EBM . . . emphasized that clinicians had to use their scientific training and their judgment to interpret [guidelines] and individualize care accordingly" (Gray, 2001b, p. 26).

Although its philosophical roots are old, the blooming of EBP as a process attending to evidentiary, ethical, and application issues in all professional venues (education, practice/policy, and research), is fairly recent, facilitated by the Internet revolution. Critical thinking is integral to this process. In both critical thinking as well as EBP, attention is given to ethical issues. If we examine the intellectual traits inherent in critical thinking suggested by Paul (1993) such as courage, integrity, and perseverance, we see that they reflect the philosophies of EBP described by the originators of EBP. Honesty and transparency (clear description of what is done to what effect) are emphasized in both. This applies to all venues of interest in the helping professions: professional education, practice and policy (what is done to what effect), and related research (its design, conduct, and reporting).

Evidence-based practice and health care arose because of troubling gaps between available knowledge and what is used by professionals. It suggests and explores ways to decrease gaps both at the level of clinical practice and decision making about groups or populations, for example, purchasing services (Gray, 2001a, 2001b). It is as much about the ethics of educators and researchers as it is about the ethics of practitioners and agency administrators. Gray (2001a) suggests that, at present, the helping process has the following characteristics:

1. Overenthusiastic adoption of interventions of unproven efficacy or even proven ineffectiveness;
2. Failure to adopt interventions that do more good than harm at a reasonable cost;
3. Continuing to offer interventions services demonstrated to be ineffective;
4. Adoption of interventions without adequate preparation such that the benefits demonstrated in a research setting cannot be reproduced in the ordinary service setting;
5. Wide variation in the rates at which interventions are adopted or discarded. (p. 366)

Descriptions of EBP differ in their breadth and attention to ethical issues ranging from the broad, systemic philosophy and related evolving technology envisioned by its originators (e.g., Gray, 1997; Sackett et al., 1997) to narrow views (use of practice guidelines) and total distortions (Gambrill, 2003). For example, many descriptions of evidence-based

decision making ignore hallmarks of this process such as involving clients as informed participants. Given these many different views, it is important to review the vision of EBP and health care as described by its creators. Otherwise, potential benefits to clients and professionals may be lost. Recently, more attention has been given to client preferences and actions because what clients do (e.g., carry out agreed-on tasks or not) often differs from their stated preferences and estimates of preferences are often wrong (Haynes et al., 2002).

EBP describes a process for and a new professional educational format (problem-based learning) designed to help practitioners to link evidentiary, ethical, and application issues. It is assumed that professionals often need information to make decisions, for example, concerning risk assessment or what services are most likely to help clients attain outcomes they value. Sackett et al. (1997) estimated that about two questions arise for every three patients physicians see and that 30% of all questions remain unanswered (p. 8). We do not know how many questions arise in the course of other professionals' work or how many of these remain unanswered. As Gray (2001a, p. 354) suggests, when evidence is not used, important failures in decision making occur:

- Ineffective interventions are introduced;
- Interventions that do more harm than good are introduced;
- Interventions that do more good than harm are not introduced;
- Interventions that are ineffective or do more harm than good are not discontinued.

Clinical expertise includes use of effective relationship skills and the experience of individual helpers to rapidly identify each client's unique circumstances, characteristics, and "their individual risks and benefits of potential interventions and their personal values and expectations" (Sackett et al., 2000, p. 1). Using clinical expertise, practitioners integrate information about a client's characteristics and circumstances with external research findings, client expectations and values, and their preferences and actions (Haynes et al., 2002; Sackett et al., 1997). Sackett and his colleagues (1997) suggest that: "Increased expertise is reflected in many ways, but especially in more effective and efficient [assessment] and in the more thoughtful identification and compassionate use of individual [clients'] predicaments, rights and preferences in making clinical decisions about their care" (p. 2). Client values refer to "the unique preferences, concerns and expectations each [client] brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the [client]" (Sackett et al., 2000, p. 1). Evidence-based health care refers to use of best current knowledge as evidence in decision making about groups and populations (see Gray, 2001a). Professional codes of ethics call for key characteristics of EBP such as drawing on practice- and policy-related research and involving clients as informed participants.

AN ALTERNATIVE TO AUTHORITY-BASED PRACTICE

Evidence-based decision making arose as an alternative to authority-based decision making in which consensus, anecdotal experience, or tradition are relied on to make decisions (see Table 1.1).

Table 1.1 Differences between Authority-Based and Evidence-Based Practitioners

Authority-Based Decision Making	Evidence-Based Decision Making
Clients are not informed or are misinformed.	Clients are involved as informed participants.
Ignores client preferences (e.g., "We know best.").	Seeks and considers client values and preferences.
Does not pose specific questions about important decisions that must be made and does not search for and critically appraise what is found and share results with clients.	Poses clear questions related to information needs, seeks related research findings, critically appraises them, and shares what is found with clients and others.
Motivated to appear well informed, to preserve status and reputation.	Motivated to help clients and be an honest and competent broker of knowledge and ignorance.
Ignores errors and mistakes.	Seeks out errors and mistakes; values criticism as vital for learning.
Accepts practice- and policy-related claims based on misleading criteria such as tradition and expert consensus.	Relies on rigorous criteria to appraise practice claims and select practices and policies (e.g., those that control for biases).
Relies solely on self-report of clients or anecdotal observations to evaluate progress.	Uses objective as well as subjective measures to evaluate progress with a focus on outcomes of concern to clients.

