Edward J Mullen

EVIDENCE-BASED PRACTICE IN A SOCIAL WORK CONTEXT - THE UNITED STATES CASE

Abstract

Edward J Mullen: *Evidence-Based Practice in a Social Work Context - the United States Case* (Näyttöön perustuva sosiaalityö Yhdysvalloissa). National Research and Development Centre for Welfare and Health (STAKES), FinSoc Working Papers 2/2004. ISBN 951-33-1577-0. ISSN 1455-9064.

This working paper consists of five papers by Professor Edward J Mullen, Willma & Albert Musher Chair Professor, Columbia University School of Social Work. Evidence-based knowledge and policy are phrases that require explanation. The reader may wonder how the two terms evidence-based and knowledge differ and what new meaning emerges when they are joined. The reader may also wonder how the phrase of evidence-based knowledge differs from the more common evidence-based practice term. Edward Mullen begins by explaining and defining these terms. He also provides an historical context for this recent emphasis on evidence-based policy and practice.

It is hoped that by strengthening its evidentiary base, social work will increase its capability to achieve outcomes that are valued by citizens and society at large. In the third paper the framework for outcomes measurement that is designed for social work policy and services is described. Social work requires a framework for conceptualizing outcomes measurement so that the profession can focus clearly on the work to be done in outcomes measurement. This framework should distinguish among the various ways that outcome measurement can be used to advance policy, programs and practice. In this paper two applications of outcomes measurement, namely for improving policies and programs, and, second, for conducting outcomes research are discussed. Other dimensions that could be included in an outcome measurement framework for social work are also identified. The author makes a strong case for the role that outcomes measurement can play in both the improvement of social work policies and programs through performance measurement, as well as in advancing the knowledge base throughout.

Ultimately, social welfare policies and services depend on frontline practitioners for their implementation so the last two papers examine issues pertaining to how evidence is used and implemented. Issues such as how social work practitioners might react to and use evidence-based statements about effective treatment are addressed. The papers explore the technologies needed to assist practitioners in identification and use of evidence-based treatments and address the challenge of applying these to individual case situations. Questions regarding quality control are identified and discussed. In addition, the last paper summarizes results from a survey of practitioners about awareness of and attitudes about standards of care, including preference for use of intervention knowledge statements developed through expert consensus and through empirical research findings.

Social work's knowledge base has grown considerably during the last decade. Its foundation in scientific research seems to have solidified. However, evidence-based practice is not yet a reality. The author argues that the future of evidence-based practice in social work rests on the profession's capacity and willingness to provide current practitioners and future generations of practitioners with training in evidence-based practice.

Tiivistelmä

Edward J Mullen: Näyttöön perustuva sosiaalityö Yhdysvalloissa. Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskus (Stakes), FinSoc Työpapereita 2/2004. ISBN 951-33-1577-0. ISSN 1455-9064.

Julkaisu koostuu viidestä kirjoituksesta, jotka on laatinut Willma & Albert Musherin professuurin haltija, professori Edward J. Mullen Columbian yliopiston sosiaalityön laitokselta. Näyttöön perustuva tieto ja politiikka ovat selitystä kaipaavia ilmaisuja. Lukijalle saattaa olla epäselvää, miten termit näyttöön perustuva ja tieto eroavat toisistaan ja millainen uusi merkitys syntyy, kun ne yhdistetään. Saattaa myös olla epäselvää, kuinka näyttöön perustuva tieto eroaa yleisemmästä käsitteestä näyttöön perustuva käytäntö. Aluksi Edward Mullen selittää ja määrittelee nämä käsitteet. Lisäksi hän tuo esiin näyttöön perustuvan politiikan ja käytännön viime aikoina korostuneen aseman historiallista taustaa.

Tekemällä sosiaalityöstä aikaisempaa enemmän näyttöön perustuvaa toimintaa pyritään parantamaan sen kykyä aikaansaada kansalaisten ja koko yhteiskunnan arvostamia vaikutuksia. Kolmannessa kirjoituksessa kuvataan sosiaalityöhön liittyvää politiikkaa ja palveluita varten suunniteltua vaikuttavuuden mittauksen viitekehystä. Sosiaalityössä tarvitaan tällaista viitekehystä vaikuttavuuden mittauksen käsitteellistämiseksi siten, että ammattikunta voi selkeästi suuntautua mittauksessa tarvittavaan työhön. Viitekehyksessä olisi eriteltävä eri tavat käyttää vaikuttavuuden mittausta politiikan, ohjelmien ja käytännön edistämisessä. Kirjoituksessa käsitellään kahta vaikuttavuuden mittauksen sovellusta, jotka koskevat politiikkojen ja ohjelmien parantamista ja vaikuttavuuden tutkimusta. Myös muita sosiaalityö vaikuttavuuden mittauksen kehykseen sisällytettävissä olevia ulottuvuuksia otetaan esille. Kirjoittaja esittää perusteluja sen puolesta, että vaikuttavuuden mittauksella voi olla merkittävä rooli sekä sosiaalityötä koskevien politiikkojen ja ohjelmien parantamisessa tuloksia mittaamalla että yleisesti tietoperustan vahvistamisessa.

Viime kädessä hyvinvointipolitiikan ja -palvelujen toteuttaminen on käytännön ammattilaisten varassa. Kaksi viimeistä kirjoitusta käsittelevätkin sitä, kuinka näyttöaineistoa käytetään ja toteutetaan. Niissä tarkastellaan muun muassa, miten sosiaalityön ammattilaiset mahdollisesti reagoivat tehokkaita menettelytapoja koskeviin, näyttöön perustuviin lausuntoihin ja käyttävät niitä työssään. Kirjoituksissa eritellään tekniikoita, joita ammattilaiset tarvitsevat avukseen tunnistaakseen ja käyttääkseen näyttöön perustuvia menettelytapoja ja pystyäkseen vastaamaan niiden yksittäistapauksissa soveltamisen asettamaan haasteeseen. Myös laadunvalvontaa koskevia asioita otetaan esille ja käsitellään. Lisäksi viimeisessä kirjoituksessa esitetään yhteenveto tutkimustuloksista, jotka koskevat alan ammattilaisten tietoisuut-

ta ja asennoitumista hoitosuosituksiin, esimerkiksi käyttävätkö he mieluummin asiantuntijoiden mielipiteiden kartoitukseen vai empiirisiin tutkimustuloksiin perustuvia toimenpiteitä koskevia lausuntoja.

Sosiaalityön tietopohja on laajentunut merkittävästi viimeisen vuosikymmenen aikana. Vaikuttaa siltä, että se perustuu yhä enemmän tieteelliseen tutkimukseen. Näyttöön perustuva käytäntö ei kuitenkaan vielä ole todellisuutta. Kirjoittajan mielestä näyttöön perustuvan käytännön tulevaisuus sosiaalityössä riippuu siitä, missä määrin ammattikunta pystyy ja haluaa järjestää nykyisille ja tuleville työntekijöilleen asiaan liittyvää koulutusta.

Sammandrag

Edward J Mullen: *Evidence-Based Practice in a Social Work Context - the United States Case* (Evidensbaserat socialt arbete i Förenta staterna). National Research and Development Centre for Welfare and Health (STAKES), FinSoc Working Papers 2/2004.ISBN 951-33-1577-0. ISSN 1455-9064.

Publikationen består av fem artiklar skrivna av professor Edward J. Mullen, som innehar Willma & Albert Musher-professuren på institutionen för socialt arbete vid Columbia universitetet. Evidensbaserad kunskap och politik är begrepp som kräver en förklaring. Läsaren kan undra hur de två termerna evidensbaserad och kunskap skiljer sig från varandra och vilken ny betydelse de får när de kopplas samman. Läsaren kanske också frågar sig hur begreppet evidensbaserad kunskap skiljer sig från det mer vanliga begreppet evidensbaserad praktik. Edward Mullen börjar med att förklara och definiera dessa begrepp. Han ger också en historisk bakgrund till varför evidensbaserad politik och praktik lyfts fram på senare tid.

Genom att stärka evidensbasen i det sociala arbetet hoppas man att möjligheterna att nå resultat som uppskattas av medborgarna och samhället i stort ökar. I den tredje artikeln beskrivs de ramar för resultatmätning som utformats för politik och tjänster i anslutning till socialt arbete. Inom socialt arbete behövs en referensram för hur man ser på resultatmätning, så att professionen mer tydligt kan fokusera även på resultat och effekter inom socialt arbete. Inom referensramen bör man skilja mellan de olika sätt som resultatmätning kan användas på för att främja politik, program och praktik. I artikeln diskuteras två sätt att tillämpa resultatmätning, nämligen för utveckling av politik och program och för genomförande av effektstudier. Andra dimensioner som skulle kunna inbegripas i en resultatmätningsram för socialt arbete identifieras också. Enligt författaren kan resultatmätning spela en viktig roll vid utvecklingen av den sociala praktiken genom att lyfta fram prestationerna i socialt arbete. Dessutom kan resultatmätning främja kunskapsbasen genomgående.

Til syvende och sist är genomförandet av social välfärdspolitik och social välfärdsservice beroende av dem som arbetar på gräsrotsnivå. Därför handlar de två sista artiklarna om hur evidens används och realiseras. Artiklarna handlar om hur socialarbetare förhåller sig till och använder evidensbaserad kunskap om effektiva behandlingar. I artiklarna undersöks de teknologier som socialarbete behöver för att kunna identifiera och använda evidensbaserade behandlingar. Dessutom diskuteras vilken utmaningen är för att kunna tillämpa evidensbaserade behandlingar i enskilda klientfall. Frågor som rör kvalitetskontroll identifieras och diskuteras. I den sista artikeln sammanfattas resultaten från en studie om socialarbetares medvetenhet om och attity-

der till vårdstandarder, inklusive huruvida socialarbetare föredrar att använda riktlinjer som utarbetats genom expertkonsensus eller empiriska forskningsresultat.

Kunskapsbasen inom socialt arbete har ökat avsevärt under det senaste decenniet. Den vetenskapliga basen verkar ha blivit starkare. Evidensbaserad praktik är emellertid ännu inte verklighet. Enligt författaren är evidensbaserad praktik inom socialt arbete beroende av förmågan och viljan inom professionen att ge dem som för närvarande arbetar på området liksom framtida socialarbetare utbildning i evidensbaserad praktik.

Preface

This working paper consists of five articles written by Professor Edward J Mullen, Willma & Albert Musher Chair Professor, Columbia University School of Social Work. We, at FinSoc, are very pleased to have the opportunity to publish his articles.

The articles selected give a broad picture of the context and process of evidence-based social work. They describe the history and background, define different meanings and designs of evidence-based policy, discuss how outcomes can be evaluated and finally explore what are the experiences and challenges of developing practice guidelines. Although the context of social work in Finland is very different from the case of the United States, there are still lessons that can be learned from experiences abroad. This is particularly relevant in a time when the issue of evidence-based social work is just now being debated in Finland. Some of the debate can be found in our published FinSocNews (1- 2/2003).

Edward Mullen tells in one of his articles a story of a clinician who had complained that New York State had announced a practice guideline for the treatment of autism. The clinician was unhappy and her assessment was that the guideline had been endorsed because the method it proposed had research support whereas her favoured approach had not been empirically evaluated. This example raises a number of questions of the role of evidence-based policy and the use of practice guidelines. Is it only research that counts, and in this case solid research such as randomized controlled studies? What about the experience, judgement and skills of professionals, don't they count for anything? Philip Davies, of the Prime Minister's Strategy Unit in London, at the recent conference of the 'Nationellt stöd för kunskapsutvecklingen inom socialtjänsten' (www.sos.se/SOS/NYTT/sosnyt04/sn0414x.htm) has said that evidence-based policy means "*integrating experience, expertise and judgement with the best available external knowledge from systematic research"*. By this he places the role of research evidence in daily practice and stresses that it is a question of integrating different types of knowledge and that judgements are made using the best available evidence. Edward Mullen also talks in his articles about the dynamic nature of evidence.

We hope that this working paper can offer our readers different aspects and perspectives and thus broaden the overall picture of evidence-based policy.

Helsinki 5th of May, 2004

Ilse Julkunen
Development manager
FinSoc

Preface – Author's Note

Few overarching issues will be more important for the social work profession in the next decade than the soundness of its evidentiary base and its ability to show that it can achieve valued outcomes. The papers in this volume address these issues. In the first paper I provide an historical context for this recent emphasis on evidence-based policy and practice. Because there is great confusion about what is meant by evidence-based policy and practice the second paper describes what these approaches entail. It is hoped that by strengthening its evidendiary base social work will increase its capability to achieve outcomes that are valued by citizens and society at large. In the third paper I describe a framework for outcomes measurement that is designed for social work policy and services. Ultimately, social welfare policies and services depend on frontline practitioners for implementation so the last two papers examine issues pertaining to how best-practice guidelines can be designed for practitioner use.

The first two papers were prepared for presentations at the 4th International Conference on Evaluation for Practice which was held at the University of Tampere, Tampere, Finland in 2002. The third paper was prepared for the 3rd International Conference on Social Work in Health and Mental Health which was held at the University of Tampere in July, 2001. This third paper was subsequently presented in a slightly modified form at the 4th Annual Meeting of the International Inter-centre Network for Evaluation of Social Work Practice which was hosted by STAKES in September, 2001.

I have learned a great deal through my associations with STAKES and many Finnish researchers during the past decade. These papers and my thinking regarding evaluation research and outcomes measurement have been stimulated and enriched through these associations. I am especially appreciative of the support and insights provided by Dr. Riitta Haverinen and Professor Mikko Mäntysaari. The paper on outcomes measurement benefited from the support of Anna Metteri and Ilmari Rostila. For the authoring of this publication I wish to acknowledge the excellent work of Dr. Riitta Haverinen, Ilse Julkunen, and Tuija Partonen. Due to their work, I am particularly pleased to see that these papers will now be made available to the Finnish audience.

Edward J Mullen, New York, NY, USA October 19, 2003
Evidence-Based Practice in a Social Work Context - the United States Case

Original Papers

This working paper consists of five papers by Professor Edward J Mullen, Willma & Albert Musher Chair Professor, Columbia University School of Social Work, which have appeared in the following sources:

Mullen, E.J. (2002). Evidence-based social work - theory & practice: Historical and reflective perspective. Paper presented at the 4th International Conference on Evaluation for Practice, University of Tampere, Tampere, Finland.

Mullen, E.J. (2002). Evidence-based knowledge: Designs for enhancing practitioner use of research findings. Paper presented at the 4th International Conference on Evaluation for Practice, University of Tampere, Tampere, Finland. This paper was revised for publication in Mullen, E. J. (2004). Facilitating practitioner use of evidence-based practice. In A. R. Roberts & K. Yeager (Eds.), Desk Reference for EVIDENCE-BASED PRACTICE IN HEALTHCARE AND HUMAN SERVICES. New York, NY: Oxford University Press.

Mullen, E. J. (2001). Outcome measurement in social work: Health and mental health (plenary session). Paper presented at the 3rd International Conference on Social Work in Health and Mental Health, University of Tampere, Tampere, Finland.

Mullen, E.J. (2002). The impact of guides on practice and the quality of services. Paper presented at the United Kingdom Social Care Institute for Excellence Inaugural International Seminar, London, England.

Mullen, E. J., & Bacon, W. F. (2003). Practitioner adoption and implementation of evidence-based effective treatments and issues of quality control. In A. Rosen & E. K. Proctor (Eds.), Developing practice guidelines for social work intervention: Issues, methods, and a research agenda. New York City: Columbia University Press. This paper was revised for publication in Mullen, E. J., & Bacon, W. F. (2003). Practitioner adoption and implementation of evidence-based effective treatments and issues of quality control. In A. Rosen & E. K. Proctor (Eds.), Developing practice guidelines for social work intervention: Issues, methods, and a research agenda. New York City: Columbia University Press.

Appreciation is expressed to Columbia University Press, Oxford University Press, and the Social Care Institute for Excellence for permission to publish these papers herein.

CONTENTS

1 DEFINING EVIDENCE-BASED PRACTICE

This paper provides some reflective observations on the historical and contemporary context of evidence-based social work in the United States. Major themes in social work research leading up to, and contributing to, evidence-based policy & practice (EBP) are described. Current views about various meanings of evidence-based social work (EBSW) in the United States are assessed. Some of the national and state level initiatives to promote evidence-based practice as well as challenges in training practitioners are examined. In conclusion it is noted that social work's journey toward evidence-based practice has been long and difficult. There has been a history which provides an important context for all to consider if this development is to be something other than a passing fad. Social work's knowledge base has grown considerably during this time. Its foundation in scientific research seems to have solidified. However, evidence-based practice is not yet a reality.

Evidence-based Social Work - Theory and Practice: Historical and Reflective Perspective

This paper provides some reflective observations on the historical and contemporary context of evidence-based social work in the United States. First, I sketch the long-view of major themes in United States social work research leading up to, and in some ways contributing to, evidence-based policy & practice. Then, I describe the meaning of evidence-based social work in the United States. I conclude with comments on some current evidence-based initiatives in the United States.

U.S. Social Work Research Themes

There have been some excellent reviews of United States social work research themes. I draw upon those reviews in this paper (Zimbalist, 1977; Orcutt, 1990; Reid, 1994; Mullen and Magnabosco, 1997; Kirk & Reid, 2002).

Early Social Work Research Looked Outward

Interestingly, five of the six social work research themes identified by Zimbalist during the sixty plus years that he reviewed, from the late nineteenth century through the 1950's, were efforts to look outward at social conditions rather than to look inward at the profession’s own interventions (Zimbalist, 1977). In rough chronological order these themes were: quantitative studies of the causes of and prevalence of poverty; descriptive surveys which documented the social ills of the urban poor; methodological research which resulted in the development of measures which could be used to describe social conditions such as economic dependency, social need, and social indicators; and, a variety of research efforts directed at describing and changing what was called the “multi-problem family”, that is families who tended to be poor and plagued with multiple social problems. These early research themes emphasized description of social problems and, to some extent, examination of their causes. These early research efforts did not question the effectiveness of social work’s interventions. Indeed, there seems to have been an implicit assumption that armed with an understanding of such social problems, social work professionals would have no trouble changing these conditions through social policies, social action, and direct intervention.

Evaluation Research Was Also an Early Theme - with an Emphasis on Demonstrating Success

However, this implicit assumption of effectiveness was being put to the test by a few social work researchers as early as the 1920’s. Beginning in the 1920’s evaluation research studies were conducted in the United States to demonstrate social work intervention effectiveness across a range of problem areas such as delinquency, economic dependency, family problems, and psychological distress. By the early 1960’s questions were beginning to be raised about effectiveness. Clearly, trouble was around the corner.

With the War on Poverty, Evaluation Research Put Social Work to the Test

The United States’ War on Poverty brought a new emphasis on evaluation research as the theme of the 1960’s and early 1970’s (Lohmann, 1999). The character of evaluation research, as applied in social work, changed radically during the 1960’s from a method used to demonstrate traditional social work intervention effectiveness to a method used to test with hard-headed skepticism the effectiveness of traditional social work interventions (Fischer, 1976). I personally experienced this transition, first as a doctoral student at Columbia University where much critical discussion began to occur in the mid-1960’s; then, as the principal investigator for one of the first highly publicized “nil-results” 1960’s evaluations of what we now call welfare-to-work programs (Mullen, 1972); and, then, as the first systematic reviewer and synthesizer of the social work experiments of the 1950s and 1960s (Mullen, Dumpson and Associates, 1972). I recall my first exposure to this turn of events when in 1964 Wyatt Jones, who together with Henry Meyer and Edgar Borgatta, was principal investigator for the infamous study Girls at Vocational High (an experiment in social work intervention designed to prevent juvenile delinquency), was invited by David Fanshel to meet with those of us in Fanshel's research class at Columbia University to learn of the "nil-results" from this evaluation (Meyer, Borgatta & Jones, 1965). I was struck by Brian Sheldon's recollection of his first exposure to these early studies. Sheldon wrote that it had been around 1978 when he was "motoring one evening to the University of Leicester -- to hear a lecture by Professor H. E. Meyer on the effectiveness of delinquency-prevention schemes in the United States" (Sheldon, 1998, 577). Sheldon was referring to these same studies. Clearly, the effects of evaluation research findings during this period in the United States ultimately reached other countries. Indeed a good account of all of this from the British perspective was captured by Geraldine Macdonald and Brian Sheldon in their 1992 book (Macdonald and Sheldon, 1992).

Within a decade the social work profession in the United States had moved from a posture of confidence in the effectiveness of its interventions to skepticism, which in many ways mirrored a growing skepticism in American society about the United States War on Poverty as well as its war in Southeast Asia. Capturing this new skepticism in his Foreword to Girls at Vocational High the President of the Russell Sage Foundation asked "Is social work on the wrong track?" He declared that social work "--- must move rapidly to develop new technologies and skills" calling for a period of innovation, research and evidence of effectiveness (Meyer, Borgatta & Jones, 1965, 5). While this skepticism was occurring among social work professionals and funding bodies it quickly spread through the informed lay public when the results of such evaluations found their way into America's newspapers (Goodrow, 1971; Shipler, 1971).

A Search for Effectiveness through Research-based Interventions

As a consequence of developments during the 1960's social work began the long journey inching toward an evidence-base. The next major research development which followed quickly upon disenchantment with traditional, conventional, nil-result interventions was a search for alternative intervention methods of demonstrated effectiveness, or if not of demonstrated effectiveness at least capable of having their effectiveness empirically assessed.

For me personally, this meant scouring the literature in search of evidence, summarizing what my students and I found, converting what we had found into what we called summary generalizations, and drawing out prescriptions for intervention in the form of what we then called practice guidelines and personal practice models. These practice guidelines and practice models were early forms of what we now call manualized interventions. This occupied my thinking during the late 1970's and early 1980's while I was at the University of Chicago (Mullen, 1978, 1980, 1981, 1983). Other social work researchers were turning to alternative forms of intervention and exploring emerging forms of research methods (Briar, 1973).