Although misleading in the incorrect assumption that EBP means only that decisions made are based on evidence of their effectiveness, use of the term does call attention to the fact that available evidence may not be used or the current state of ignorance shared with clients. It is hoped that professionals who consider related research findings regarding decisions and inform clients about them will provide more effective and ethical care than those relying on criteria such as anecdotal experience, available resources, or popularity. The following examples illustrate reliance on authority-based criteria for selection of service methods:

> Ms. Riverton has just been to a workshop on eye movement desensitization therapy. The workshop leader told the participants that this method "works and can be used for a broad range of problems." Ms. Riverton suggests to her supervisor at the mental health clinic where she works that agency staff should use this method. When asked why, she said because the workshop leader is a respected authority in the field.

> Mr. Davis read an editorial that describes the DARE programs as very effective in decreasing drug use. No related empirical literature was referred to. He suggests to his agency that they use this method.

In the first example, the authority of a workshop leader is appealed to. In the second, the authority of an author of an editorial is appealed to. Evidence-based decision making involves use of quite different criteria. A key one is information about the accuracy of practice and policy-related claims. EBP draws on the results of systematic, rigorous, critical appraisals of research related to different kinds of questions such as "Is eye movement desensitization effective for certain kinds of problems? Are DARE programs effective?" For example, review groups in the Cochrane and Campbell Collaborations prepare comprehensive, rigorous reviews of all research related to a question (see later descriptions).

THREE PHILOSOPHIES OF EVIDENCE-BASED PRACTICE

Evidence-based practice and social care involve a philosophy of ethics of professional practice and related enterprises such as research and scholarly writing, a philosophy of science (epistemology—views about what knowledge is and how it can be gained), and a philosophy of technology. Ethics involves decisions regarding how and when to act; it involves standards of conduct. Epistemology involves views about knowledge and how to get it or if we can. The philosophy of technology involves questions such as: Should we develop technology? What values should we draw on to decide what to develop? Should we examine the consequences of a given technology? Evidence-informed practice encourages the integration of research and practice, for example, by highlighting the importance of clinicians critically appraising research reviews and developing a technology to help them to do so; "the leading figures in EBM . . . emphasized that clinicians had to use their scientific training and their judgment to interpret [guidelines] and individualize care accordingly" (Gray, 2001b, p. 26). It encourages clinicians to think for themselves—to develop critical appraisal skills. It offers practitioners and administrators a philosophy that is compatible with obligations described in professional codes of ethics as well as an evolving technology for integrating evidentiary, ethical, and practical issues. The uncertainty associated with decisions is acknowledged, not hidden.

EBP requires considering research findings related to important practice/policy decisions and sharing what is found (including nothing) with clients. Transparency and honesty regarding the evidentiary status of services is a hallmark of this philosophy. For example, on the back cover of the seventh edition of *Clinical Evidence* (2002), the continually updated book distributed to physicians, it states that "it provides a concise account of the current state of knowledge, ignorance, and uncertainty about the prevention and treatment of a wide range of clinical conditions." In what books describing practices in psychology, psychiatry, or social work do we find such a statement? To the contrary, we find books titled *What Works in Child Welfare* (Kluger, Alexander, & Curtis, 2002) and *A Guide to Treatments That Work* (Nathan & Gorman, 2002).

Steps in Evidence-Based Practice

Steps in EBP include the following:

1. Convert information needs related to practice decisions into answerable questions.
2. Track down, with maximum efficiency, the best evidence with which to answer them.
3. Critically appraise that evidence for its validity, impact (size of effect), and applicability (usefulness in practice).
4. Integrating the critical appraisal with our clinical expertise and with our client's unique characteristics and circumstances, including their preferences and values. This involves deciding whether evidence found (if any) applies to the decision at hand (e.g., is a client similar to those studied, is there access to services described) and considering client values and preferences in making decisions as well as other applicability.
5. Evaluate our effectiveness and efficiency in carrying out steps 1 to 4 and seek ways to improve them in the future (Straus, Richardson, Glasziou, & Haynes, 2005, pp. 3–4).