The Emergence of Evidence-based Social Work

In the United States the first half of the twentieth century was characterized by the profession's search for a theory-base. During this period the profession succeeded in adapting various psychodynamic and sociologic theories for use in social work. The profession's intellectual capital became invested in a small number of theories which provided the conceptual underpinnings for its primary direct service interventions (e.g., diagnostic casework, psychosocial casework and social groupwork, functional practice, problem-solving practice). However, confidence in these theoretical underpinnings was soon replaced in much of the research community by skepticism and a move toward either alternative theoretical underpinnings or pragmatism. And, of course in America, pragmatism dictated that the validity of social work's interventions was to be tested by the consequences of those interventions. It was a short journey to the current embrace of evidence-based social work, but that journey would take the profession through a number of dead-end or, at least incomplete solutions such as eclecticism, empiricism, and the blending of science and practice in the scientific-practitioner model of social work. In addition, because the skepticism and search for pragmatic alternatives was occurring mostly in the social work research community and not in the practice community a widening gap between practice and research grew to its current dimension, which is nothing short of a chasm (Mullen, 1993; Hess and Mullen, 1995). This move toward research set off a counter-movement within the profession which fuelled a move toward social constructionist and heuristic approaches (Mullen, 1985).

I comment next on each of these major research themes occurring during the past 25 years which served as signposts on the journey to evidence-based social work.

The Journey towards an Evidence Base Eclecticism

Among the first reactions to disenchantment resulting from the nil-results was the embrace of what came to be called eclectic social work practice made popular by Joel Fischer (Fischer, 1978). This emphasis emerged in the late 1970s and became strong in the early 1980s. Eclectic social work meant abandoning theoretical camps and patching together whatever interventions one could find that had some degree of research support. For Fischer this resulted in combining the nondirective (or client-centered) psychotherapy core conditions, as basic relationship variables, with a number of behavioral techniques (Fischer, 1978). An early expression of pragmatic, eclectic practice was William J Reid, Laura Epstein and their many students' task-centered practice, which itself grew out of evaluation research findings, as well as psychosocial and problem-solving theoretical frameworks (Reid and Shyne, 1968; Reid and Epstein, 1972). Extreme eclecticism was criticized for its lack of conceptual cohesion (task-centered practice avoided this criticism to some extent since a conceptual rationale was developed over time). Yet, despite these criticisms, for a time eclecticism was attractive to many social workers because it was an early attempt to leave old, discredited theories behind and to rely on research-based interventions.

Empiricism & the Scientist-Practitioner Model

While eclecticism faded in significance, a move toward empiricism and the merging of researcher and practitioner roles in the scientist-practitioner model continued to influence the social work research agenda. Indeed some view the current form of evidence-based social work as yet another expression of the empirical practice movement (Howard, McMillen, & Pollio, 2003). Empirical social work is based on the assumptions that research can be used to shape assessment, intervention planning and case evaluation; that interventions of demonstrated effectiveness should be selected rather than those of questionable or unknown effectiveness; and, that social workers should engage in research including using standardized assessment measures and single-subject evaluations. Behavioral and cognitive-behavioral interventions became favored because of their research foundations (Reid, 1994).

Because social workers were expected to be critical users of the latest research findings, especially pertaining to effectiveness, as well as experts in the use of single-subject research methods and assessment instruments to evaluate their own practice, the idealized social worker was referred to as a scientist-practitioner (Orcutt, 1990). However, few practitioners embraced this point-of-view, and rarely was the ideal realized. As a consequence, many now question how realistic the scientist-practitioner model really is, and wonder what the respective roles should be in this new partnership between practitioners and researchers (Mullen, 1993; Hess and Mullen, 1995). This ambiguity continues into the present. It will need to be addressed yet again in the current context of evidence-based social work. The current attention being given to the need for translational research (i.e., research that seeks to adapt controlled research findings to real-world field contexts) and the problems of implementing evidence-based interventions is recognition that interventions found to be efficacious in controlled research are not necessarily adopted by practitioners in their routine work.

Developments in Research Methodology

Three methodological developments have contributed to the current movement toward evidence-based social work. I will identify them and highlight their key relevance to evidence-based social work.

Social Intervention Research

In the 1970's American social work researchers became acquainted with the research & development approach of industry, primarily through the work of Jack Rothman and Edwin Thomas at the University of Michigan (Rothman and Thomas, 1993). As translated to social work research, this R&D approach became known as social intervention research. As a research-development methodology, social intervention research has provided the profession with a systematic, cumulative research methodology for developing, refining, testing and disseminating research-based social interventions. Accordingly, rather than wasting research resources on the evaluation of poorly conceptualized interventions, this methodology has contributed to the development and identification of interventions of proven effectiveness. Evidence-based social would have a weak foundation without such developmental studies. A social intervention group web site that illustrates this type of work can be found at http://www.columbia.edu/cu/ssw/sig/

Outcomes Measurement

In the early years of evaluation research there were many flawed attempts to identify and measure social intervention outcomes (Jones & Borgatta, 1972). However, with experience and increased methodological prowess the science of outcomes measurement has developed into a sophisticated specialization (Mullen, 2001 – in this volume). While fueled by many sources in the larger society the recent emphasis on outcomes measurement in all areas of the human services has become an integral aspect of evidence-based social work with measurable outcomes being a critical criteria used to assess what is evidence-based (Mullen & Magnabosco, 1997).

Systematic Review Methods, Research Syntheses & Meta-Analysis

While the outcome of a single evaluation may be cause for attention, one study does not establish a foundation for decision making. In the early 1970's social work researchers used narrative reviews to summarize findings from groups of evaluations, sometimes using systematic methods and sometimes not (Mullen, Dumpson and Associates, 1972; Fischer, 1973). When few studies existed this approach served the profession well. However, in other areas such as in medicine, psychotherapy and behavior therapy, as the number of studies pertaining to a single outcome grew, narrative reviews were found wanting. Furthermore, without explicit, systematic review methods such overviews were subject to unknown bias. Accordingly, the development of systematic review methods as well as sophisticated, quantitative meta-analytic procedures has made it possible to specify with greater confidence and precision the combined outcomes of many studies. The growth of methodological sophistication in the review and syntheses of outcomes from multiple studies has been a singularly important methodological development in the move toward evidence-based approaches (Cooper & Hedges, 1994).

Evidence-based Practice

I now summarize what evidence-based practice means in the United States context. I mention a few recent developments pertaining to evidence-base practice.

Current Views about the Meaning of Evidence-based Practice

Like so many other American developments, ideas about evidence-based practice as currently conceptualized have origins in British thinking, and they are arguably best developed in the United Kingdom. Also, like many other contemporary American social work events the shift towards evidence-based approaches is most pronounced in health and mental health. Other areas such as family and child welfare may be not far behind. I should make a note on terminology since I have referred to evidence-based social work, evidence-based practice, and, I should also refer to evidence-based policy. I note that in the United Kingdom it is customary to refer to evidence-based policy and practice with clear implications that an evidence-base is required for both policy-making as well as direct social care (Gray, 2001). This is a good point. In the United States it is more customary to use the single phrase evidence-based practice which I will use subsequently, with apology for the blurring of import distinctions between policy and practice.

In medicine and mental health the phrase evidence-based practice has been used to convey two different meanings.

First, an evidence-based practice is considered any practice that has been established as effective through scientific research according to some set of explicit criteria. For example in 1998 a Robert Wood Johnson Foundation consensus panel concluded that its review of research findings supported identification of six evidence-based practices for the treatment of persons with severe mental illness: assertive community treatment (ACT); supported employment; family psychoeducation; skills training and illness self-management; psychopharmacological treatements; and, integrated dual-disorder treatment (PORT Study Publications, 1998; U.S. Department of Health and Human Services, 1999). To be considered an evidence-based practice four selection criteria were used: the treatment practices had been standardized through manuals or guidelines; the treatment practices had been evaluated with controlled research designs; through the use of objective measures important outcomes were demonstrated; and, the research was conducted by different research teams. Accordingly, we can say that evidence-based practices or best-practices were identified for the treatment of persons with severe mental illness through efficacy trials meeting these four criteria (Torrey, Drake, Dixon, Burns, Flynn, Rush, et al., 2001).

In contrast to this usage of the phrase evidence-based practice a second popular meaning is the one most often attributed to David Sackett, who in 1996 described evidence-based medicine as “ --- the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, 1996, 71). Subsequently, Sackett wrote that evidence-based medicine is the "integration of best research evidence with clinical expertise and patient values" (Sackett 2000, 1). Adapting Sackett’s description to British social care Brian Sheldon described evidence-based social care as “--- the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare of service-users and carers” (Sheldon 2002). These quotes describe evidence-based practice as a decision-making process in which practitioners make decisions on a case-by-case basis, rather than as a set of products or best-practices which is connoted in the first meaning of the phrase which I previously described.

It is instructive to consider how these two rather different meanings of evidence-based practice can be applied in social work. Regarding the first meaning which focuses on the products (the effective practices supported by research), social work can benefit greatly from clear identification of interventions that work, through systematic reviews such as undertaken by the Cochrane and Campbell Collaborations as well as the many evidence-based practice centres around the world. Furthermore, what is learned about best-practices through such reviews needs to be effectively disseminated and made available to policy and practice professionals and service organizations for their use. However, this is not enough. In contrast to this top-down approach to evidence-based practice, it is essential that social work policy and practice professionals be prepared to engage in a process of critical decision-making with clients about what this information means when joined with other evidence, professional values, and individualized intervention goals. A bottom-up approach is needed. Social work practitioners need to be provided with educational opportunities which prepare them for this new world of evidence-based practice. This is similar to Sackett's description of evidence-based medicine.

Evidence-based Practice Developments in the United States

Currently, there is a flurry of activity pertaining to evidence-based practice in the United States. Evidence-based practice is associated with and supported by other popular emphases such as outcomes measurement; performance measurement and management; continuous quality improvement; best-practices; practice guidelines; and manualization of assessments and interventions. (See annex)

As noted by Sackett in reference to the British medical scene:

Evidence-Based Medicine, whose philosophical origins extend back to mid-19th century Paris and earlier, remains a hot topic for clinicians, public health practitioners, purchasers, planners, and the public. There are now frequent workshops in how to practice and teach it ---; undergraduate and post-graduate training programmes are incorporating it (or pondering how to do so); British centres for evidence-based practice have been established or planned in adult medicine, child health, surgery, pathology, pharmacotherapy, nursing, general practice, and dentistry; the Cochrane Collaboration and the York Centre for Review and Dissemination in York are providing systematic reviews of the effects of health care; new evidence-based practice journals are being launched; and it has become a common topic in the lay media. (Sackett, 1996, 71)

Conclusion

Since few social work educational programs in the United States now provide training in evidence-based practice a major educational challenge lies ahead (Weissman & Sanderson, 2001). In the coming years social work educators will need to experiment with innovative evidence-based practice training programs. As a consequence of this relative absence of training few social work practitioners in the United States now engage in evidence-based practice. Probably it is fair to say that few are even familiar with the concept or prone to critically use evidence, especially research evidence in routine practice decision-making. Although not representative, our survey of practitioners in a large New York City social agency suggests that this is the case (Mullen & Bacon, 2004; Mullen & Bacon, this publication). However, this may be changing. There are indications that evidence-based approaches may be finding their way into social work educational programs. For example, the George Warren Brown School of Social Work at Washington University in St. Louis has recently adopted evidence-based practice as one of its two approaches to graduate education (Howard, McMillen, & Pollio, 2003).

The profession needs resources to support training in evidence-based practices. Special funding to support experimental programs is needed. Particular attention will need to be given to the linkage during training of social work educational programs and service organizations since there may be a troubling gap between what students will be taught and what the practice reality is pertaining to understanding of and delivery of evidence-based practices. Educational materials need to be developed for use in social work training programs including practice guidelines, manualized best-practices, algorithms, and reference texts. The recently published edited volume by Aaron Rosen and Enola Proctor promises to be one such resource (Rosen and Proctor, 2003). Also, Leonard Gibbs' text on teaching evidence-based practice is an important new resource (Gibbs, 2003).

Social work's journey toward evidence-base practice has been long. As I have described, there has been a history which provides an important context for all to consider if this development is to be something other than a passing fad. Social work's knowledge base has grown considerably during this time. Its foundation in scientific research seems to have solidified. But, evidence-based practice is not yet a reality.

In this paper I have provided a general overview of developments and challenges ahead in the United States pertaining to evidence-based practice. Yet, this is a global development especially evident in the United Kingdom, northern continental Europe, North America and Australia. Hopefully, we can learn from one another in the years ahead.

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Evidence-based Knowledge: Designs for Enhancing Practitioner Use of Research Findings

What is Evidence-based Knowledge?

The title of this paper is a bit of a play on words. Evidence-based knowledge (EBK) is a phrase that requires explanation. The reader may wonder how the two terms evidence-based and knowledge differ and what new meaning emerges when they are joined. The reader may also wonder how this phrase differs from the more common evidence-based practice (EBP) term. I begin by explaining the reason for my choice of terms.

The Special Meaning of "Knowledge" in EBP When Applied to Social Work

The term knowledge can be used to describe something external to the knower, a static body of information about something such as what is found in an encyclopedia. However, the term can also be used to refer to a subjective state of the knower, such as when I say that "I know about how to cook good meals". It is in this later dynamic sense that I would say that social work practitioners have knowledge of social work practice. An individual practitioner "knows" how to assess and intervene when seeing a client who needs help with a problem. The practitioner's knowledge is derived from many sources, but it is always derived through a process involving personal experiences with those sources. These personal experiences can include what has been learned through practice with previous clients, what the practitioner has learned from supervisors and professional associates, information provided at professional meetings, reading and formal education, and so forth. When this knowledge has been gained recently, the practitioner is quite conscious of what has been learned. However, over time this knowledge becomes an integral part of the practitioner's style and the knowledge is used unthinkingly or intuitively. And, so, I use the term knowledge to underscore the dynamic personal character of a practitioner's cognitive processes.

"Evidence-based" Has a Special Meaning in EBP When Applied to Social Work

My second term evidence-based has a special meaning as well. The term evidence implies a source external to the knower. For instance in a court of law various types of evidence can be presented to a judge, jury or tribunal. The evidence does not speak for itself, even if it is what might be considered direct evidence. Rather someone needs to interpret the evidence and draw inferences of relevance to the task at hand. And so, social work practitioners consider evidence, just as a judge considers evidence. Rather than drawing conclusions regarding legal matters, the social work practitioner attempts to draw relevant inferences from available evidence about such things as case assessment, intervention planning, and selection of intended outcomes pertaining to his or her professional work. Accordingly, social workers typically consider evidence of all sorts, direct and indirect, circumstantial, and, yes, even hearsay evidence.

The Meaning of "Evidence-based Knowledge"

So, it should be clear that when I join these two terms into the phrase evidence-based knowledge I do not limit this to any particular type of evidence, and I do stress that what I am talking about is the practitioner's personal, experiential knowledge gained through a dynamic process of making judgments about evidence presented over time.

Designs for Knowledge Utilization Needed

This paper's subtitle, designs for enhancing practitioner use of research findings, is meant to convey two additional ideas. First, I use the term design because I think that there needs to be purposeful, structured plans or roadmaps made available to practitioners so that research findings and other types of evidence can be critically accessed and used for purposes of practice. Second, social work practitioners need more assistance than they are currently receiving with the development of critical reasoning skills pertaining to all sources of evidence, especially evidence coming from research.

Two Meanings of Evidence-based Practice

You may wonder how my focus differs from or is similar to the general topic of evidence-based practice which is now so popular in many countries. I think it is a matter of emphasis. I am talking about evidence-based social work practice, and I want to make clear what I mean by evidence and I want to stress the point that practitioners need to be actively engaged in a dynamic process of making judgments with their clients about what the full range of evidence implies. I also want to distinguish my emphasis from some other popular approaches to evidence-based practice that I observe, especially in medicine and mental health. In social work, evidence-based practice should not imply unthinking, routine use of what some authority decides is best practice.

In medicine and mental health in recent years the phrase evidence-based practice has been used with two different meanings. These have been described in the prior paper and are summarized here.

Best-practice (Static Product)

First, an evidence-based practice is considered any practice that has been established as effective through scientific research according to some set of explicit criteria. For example in 1998 a Robert Wood Johnson Foundation consensus panel concluded that research findings identify six evidence-based treatment practices for the treatment of persons with severe mental illness: assertive community treatment (ACT); supported employment; family psychoeducation; skills training and illness self-management; and, integrated dual-disorder treatment. To be considered an evidence-based practice four selection criteria were used: the treatment practices had been standardized through manuals or guidelines; evaluated with controlled research designs; through the use of objective measures important outcomes were demonstrated; and, the research was conducted by different research teams. Accordingly, we can say that evidence-based practices or best-practices were identified for the treatment of persons with severe mental illness through efficacy trials meeting these four criteria.

Decision-making (Dynamic Process)

In contrast to this usage of the phrase evidence-based practice a second popular meaning is the one often attributed to David Sackett who in 1996 described evidence-based medicine as “ --- the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.” (Sackett, 1996, 71) Subsequently, Sackett notes that evidence-based medicine is the "integration of best research evidence with clinical expertise and patient values" (Sackett 2000, 1). Adapting Sackett’s description to social care Brian Sheldon described evidence-based social care as “--- the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare of service-users and carers.” (Sheldon 2002).

In this second meaning evidence-based practice is a decision-making process in which judgments are made on a case-by-case basis using best-evidence.

Social Work Needs Both Types of Evidence-based Practice

I make these distinctions not to say that one meaning is better than another but rather to point out that differences exist and meanings should not be assumed without clarification. Furthermore, what is important for what I have to say is that when applied to social work professional practice, we need to consider how these concepts, generated primarily in the context of medicine, can be fruitfully applied to social work contexts. Social work practitioners need to know what has been identified as best-practices, the first meaning of evidence-based practice; and, social work practitioners need to be prepared to be evidence-based decision-makers, the second meaning of the term evidence-based practice. What remains then is to discuss how both purposes can be achieved.

Both Top-down & Bottom-up Strategies Needed

Top-Down Strategy

Social work can benefit greatly from clear identification of interventions that work, through such efforts as seen in the Cochrane and Campbell Collaborations, as well as the work of the many evidence-based practice centres around the world. These collaborations and centres are using systematic reviews to identify effective interventions or best-practices. Of course what is learned about best-practices through such reviews needs to be effectively disseminated and made available to policy and practice professionals and service organizations for their use (Nutley and Davies, 2000b; Nutley, Davies, & Tilley, 2000; Eisenstadt, 2000). Dissemination and implementation of EBP presents special challenges when the intended users are social work practitioners and their clients. I comment on these special challenges next.

As noted by Nutley and Davies two rather different approaches to dissemination and implementation of best-practices have been used, namely macro and micro, or what I call top-down and bottom-up strategies (Nutley & Davies, 2000a). In top-down strategies findings are disseminated for use by front-line practitioners through agency directives, guidelines, manualized interventions, accreditation requirements and so forth. Top-down or macro strategies can serve to get the word out about what works or what is favored by those in authority, but such methods do not guarantee adoption of best-practices on the front lines.

Bottom-up Strategy

To increase the likelihood of adoption a bottom-up approach is needed. In contrast to the top-down approach it is essential that social work policy and practice professionals be prepared to engage in a process of critical decision-making, with clients, about what this information means when joined with other evidence, professional values and ethics, and individualized intervention goals.

Training is needed to Prepare for EBP

Social work practitioners will need to be trained for this new world of evidence-based practice. In medicine there has been much discussion of evidence-based medical education and how this differs from traditional medical education. We are only beginning to have this discussion in social work. The future of evidence-based practice in social work rests on the profession's capacity and willingness to provide current practitioners and future generations of practitioners with training in evidence-based practice. Because such training is so critical for the profession's future my remaining comments are about education for evidence-based practice. What might an evidence-based social work education program look like?

Beginning Assumptions

I make five key assumptions.

1. Evidence-based practice will be required within a few years.
2. Social work practitioners currently are not engaged in evidence-based practice (Mullen & Bacon, 2003; Mullen & Bacon, this publication; Weissman & Sanderson, 2001).
3. Social work educational programs currently are not training for evidence-based practice (Weissman & Sanderson, 2001).
4. The future belongs to those disciplines & professions that adopt evidence-based practice modalities (Sanderson, 2002).
5. Evidence-based practice is more than the sum of its parts

This last assumption requires some clarification as to my meaning. What do I mean when I say that "evidence-based practice is more than the sum of its parts"? What are the parts and why is the whole package more than all of them combined?

In contrast to prevailing methods of practice, evidence-based practice should include the following parts (and more!):

1. A realignment of the relationship between the practitioner and the client. Rather than a relationship based on asymmetrical authority, in EBP the relationship is characterized by **"shared-power"**. The practitioner does not decide what is best for the client, but rather as appropriate the practitioner provides the client with up-to-date information about what the best-evidence is regarding the client's situation, what options are available, and likely outcomes. With this information communicated in culturally & linguistically appropriate ways clients and their caretakers are supported to make decisions for themselves to the extent possible (New York Times, 2002).
2. A focus on **fidelity in implementation** of client chosen interventions rather than assuming that selected interventions will be provided as intended. Fidelity of implementation requires that the specific evidence-based practice be provided as it was tested when re-

search supported its effectiveness. Too often serious distortion occurs during implementation.

3. An **inquisitive attitude regarding the achievement of valued outcomes and unintended negative effects** rather than an unquestioning belief that only intended outcomes will be achieved (and, therefore a failure to secure information about actual outcomes, or permitting prior expectations to color achievements).
4. **Aggressive pursuit of new information** about outcomes rather than relying on static prior beliefs. This new information is derived from: a) researching what happens when chosen interventions are implemented; and, b) new research findings promulgated by others.
5. **Ongoing knowledge revision** based on this new information which in turn is **communicated to clients** in a shared power relationship.
6. A relative **weighting of information** for use in evidence-based practice, placing information derived from scientific inquiry as more important than information based on intuition, authority or custom.

While any one of these qualities might characterize a social worker's practice style, when all of them are combined a new and powerful practice model emerges, and I will call that new style evidence-base social work practice.

Implementation Assumptions

Implementation of EBP in social work organizations depends on many parts fitting together into a coherent whole (United Kingdom National Health Service Centre for Reviews and Dissemination, University of York, 1999).

1. **Organizational culture, policies, procedures and processes** must provide opportunities and incentives supporting EBP (e.g., financial incentives, funding, openness to change, workload, information supports, and legal protection).
2. The **organization's external environment** must provide similar opportunities and incentives supporting EBP (e.g., national, regional and local authorities, funders and accrediting groups).
3. Applied practice **research & evaluation must provide scientific evidence** pertinent to the organization's practice domain and most common practice objectives.
4. **Scientific syntheses** must be conducted assessing the weight of the evidence generated by current research & evaluation studies.
5. **Prescriptive statements** based on these syntheses must be developed and communicated in user-friendly forms (e.g., practice-guidelines, manuals, toolkits, algorithms).