Questions that arise in the fourth step include: Do research findings apply to my client? That is, is a client similar to clients included in related research findings? Can I use this practice method in my setting (e.g., Are needed resources available?)? If not, is there some other access to programs found to be most effective in seeking hoped-for outcomes? What alternatives are available? Will the benefits of service outweigh harms of service for this client? What does my client think about this method? Is it acceptable to clients? What if I don't find anything (Glasziou, Del Mar, & Salisbury, 2003)? What is the number needed to treat, that is, how many people must receive a service for one person to be helped? (See Sinclair, Cook, Guyatt, Pauker, & Cook, 2001.) What is the number needed to harm? Evidence-informed practitioners take advantage of efficient technology for conducting electronic searches to locate the current best evidence regarding a specific question; information literacy and retrivability are emphasized (Gray, 2001a, 2001b).

DIFFERENT KINDS OF QUESTIONS

Different questions require different kinds of research methods to critically appraise proposed assumptions (e.g., Greenhalgh, 2006; Guyatt & Rennie, 2002; Straus et al., 2005). These differences are reflected in the use of different "quality filters" to search for research findings that reflect the particular terms associated with research likely to offer critical tests of questions. Kinds of questions include the following:

- *Effectiveness:* Do job training programs help clients get and maintain jobs?
- *Prevention:* Do Head Start programs prevent school drop out?
- *Screening (risk/prognosis):* Does this measure accurately predict suicide attempts?
- *Description/assessment:* Do self-report data provide accurate descriptions of parenting practices?
- *Harm:* Does (or will) this intervention harm clients?
- *Cost:* How much does this program cost compared to others?
- *Practice guidelines:* Are these practice guidelines valid and are they applicable to my client/agency/community?
- *Self-development:* Am I keeping up-to-date? How can I keep up-to-date?

Sackett et al. (1997, 2000) suggest posing four-part questions that describe the population of clients, the intervention you are interested in, what it may be compared to (including doing nothing), and hoped-for outcomes (PICO questions). Gibbs (2003) refers to these as COPES questions. They are **C**lient **O**riented. They are questions clinicians pose in their daily practice that affect clients' welfare. Second, they have **P**ractical importance. They concern problems that arise frequently in everyday practice and that are of concern to an agency. For example, child protective service workers must assess risk. Asking the question about what types of clients present the greatest immediate risk for child abuse is a critical one. Third, COPES (PICO) questions guide an **E**lectronic search for related research findings. The process of forming a specific question often begins with a vague general question and then proceeds to a well-built question. Fourth, hoped-for outcomes are identified. **S**ynonyms can be used to facilitate a search (e.g., see Gibbs, 2003; Glasziou

et al., 2003). For example, if abused children are of concern, other terms for this may be "maltreated children," "neglected children," "mistreated children." Sackett et al. (1997) suggest that a well-formed question should meet the following criteria:

- It concerns a problem of concern to clients.
- It affects a large number of clients.
- It is probably answerable by searching for related research findings.

A careful search requires actively seeking information that challenges or disconfirms our assumptions as well as for information that supports them. In addition to the development of the systematic review, the availability of the Internet has revolutionized the search for information making it more speedy and more effective. The Cochrane Collaboration prepares, maintains, and disseminates high-quality reviews of research related to a particular practice question. The Cochrane Library is an electronic publication designed to supply high-quality evidence to those providing and receiving care and those responsible for research, teaching, funding, and administration at all levels. The Cochrane database includes thousands of systematic reviews. It is distributed on a subscription basis. Abstracts of reviews are available without charge and can be searched. Both published and unpublished content (the gray literature) is sought in all languages, and journals are hand-searched. Reviews are prepared by people who are also responsible for identifying and incorporating new evidence as it becomes available. Entries include completed reviews, available in full text, as well as protocols that are expressions of intent and include a brief outline of the topic and a submission deadline. Reviews are prepared and maintained, based on standards in *The Reviewers' Handbook*, which describes the process of creating Cochrane systematic reviews (Higgins & Green, 2005). It is revised often to ensure that it remains up to date. The Cochrane Collaboration focuses on health concerns, however, many reviews are relevant to a wide variety of professionals. Examples are "Psychoeducation for Schizophrenia" (Pekkala & Merinder, 2004) and "Psychological Debriefing for Preventing Posttraumatic Stress Disorder" (Rose, Bisson, Churchill, & Wessely, 2000). The Cochrane Library also includes a Controlled Trials Register and the Cochrane Review Methodology Database that is a bibliography of articles concerning research synthesis and practical aspects of preparing systematic reviews.

The Campbell Collaboration, patterned after the Cochrane Collaboration, prepares reviews related to education, social intervention, and criminal justice. Coordinating groups include communication and dissemination, crime and justice, education, social welfare, and a methods group. Like the Cochrane Collaboration, detailed instructions are followed for preparing high-quality reviews, and reviews are routinely updated. They, like the Cochrane Collaboration, have an annual conference and both are attended by methodologists as well as those interested in particular problem areas (www.campbellpenn.com).

DIFFERENT STYLES OF EVIDENCE-BASED PRACTICE

Sackett and his colleagues (2000) distinguish among three different styles of EBP, all of which require integrating evidence with a client's unique personal and environmental circumstances. All require step 4 (see prior list of steps in EBP) but they vary in how other