6. Organizational procedures need to be put in place to assure **fidelity of implementation** of these prescriptions.
7. **Systematic, structured evaluation processes** capable of providing timely feedback to various stakeholders as to the fidelity of implementation and outcomes must be designed and implemented as an ongoing process.
8. The organization must have **social workers available** who are trained as EBP practitioners capable of functioning in EBP organizations.

Training EBP Social Work Practitioners

As this last point notes, unless social work practitioners are trained for EBP it is unlikely that organizations will be capable of providing such services to clients (Weissman & Sanderson, 2001; Mullen & Bacon, 2003; Mullen & Bacon, this publication; Goisman et al.,1999). In the immediate future EBP training will need to be provided for both new social work students as well as for professional social workers already in practice. Social work can learn from attempts to implement evidence-based training in both medicine and education (Sackett, et al., 2000; Willinsky, 2001).

Continuing Education for Current Practitioners

For the later group, social workers who are engaged in practice, training opportunities need to be made available by the employing organizations if the organizations are to adopt EBP. Since EBP is a relatively new development it is likely that most practitioners are not prepared to engage in EBP. We have some evidence that this is the case (Mullen & Bacon, this publication; Mullen & Bacon, 2004). As noted by Weissman & Sanderson when discussing training for psychotherapy:

> --- one major obstacle to the use of evidenced-based treatments is their near absence in many training programs for psychologists and social workers and in residency training programs for psychiatrists. This lag may be due in part to the recency of the evidence, although some is due to ideologic differences. Training efforts are more vigorous in Canada, Great Britain, Holland, Iceland, Germany and Spain where calls for workshops, individual training and supervision in EBT by psychiatrists, general practitioners (in Canada) and psychologists have been overwhelming (Weissman & Sanderson, 2001, 18).

> Clinicians trained ten years ago are unlikely to be up-to-date with the newer, evidence-based psychotherapies, since the data supporting EBTs have appeared in the past 10 to 15 years. Continuing Education (CE) Programs have the potential to fill this void." (Weissman & Sanderson, 2001, 23).

I agree. Accordingly, a fairly large investment will need to be made by organizations through continuing education and other in-service training programs. However, because experienced social work practitioners typically already have developed core skills, values and professional identities, training in EBP may need to be less costly than that provided to new students entering social work educational programs.

Implementing EBP Curricula in Social Work Educational Programs

Since few social work educational programs now provide training in EBP a major curricular challenge lies ahead (Weissman & Sanderson, 2001). Nevertheless, there are indications that this may be changing. For example, the George Warren Brown School of Social Work at Washington University in St. Louis has recently adopted EBP as one of two approaches to graduate education (Howard, McMillen, & Pollio, 2003). Also, Leonard Gibbs has published a text on evidence-based practice which is a valuable resource (Gibbs, 2003). As we develop curricula, much can be learned from attempts to teach evidence-based practice in allied health professions (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). In the years ahead the profession needs to experiment with innovative EBP curricula.

Based on what is currently known what would an EBP curriculum include in its core? In what follows I am drawing from experiences that I have had at the University of Chicago as well as Columbia University in teaching an approach to evidence-based practice that I call personal practice model development (PPMD) (Mullen, 1978, 1981, 1983, Mullen & Bacon, 2003; Mullen & Bacon, this publication). This approach to practice is discussed as a form of evidence-based practice in the recent Rosen and Proctor book on developing practice guidelines for social work interventions (Mullen & Bacon, 2003; Mullen & Bacon, this publication). PPMD is based on the assumption that practitioners need to be prepared to engage in a process of information gathering, analysis and decision making with clients about what would be a best-practice for a given client situation. This idea is in agreement with Lawrence Green's notion that it is best processes rather than best-practices that should be advocated in public health promotion (Green, 2001).

Core Components of EBP Training

A proposed outline of the core components of an EBP training program follows. Such a program would need to provide the now required social work foundations and advanced specializations (such as currently offered in United States graduate level social work programs). In addition students would be provided with training in:

- Critical thinking skills (Gambrill,1999)
- Evidence-based practice as a framework for and requirement of contemporary social work practice
- Practice guidelines, manuals, toolkits and other forms currently used to translate evidence into practice prescriptions
- Information retrieval and critical assessment skills
- Systematic review methods, data syntheses and meta-analytic procedures
- Methods of social intervention research as a process for developing, testing, refining and disseminating scientifically validated social work practices
- Foundations of scientific thinking; research and evaluation methods; and, quantitative and qualitative modes of inquiry and analysis
- Skills for personal practice model development (Mullen, 1978, 1981, 1983, Mullen & Bacon, 2003; Mullen & Bacon, this publication).

Conclusion

In closing I would like to pose some questions for consideration.

- Social work has been prone to embrace “fads”. Is EBP another fad or does it represent a basic change in the way we do business?
- How much solid evidence is available for use? What are the implications if we find little solid evidence exists for much of what social work addresses?
- Will the necessary resources be made available by governments and private sources to support a large-scale investment in EBP?
- How can social workers collaborate effectively with other professionals, clients, funders, governmental and voluntary groups to develop evidence based practices and policies?

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2 FOCUSING ON OUTCOMES IN SOCIAL WORK

Outcomes measurement in health and mental health should be of vital concern to social workers since public support and financing will follow evidence of effectiveness. Social work in health and mental health requires a framework for conceptualizing outcomes measurement so that the profession can focus clearly on the work to be done in outcomes measurement. This framework should distinguish among the various ways that outcomes measurement can be used to advance policy, program and practice. This paper discusses two applications of outcomes measurement, namely for improving policies and programs, and, second, for conducting outcomes research. Other dimensions that could be included in an outcomes measurement framework for social work in health and mental health are identified but not elaborated. The author's objective is to make a strong case for the role that outcomes measurement can play in both the improvement of social work policies and programs in healthcare, through performance measurement, as well as in advancing the healthcare knowledge base, through outcomes research.

Outcomes Measurement: A Social Work Framework for Health and Mental Health Policy and Practice

This paper examines measurement of social work outcomes in health and mental health. Outcomes measurement is the systematic, empirical observation of the effects of social programs on the achievement of objectives having to do with improving the health and mental health of individuals and populations. Outcomes measurement plays an important role in both the improvement of social work policies and programs, through performance measurement, as well as in advancing knowledge about how to provide effective and efficient social services in health and mental health, through outcomes research. Outcomes measurement in health and mental health is of vital concern to social workers since evidence of effectiveness is required for public support and financing.

Concern with cost-containment is ever present. But in addition to cost-containment purchasers and payers of health care as well as some health care providers are expecting quality and evidence of desired outcomes from care provided. Payers no longer accept the argument that increased funding will improve quality and outcomes. At one time healthcare professionals including social workers may have enjoyed public confidence regarding the effectiveness of their interventions but that is no longer the case. Rather, the assumption now is that there is room for improvement in performance. Public confidence has shifted to public skepticism. Consumers and payers now expect professionals to provide evidence of effectiveness, responsiveness to expectations, and fairness in financial burden. In response to these widespread expectations health care systems are shifting rapidly toward performance measurement and management with a focus on outcomes. Calls for evidence-based practice, practice guidelines, and best value are ever present. In the coming years these efforts will intensify. Each of the health care professions, including social work, will be challenged to provide evidence regarding their respective contributions to healthcare system performance. Social work in health and mental health will be expected to articulate the specific contributions the profession can make to health system goal attainment and to provide evidence that health system outcomes are measurably improved because of social work interventions.

Social Work Needs an Outcomes Framework

Social work is vulnerable because it lacks a conceptual framework for defining specifications of the profession's outcomes in healthcare and for clearly focusing on the work to be done in outcomes measurement. If social work is to address the demand that its contribution to healthcare be documented, the social work community needs to engage in discourse regarding how to conceptualize the intended outcomes of its interventions; what criteria can be used to indicate attainment of those objectives; and, how to measure those outcomes. This framework must specify social work's particular contribution to healthcare, consistent with health system goals set by broader constituencies. Social workers must develop a common language for talking about objectives and outcomes in healthcare. A common outcomes language is required for effective communication between social work practitioners themselves as well as for clear communication among practitioners, managers, policy analysts and researchers both within the profession and across professions. The profession's outcomes framework needs to be inclusive of the range of interventions that contribute to health system performance, from policy to direct practice interventions, and cutting across system levels, from neighborhoods to nations. Defining such a framework presents a significant challenge since social workers in health and mental health are deeply involved in efforts to improve the health status and care of whole populations - internationally, nationally, and locally – as well as with efforts to improve outcomes for individuals and families at the clinical level.

A number of outcomes related conceptual frameworks currently exist in health and mental health that social work can draw from in specification of social work outcomes. For example, the Australian National Health Information Management Group Working Party on Health Outcomes and Priorities developed an outcomes indicator framework that can be applied to specific health conditions and population groups (Australia Institute of Health and Welfare and Commonwealth Department of Health and Family Services, 1997). A similar framework has been developed by Statistics Canada and the Canadian Institute for Health Information (2001) in their Health Indicators project. Mrazek and Haggert (1994) outline a useful framework for considering mental health outcomes pertaining to prevention. Nevertheless many of these frameworks are specific to a particular national context or a specific aspect of health or mental health. Most importantly they are silent regarding social work's specific contributions to health and mental health outcomes.

Some argue against an outcomes measurement framework specific to social work. Critics say that health and mental health outcomes frameworks should be general, cutting across professional contributions. However, while social work shares many objectives with other healthcare professionals, social work does have special objectives and special emphases that need to be made explicit by framing objectives as well as outcomes indicators pertaining to those objectives. For example, whereas medical professionals may stress outcomes pertaining to disease states and outcomes indicators such as physiologic measures, social work is focused on quality of life objectives and outcomes. Most importantly there is great confusion in practice as well as in the literature about social work's objectives, intended outcomes, and ways of demonstrating the attainment of outcomes in health and mental healthcare. This confusion undermines the profession's capacity to speak clearly and convincingly about its contributions. Accordingly, the profession needs to establish some common understanding about objectives and outcomes, and this requires a broad conceptual framework as well as specialized frameworks applicable to specific areas of social work practice.

What Is Outcomes Measurement?

Although the topic of outcomes measurement attracts considerable attention in many countries, there is confusion regarding what is meant by the phrase "outcomes measurement". A common language pertaining to "outcomes" and "outcomes measurement" is missing. Moreover, as a profession social workers lack a common understanding of why we engage in outcomes measurement. As noted recently by Maloney and Chaiken (1999, p. 3): "An outcomes vocabulary has emerged in healthcare. However, there is no consensus to date on the best approach to defining and measuring outcomes." They continue, "Without a precise translation of the word outcome in its application to health-care, outcome means different things to different people." They observe that "… the definition used by one organization or person can vary significantly from that used by other groups or individuals. Most often outcomes are categorized according to the perspective of the users of the data ….” They cite differences among such users as managed care organizations (e.g., focusing on cost-effective service indicators), accrediting organizations (e.g., screening for early detection), clinicians (e.g., clinical results), and patients (e.g., health improvement, functional status, quality of life).

Donabedian (1981) defined health outcomes as changes in a patient’s current and future health status that can be attributed to antecedent health care. This definition is widely accepted within healthcare. In the report Australia’s Health 2000, health outcome is defined as “A health related change due to a preventive or clinical intervention or service. (The intervention may be single or multiple and the outcome may relate to a person, group or population or be partly or wholly due to the intervention)” (Australia Institute of Health and Welfare, 2000, p. 444). The British National Health Service describes outcomes as “The attributable effect of an intervention or its lack on a previous health state” (United Kingdom Clearing House on Health Outcomes, March 1997). Definitions of “outcomes” applicable to general public sector services are consistent with these health definitions. In the United States the Government Performance and Results Act of 1993 (1993, §1115) defines outcome as “…the results of a program activity compared to its intended purpose.” All of these references tie outcomes to identifiable, traceable interventions, at least in part.

Origins of Outcomes Measurement in Healthcare

Elsewhere we have reviewed the origins of outcomes measurement in the human services (Mullen & Magnabosco, 1997). In healthcare the interest in outcomes measurement was stimulated in the early 1980s when studies of healthcare interventions documented great variation in the use of specific types of medical interventions among practitioners, and that little was known about what caused the variation or the effectiveness of the interventions. As noted by the Agency for Healthcare Research and Quality (2000, § 2):

> --- researchers discovered that ‘geography is destiny.’ Time and again, studies documented that medical practices as commonplace as hysterectomy and hernia repair were performed much more frequently in some areas than in others, even when there were no differences in the underlying rates of disease. Furthermore, there was often no information about the end results for the patients who received a particular procedure, and few comparative studies to show which interventions were most effective.

In response to the recognition that evidence of effectiveness was lacking and wide variation existed in practice, it has now become widely accepted that outcomes measurement can be of benefit: (1) to clinicians and patients by providing evidence of benefits, risks, and results of interventions so that they are able to make more informed decisions; and, (2) to healthcare managers and purchasers, by providing information regarding effective interventions that can be used to improve the quality and value of healthcare (Agency for Healthcare Research and Quality, March 2000). The widespread emphasis on public accountability has moved outcomes measurement in many countries into the forefront. As noted by the Australia Institute of Health and Welfare and Commonwealth Department of Health and Family Services (1997, p. 3) concerning national health priority areas:

A changing focus of accountability in government, from inputs (for example, total expenditure) to outputs and outcomes, has led to an increasing emphasis on the measurement of activities and the impact that these activities have. In the health sector, this has seen a general shift in emphasis from a focus on service providers and inputs, to a system also incorporating a focus on outcomes and the consumer.

Dimensions of a Social Work Health and Mental Health Outcomes Measurement Framework

In the following I outline dimensions to be included in a health and mental health social work outcomes measurement framework. Such a framework should provide for outcomes measurement variation by: (1) system level; (2) geographical unit; (3) outcomes measurement questions asked; (4) effects sought across a continuum of possibilities; and, (5) purpose of the outcomes measurement program.

System Level

An outcomes framework should distinguish among system levels. Here the question is "What level of intervention is being examined?" In healthcare there are at least three levels: (1) clinical level involving outcomes of clinical interventions with specific individuals; (2) program level involving outcomes of a program or a program component on a population or a sample of a population; (3) system level involving outcomes of a health care system on a population or a sample of a population.

Geographical Unit

Geographical unit can further classify system level outcomes with possible units being: (1) local community or neighborhood where questions would address outcomes of a health system program on community residents; (2) municipality where questions would address health program outcomes on a municipality's population or subpopulation; (3) state, province, region or the like where questions would focus on even larger population aggregates; (4) nation in the case of questions regarding national health system outcomes; and, (5) sets of nations such as health system outcomes on World Health Organization or Organization for Economic Co-operation and Development member nations.

Question Asked

This outcomes measurement dimension pertains to the questions asked. There are at least five types of question: (1) efficacy - what are the outcomes, as measured under highly controlled conditions? - the ability of health care, at its best, to improve the patient's well-being and the degree to which this is achieved; (2) effectiveness – what are the outcomes, as measured in routine practice?; (3) efficiency – what is the greatest outcomes at the lowest costs; (4) quality – how good are the outcomes, as compared to some standard of desirability?; (5) equity – how fair are the outcomes, as distributed across groups according to some view of what is a fair share of benefits and burdens?

Of particular importance to a social work outcomes framework are questions of effectiveness and equity. Efficacy refers to outcomes examined in controlled trials removed from practice contexts, but effectiveness refers to outcomes found in the context of real world applications, the settings in which social workers function. Oftentimes what is found to be effective in controlled trials is found to be ineffective in natural settings unless additional environmental modifications are made. Social work has a special skill in addressing effectiveness questions involving real world applications. And, with social work's commitment to social justice, equity questions are directly relevant at all system levels.

Effects

Five types of effects relevant to health and mental health are described by Clancy and Eisenberg (1998): (1) mortality (e.g., infant death rate); (2) physiologic (e.g., blood pressure); (3) clinical events (e.g., stroke); (4) generic or specific health related quality of life measures of symptoms (e.g., difficulty breathing), of function (e.g., social adjustment or adaptation), and, of care experience (e.g., consumer survey); and, (5) composite measures of outcomes and time (e.g., quality-adjusted life years; potential years of life lost; disability adjusted life years; health-adjusted life expectancy). This is a particularly important dimension for social work in health care. As noted by Clancy and Eisenberg (1998, p. 245-6):

> "Clinical success has traditionally been appraised in terms of mortality, physiological measures such as blood pressure or diagnostic test results that are surrogates for physiologic function (such as laboratory tests, radiographic findings, or biopsy results), and definable clinical events. Clinical trials have produced these objective measures as their primary dependent variables. Seldom have patients' preferences for outcomes and risks of treatment been used to evaluate health services; they often have been perceived as important but subjective and unreliable. However, patients and clinicians must increasingly make decisions associated with different types of outcomes, such as length of survival, preservation of function, or pain relief."

Of special importance to social work Clancy and Eisenberg observe:

> "The dimensions of health and well-being that encompass consequences for the daily lives of individual patients are referred to as health-related quality of life (HRQL). Broad aspects of HRQL include health perceptions, symptoms, functioning, and patients' preferences and values. The sum of these constitutes a continuum of effects of health care services on health and well-being, ranging from mortality to patient satisfaction."

Social workers have special expertise and interest in measures of health related quality of life, such as symptoms, functional measures, and experiences with care including satisfaction and access. Mortality measures and composite measures, which address life quality as well as length of life, are of special pertinence to the formation of social work policy. Social work has special sensitivity to measures that take into account the preferences and perspectives of clients.

Purpose of Outcome Measurements

There are two equally important but very different purposes for doing outcomes measurement. The first is to support performance measurement and management. The second is to conduct outcomes research. Confusion has resulted when these differences of purpose have been ignored in outcomes measurement practice and in the literature.

Outcomes Research as a Purpose of Outcomes Measurement

Outcomes measurement can serve the purpose of outcomes research. In healthcare, outcomes research, like performance measurement, has as its purpose improving the quality of interventions and policies governing interventions. In outcomes research, applied social science research methods are typically used to enhance the validity of causal assertions regarding measured associations between interventions and outcomes whereas such methods may be less important in performance measurement. Outcomes research is conducted, not to improve the performance of individual programs directly, but rather to contribute to general knowledge about healthcare intervention outcomes. Consequently, with increased understanding of what works, policies and programs can be improved. The Agency for Healthcare Research and Quality (March 2000, § 1) has defined outcomes research as:

> Outcomes research seeks to understand the end results of particular health care practices and interventions. End results include effects that people experience and care about, such as change in the ability to function. In particular, for individuals with chronic conditions—where cure is not always possible—end results include quality of life as well as mortality. By linking the care people get to the outcomes they experience, outcomes research has become the key to developing better ways to monitor and improve the quality of care.

Two types of outcomes research are important in healthcare. One focuses on efficacy and effectiveness studies, which seek to establish the effects of specific healthcare interventions using social science research methods. The product of this line of research is seen in what is now called "evidence-based practice" and "practice guidelines". The second type of outcomes research in healthcare is the study of social indicators, but only when social indicators are used to assess and monitor health system performance at the population level. Also of importance is a third type of outcomes research, namely methodological research, which aims to develop measures for use in subsequent outcomes research.

Methodological research – developing measures

Methodological research aimed at developing measuring instruments has resulted in the production of a large number of measures that can be used in both outcomes research and performance measurement. These measures are readily available in print (e.g., Murphy, Plake, Impara, Spies, & Buros Institute of Mental Measures, 2002) and on the web (e.g., Agency for Healthcare Research and Quality, 1997). This area of outcomes research has been very productive yet much more needs to be done, especially pertaining to measures that are sensitive to cultural variations, consumer expectations and preferences, and quality of life measures.

Efficacy and effectiveness research

Outcomes research examining the efficacy and effectiveness of specific healthcare interventions has received considerable attention both in social work and in healthcare for some time. During the past two decades this area of research has been unusually productive. Accordingly, information regarding the effectiveness of a wide range of healthcare interventions is now readily available and much of this information is easily accessible on the web (e.g., Cochrane Collaboration, 2002). The Cochrane Collaboration has established a library available on the web that provides over one thousand systematic research syntheses (reviews) and over 800 protocols (proposed reviews in preparation) encompassing a large spectrum of health and mental health intervention and disease areas. The recently formed Campbell Collaboration, which is modeled on the Cochrane Collaboration, is especially relevant since it focuses on social work and social welfare intervention effectiveness research (as well as education and criminal justice research). A global network of Cochrane and Campbell collaborators are contributing to a database of randomized controlled trials and controlled clinical trials (C2-SPECTR) which now contains approximately 11,000 studies.

It is remarkable how productive this area of outcomes research has been in the last decade. Whereas no clear evidence was available about social work intervention effectiveness when my colleagues and I examined this in the early 1970s, much information is now available for use by policy makers, managers, clinicians, and consumers alike (Mullen, Dumpson & Associates, 1972). Perhaps because the evidence has mounted so recently little has yet found its way into everyday practice (Mullen & Bacon, 2003; Mullen & Bacon, this publication). Accordingly, transfer of this evidenced-based practice knowledge into clinical settings and into policy is a high priority.

Policy Research and monitoring.

Social indicators research designed to monitor health and mental health status as well as trends in status is an increasing significant type of outcomes research. The intent of this research is to inform policy as well as program decisions and directions. Social indicators research conducted to examine the effects of healthcare policies or programs on populations is a powerful application of outcomes research methods. Many outcomes measurement efforts at local, national, and international levels now include such policy research efforts under the rubric of outcomes measurement. For example the framework of health indicators for outcome-oriented policy making developed in the 1999 Occasional Paper issued by the Organisation for Economic Co-operation and Development (OECD) on health outcomes in OECD countries includes social indicators in its definition of outcomes research. The OECD report states: "Given that the primary objective of health policy is to improve the health status in a population, health status indicators are included under the umbrella of health outcomes to describe the level of health and the variations across countries and over time" (Jee and Or, 1999, p. 12).

The OECD framework identifies outcome-oriented policy making health indicators for four measures of health status: (1) mortality (e.g., life expectancy, infant mortality, standardized causes of mortality rates, premature mortality – potential years of life lost); (2) general and disease specific morbidity and quality of life (e.g., perceived health status; measures of impairment, disability, and handicap; multi-dimensional health status measures such as the SF-36, EuroQol, and Health Utility Index; prevalence and incidence of specific diseases); (3) composite health measures of mortality and morbidity (e.g., disability-free life expectancy; health-adjusted life expectancy; disability-adjusted life years).

Another example of social indicators health research is found in the human development reports issued annually since 1990 by the United Nations Development Programme (UNDP). The Human Development Report 2000 uses four composite indices to measure different dimensions of human development, which are of significance to health and mental health (Human Development Index, Gender-related Development Index, Human Poverty Index for Developing Countries; Human Poverty Index for Industrialized Countries). As noted in the UNDP report "tracking changes in outcomes is the focus of the human development indices" (United Nations Development Programme, 2000, p.99). To assess the adequacy of progress in achieving outcomes the report calls for benchmarking so that countries set specific, time-bound targets for making progress toward achieving publicly stated outcome goals. This is an excellent example of using outcomes measurement for policy research purposes.

Performance Measurement

Outcomes measurement is used to measure the performance of single programs or systems, not comparing the performance with that of other programs or systems. Also, outcomes measurement can be used to compare program or system performance with other programs or systems of like kind.

Non-comparative performance measurement.

Outcomes measurement is widely used in both the public and private sectors to examine the performance of individual health and mental health systems and programs. The information resulting from performance measurement is used for system and program improvement. Performance measurement typically includes the regular collection and reporting of information about the efficiency, quality, and effectiveness of programs. The widespread use of performance measurement, especially in public sector programs, marks a shift from the traditional focus on inputs or resources used and processes or program activities, to outcomes, or what is being accomplished. Martin and Kettner (1996) outline a comprehensive performance measurement model in which outcomes are key to what are called effectiveness measures where effectiveness is defined as the ratio of results, accomplishments, or impacts (outcomes) to resources consumed (inputs) as measured by cost per outcome, outcomes per full-time-equivalent employee, and outcomes per hour worked. As noted by Martin and Kettner, outcomes measurement for assessing program performance is rapidly becoming the expectation in governmental agencies and publicly funded programs. For example in the United States the Government Performance and Results Act of 1993 now requires that all federal departments report effectiveness (outcomes) performance data to Congress as part of the annual budget process. This legislation requires that all federal agencies set specific outcome objectives, identify outcomes indicators pertaining to those objectives, measure achievement of outcomes, and report results. It is expected that these results will then be used to set new objectives in a continuous year-to-year process of improvement.

When used in performance measurement, outcomes measurement is usually incorporated into a continuous quality improvement process. Performance frameworks incorporating outcomes measurement have been promulgated for some time by organizations such as the European Foundation for Quality Management. The Foundation's EFQM Excellence Model (©EFQM) places results and outcomes measurement center stage. The model is promulgated by a number of European governments. For instances in the United Kingdom Cabinet report "Getting it Together: A Guide to Public Schemes and the Delivery of Public Services" (United Kingdom Cabinet Report, 2000) the EFQM model is explicitly promoted for public sector organizations as part of the Modernizing Government programme. This report presents a comprehensive guide to quality schemes relevant to public sector policies and programs with particular reference to health and education. The report promotes other quality schemes as well including Investors in People, Charter Mark, and ISO 9000. These schemes are promoted as a way to help the public sector deliver Modernizing Government policy, including improved outcomes.

Another example of the use of outcomes measurement to assess performance is illustrated in the report of the Organization for Economic Cooperation and Development (OECD) examining performance measurement in OECD country health systems (Hurst & Jee-Hughes, 2001). The OECD paper places outcomes measurement at the center of the performance measurement and management cycle. This cycle begins with the health care system and an assumption that improvements in this system are desired. In the next phase in the cycle, conceptualization and measurement of performance including outcomes, specific intended outcomes would be identified and outcomes indicators would be specified for measurement. The third phase is an analysis of the outcomes indicator data that is collected and comparison of the data with intended objectives. Action to improve the health system based on the analysis of performance data is the final step in the cycle. The OECD paper defines health system performance as the extent to which the system is meeting established objectives.

The OECD report notes:

There is mounting pressure on health systems to improve their performance. Technological advances and rising consumer expectations continue to raise demand. There is also growing concern about medical errors. Meanwhile, both public and private funders continue to strive to contain costs and control supply. Consequently, there is an intensification of the search for improvement in value for money. …. The result is widespread interest in the explicit measurement of the 'performance' of health systems, embracing quality, efficiency and equity goals and in influencing or managing performance (Hurst & Jee-Hughes, 2001, p. 8).

According to the OECD report 12 member countries are developing performance frameworks and indicators for the country's health care systems.

Comparative performance measurement.

Typically performance measurement schemes are used to examine how well a program is doing relative to some internal criteria, such as baseline performance, or in relation to a desired level of performance. Outcomes measurement can also be used in a process of comparative performance measurement (CPM). In CPM the questions are: "how well is a program performing relative to other similar programs?"; Is a program's performance among the best of its kind or among the worst of its kind?" CPM can be used to identify which programs are among the best of their kind, and, in doing so, suggest best practices. As noted in an Urban Institute report, when applied to public sector and non-profit organizations such comparisons increase competition for limited resources and clientele (Morley, Bryant, & Hatry, 2001).

An example of comparative performance assessment in health and mental health is the United Kingdom's Best Value program (United Kingdom Office of the Deputy Prime Minister, 2002). In the United Kingdom comparative performance assessment is an integral component of the national Modernizing Government initiative. The UK's Best Value regime, a part of that initiative which is applicable to all parts of local government, requires that local councils compare their performance with other similar councils. In health and social services local authorities are required to measure and report on Best Value outcomes, that is, established performance targets and national standards. The Best Value program mandates that local councils seek continuous improvement in services with respect to cost and outcomes; disseminate Best Value performance plans for public comment; and implement regular performance reviews to raise standards and reduce costs. The UK National Health Service Plan stipulates that comparative performance improvement be supported by a new system of targets and incentives (United Kingdom National Health Service, 2000).

A second example of comparative performance measurement in the public sector is the Comparative Performance Measurement Program of the International City/County Management Association (ICMA) based in Canada and the United States (International City/County Management Association, 2002). Through this program, the ICMA assists local governments in measuring, comparing, and improving municipal service delivery. In keeping with the goals of comparative performance measurement, this program provides a means for local governments to share data on a range of programs, benchmark their performance to comparable jurisdictions, and improve service delivery through the application of best management practices and efficient use of resources.

An important example of comparative performance assessment is found in the World Health Organization (WHO) publication "The World Health Report 2000". This report assesses and compares national health system performance among its 191 member countries. A number of performance measures are used to report on each country's absolute performance. The WHO report argues that it is achievement relative to resources that is the critical measure of a health system's performance. By matching countries with similar resources allocated to healthcare, the WHO calculates potential. In addressing the question of how well health systems perform the WHO report states:

> "Assessing how well a health system does its job requires dealing with two large questions. The first is how to measure the outcomes of interest – that is, to determine what is achieved with respect to the three objectives of good health, responsiveness and fair finan-

> cial contribution (attainment). The second is how to compare those attainments with what the system should be able to accomplish – that is, the best that could be achieved with the same resources (performance)." (p. 23)

Accordingly, to assess relative performance the WHO calculated an upper limit or performance “frontier”, corresponding to the most that could be expected of a health system. As the report notes:

> "This frontier – derived using information from many countries but with a specific value for each country – represents the level of attainment which a health system might achieve, but which no country surpasses. At the other extreme, a lower boundary needs to be defined for the least that could be demanded of the health system. With this scale it is possible to see how much of this potential has been realized. In other words, comparing actual attainment with potential shows how far from its own frontier of maximal performance is each country’s health system." (p. 41)

Comparative performance assessment is a powerful use of outcomes measurement. It is through comparison that explanations for important differences in performance emerge. For example, because of the comparative approach taken in the WHO analysis, the authors were able to draw the following conclusion.

This report asserts that the differing degrees of efficiency with which health systems organize and finance themselves, and react to the needs of their populations, explain much of the widening gap in death rates between the rich and poor, in countries and between countries, around the world. Even among countries with similar income levels, there are unacceptably large variations in health outcomes. The report finds that inequalities in life expectancy persist, and are strongly associated with socioeconomic class, even in countries that enjoy an average of quite good health. Furthermore the gap between rich and poor widens when life expectancy is divided into years in good health and years of disability. In effect, the poor not only have shorter lives than the non-poor, (but) a bigger part of their lifetime is surrendered to disability. (p. 2)

Conclusion

Social work has an important contribution to make to the performance of health systems worldwide, a contribution at all system levels, ranging from clinical services to policy and system shaping at national and international levels. However, documentation of those contributions is required. At the clinical level the profession must move rapidly toward evidence based practice models (Mullen, 2002a & 2002b – this publication), adopting practice guidelines that have empirical support (Mullen & Bacon, 2003; Mullen & Bacon, this publication), derived from outcomes research. Social work research can contribute to the development of validated practice guidelines and system and policy relevant indicator systems. Outcomes measurement, guided by clearly articulated conceptual frameworks, can strengthen social works' voice in health and mental healthcare. A framework oriented to social work outcomes should highlight the specific contributions that the profession intends to make to individuals, families, and communities -- in addition to its contributions to system performance and knowledge development. These outcomes can be planned in partnership with other health and mental healthcare stakeholders, including potential recipients of care. A clearly defined framework will enhance our ability to communicate about outcomes with clarity. Transparency of objectives and intended outcomes will strengthen the profession's position in increasingly skeptical national debates about best value in health and mental health.

My purpose has been to urge the social work profession to adopt an outcomes-oriented view. I have said that an outcomes-oriented approach to social work policy and practice is necessary if the profession is to make the contribution to health and mental health that it has the potential to make. However, I have concluded that we cannot move toward an outcomes-oriented approach unless we think clearly about what we mean by outcomes, and how outcomes can be measured, so that the data gathered is relevant to social work purposes. I have argued for a conceptual framework pertaining to outcomes measurement in social work in health and mental health that incorporates four key dimensions: the purpose for conducting outcomes measurement; the system level wherein outcomes measurement is to be applied; the questions asked in outcomes measurement; and, the continuum of effects included in the measurements.

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3 PRACTICE GUIDELINES – DEVELOPMENT, EXPERIENCES AND IMPACT

The two papers in this section address the use of guides in social work practice. The first paper was prepared for the United Kingdom Social Care Institute for Excellence (SCIE) and it addresses SCIE's efforts to develop practice guidelines. The second paper examines the challenges associated with practitioner adoption and implementation of evidence-based effective treatments and issues of quality control. Issues such as how social work practitioners might react to and use evidence-based statements about effective treatment are addressed. The papers explore the technologies needed to assist practitioners in identification and use of evidence-based treatments and address the challenge of applying these to individual case situations. Also explored are extant research as well as Edward Mullen's earlier work on personal practice model development, that attempted to place individual practice models in the context of professional function and mission, professional and personal values and ethics, theory, and experience. Questions regarding quality control are identified and discussed. In addition, the second paper summarizes results from a survey of practitioners about awareness of and attitudes about standards of care, including preference for use of intervention knowledge statements developed through expert consensus and through empirical research findings.

The Impact of Guides on Practice and the Quality of Services

I would like to thank the Social Care Institute for Excellence (SCIE) and especially, the SCIE Director of Research and Dissemination, Professor Mike Fisher, for the invitation to spend a week with SCIE learning about SCIE's best practice guide program, as well as the invitation to present this seminar. I note that Mike has framed this as a seminar rather than a lecture, so I will be somewhat informal and I will look forward to the discussion.

One of the benefits of my age is that I have had the opportunity to learn a good bit from my experiences in social research and practice over the past forty years. I try not to get too stuck in those experiences, but use whatever I can to shed light on current issues. Accordingly, I would like to begin with some reflections on lessons I have learned that I think have some relevance to evaluating the impact of guides on practice and the quality of care.

Lessons from past research experiences

Social Experimentation of the 1960's and 1970's

In the late 1960's and early 1970's I was associated with and became director of the Institute of Welfare Research at the Community Service Society of New York, a very large and resourceful voluntary social care agency. The Institute was engaged in both policy and practice research. During the time of my directorship the United States had just emerged from the so-called "War on Poverty", a period during which social problems and social programs had high visibility. There was an unprecedented flurry of social experimentation and the Institute was in the middle of this experimentation in social work. For example, a study I directed sought to demonstrate that an intensive investment in social service provision to newly financially dependent families could prevent chronic dependency (Mullen, Chazin, and Feldstein, 1972). Another study tested the idea that time-limited short-term, sharply focused counselling services for families experiencing relationship problems could have better results than more traditional open-ended services (Reid and Shyne, 1969). For the most part these social experiments were built upon assumptions rather than data about what might work in practice. After a period of extensive investment in measurement development and carefully designed field experiments the findings from these studies were disappointing. The effects observed were typically nil, or small, or, at times negative. With James Dumpson and others (Mullen, Dumpson and Associates, 1972), I reported these results together with the results of all other social intervention experiments conducted up to that time in social work in a book titled Evaluation of Social Intervention. There are four lasting impressions that have remained with me from those days.

- First, even the most firmly held assumptions about valued social interventions must be tested, before exposing users or investing valuable resources that might be used better elsewhere.
- Second, rigorous and expensive evaluation research studies can produce results that in the long run save money and lives.
- Third, in retrospect one of the faults of the social interventions evaluated was the failure of program designers to build upon prior research findings regarding the characteristics, needs, and preferences of users; organizational dimensions of interventions; and effectiveness research. And, these interventions were evaluated out-of-context and without reference to a research and development process.
- Fourth, it became clear that schools of social work were not preparing professionals for effective practice. Educational reform was needed. Essentially, these studies were putting the graduates of social work education programs to the test.

Educational reform in the 1970's and 1980's

For the next decade, from 1876 through 1986, I turned my attention to one aspect of that educational reform, namely developing a method whereby social work students and practitioners might become more critical users of knowledge to guide their practice decision making. With funding from the Ittleson Foundation I formed a group at the University of Chicago focused on developing methods for enhancing knowledge use by social work graduate students so that they might provide more relevant and effective services to users. This work resulted in what came to be known as Personal Practice Model Development (Mullen, 1978, 1981, 1983).

A number of things were learned during this period of educational reform.

- We learned that social workers need to be trained to critically use best evidence to make decisions about care.
- We learned that these decisions need to be integrated with the practitioner's clinical expertise and user values, preferences , and needs.
- We came to understand that knowledge of relevance to practice decision-making comes in many forms including findings from research , assumptions and explanations provided by theory, information gained from past experiences of individual practitioners as well as collective professional experience, regulatory frameworks, values, ethics and user and carer expectations and values.
- We learned that practice decision-making is a complex and challenging process not easily described as based on only one source.
- Accordingly, we concluded that what was needed was a training program that prepared practitioners to engage in the complex task of individualizing practice decisions using explicit, well informed, value-based practice models. This approach was in marked contrast to the prevailing teaching methods which stressed learning of one or two approaches to practice that had been handed down from prior generations, applied across the board to nearly every user coming for service.

Practice and research partnerships in the 1990's and early 2002's

More recent experiences have also provided some useful lessons pertinent to today’s topic. For the past ten years I have directed a research centre at Columbia University in New York City, the Center for the Study of Social

Work Practice. The Centre's mission is to bridge the gap between practice and research by engaging in research studies which are valued by both academics and agency-based practitioners. Because the Centre has a substantial endowment it can pursue this agenda with some degree of freedom and flexibility. And, because it is co-sponsored by a research oriented academic institution, Columbia University, and the largest private, non-profit mental health/social service agency in the United States, the Jewish Board of Family and Children's Services, we have been provided with ample opportunity to engage in a wide range of practice and policy relevant research. The co-sponsoring practice organization is a comprehensive agency that serves over 54,000 New Yorkers annually from all religious, ethnic, and economic backgrounds through 140 community-based programs, clinics, residential facilities, and day-treatment centers. It employs 1,400 staff including professional social workers, licensed psychologists, and psychiatrists, as well as a cadre of clinical support personnel in continuing day treatment and residential treatment centers. In addition approximately 1,700 volunteers provide services.

I take three key lessons from this experience that I think are of importance to this seminar's topic.

- First, it has been most difficult to bridge the gap between the world's of research and of social care policy and practice. I have found no one way to create productive, happy and enduring practice & research partnerships. Rather, what has worked best has been the creation of a stable infrastructure that creates an expectation of partnership, facilitates the implementation of partnerships, and, which holds every potential research question to the test of practice or policy relevance. Some of this experience was described in a book edited by Hess and me in 1995 in which we described some of the more promising partnership experiences and why we thought they worked (Hess and Mullen, 1995).
- A second lesson is that outcomes matter. For many reasons that I do not need to elaborate here, both in North America as well as in the United Kingdom, health and social programs are now required to provide evidence of effectiveness. Gone are the days when policies and programs can stand without evidence of value for cost. Our book on outcomes measurement in the human services provides much detail regarding the forms of outcomes measurement that we have found useful (Mullen and Magnabosco, 1997).
- A third lesson is that it is dangerous to proceed in research (or for that matter in policy or program development) without acquiring good evidence about what actually occurs in practice. What is assumed about what practitioners do as well as what users and carers experience is oftentimes off the mark. Let me pro-

vide one example of this, one that is pertinent to this seminars topic: Recently, we were interested in proposing research regarding the use of practice guidelines at this partner organization. We wondered to what extent the organization's staff was aware of practice guidelines. We also wondered what sources the staff used to access new knowledge pertaining to practice decision-making. We wondered to what extent research findings were used to inform practice decisions. We thought that since this organization was noted for the high quality of its mental health and social services, and since its staff was graduate trained there would be a high level of knowledge-use occurring among practitioners pertaining to practice decision making. However, because we wanted to establish a baseline we decided to survey the staff to gather information about these questions. What we found was not what we had expected to find. The findings are being reported in a forthcoming publication and the following is adapted from that publication (Mullen & Bacon, 2003 – in this publication; Mullen & Bacon, 2004). The three professions represented in the survey were strikingly different in their knowledge of practice guidelines, use of the literature, and use of research findings for practice decision making. Psychiatrists appeared to be relatively well informed about relevant practice guidelines, whereas social workers were poorly informed, typically not even aware of the meaning of practice guidelines. Psychologists were somewhere in between. Once social workers were told what practice guidelines are, they generally reported openness to their use. However, when practitioners were asked whether they would prefer guidelines that represented research evidence or those that represented professional consensus, the social workers stated a preference for guidelines based on professional consensus. This contrasts with the views of the psychiatrists and psychologists, who more strongly valued guidelines based on research evidence. The social workers' apparent devaluing of research evidence as a basis for practice guidelines was consistent with their reported attitudes toward research in general. Consistent with previous research, the social workers we surveyed reported low levels of utilizing research findings or research methods for practice decision making. Psychiatrists and to a lesser extent psychologists reported regularly using research-based findings and methods of assessment. Many social workers did not read the research literature or even other professional literature. Psychiatrists read this literature frequently. So where do social workers turn for guidance on practice issues? We found that social workers were heavy users of consultation, much more so

> than the other professionals who functioned more autonomously. Social workers reported frequently seeking guidance and direction from supervisors and other consultants who were viewed as repositories of knowledge based on experience and spokespersons for organizational policy. Based on these findings we drew some important conclusions that I think may be of relevance to efforts directed at providing support to social work or social care practitioners so as to enhance the quality of the information used in practice decision making. Given the low use of research methods and infrequent reading of professional literature it is not likely that social work practitioners will be influenced significantly through these routes. Rather, supervisors, consultants, and teams seem to be the most promising conduit for knowledge dissemination in organizations such as the one represented in this survey, regarding practice guides and other forms of evidence-based practice for social workers. My point with this example is that it is dangerous to proceed in research (or for that matter in policy or program development) without acquiring good evidence about what actually occurs in practice. What is assumed about what practitioners do as well as what users and carers experience is oftentimes off the mark.

Implications of these experiences for SCIE's work on guidelines

Let me turn to the issues at hand, namely the impact of SCIE's practice guides on practice and the quality of services.

Placing SCIE's guidelines in the broader context of evidence-based practice, practice guidelines, outcomes and performance measurement

When I first learned of SCIE's practice guides I wondered where they fit within the framework of the current discussions regarding evidence based practice, practice guidelines, outcomes and performance measurement and other such terms. So let me comment briefly on what I have concluded in this regard.

Improving organizational performance

In the last ten years there has been an explosion of terminology all having to do with improving the quality, efficiency, effectiveness and outcomes of health, education and social care services. Ultimately, most of this has to do with enhancing the performance of service systems through some form of continuous quality improvement process. Examples are seen in the United States Government Performance and Results Act of 1993 (for a good account of the Act and the human services see Martin and Kettner,1996); and the UK Cabinet report Getting it Together: a Guide to Public Schemes and the Delivery of Public Services (United Kingdom National Health Service, 2000).

In the UK these schemes have been used in the public sector to deliver modernizing government policy. The Modernizing Government White Paper issued in March 1999 promoted policies to deliver outcomes that matter (United Kingdom, March 1999). Comparative performance measurement is an elaboration of performance measurement (Morley, Bryant, & Hatry, 2001). The United Kingdom's Best Value program is an example of comparative performance assessment. In social care the emphasis on performance is seen in the Care Standards Act 2000, the Quality in Social Care National Institutional Framework, the Social Care Quality Programme and the Quality Strategy for Social Care.

Systematic reviews of research

In this broader context of continuous quality improvement toward enhancing system performance, the place of systematic reviews of effectiveness research has grown in importance, such as seen in the Cochrane and Campbell Collaborations. Systematic reviews provide an important means to accumulate and assess the cumulative results of research pertaining to outcomes of health, education and social interventions. However, systematic reviews do not provide a direct linkage to practice prescriptions. This is because practice decisions need to be made on the basis of knowledge derived from not only scientific investigations, but also experience, values, preferences, and other considerations deliberated by providers, users, and carers within the constraints of available resources.

Clinical practice guidelines

To partially address the gap between the findings of systematic reviews of research and practice application, we have seen the widespread emergence of clinical practice guidelines. Professional organizations and government agencies have promulgated practice guidelines for various clinical conditions such as depression and schizophrenia. These guidelines prescribe how clinicians should assess and treat patients. Guidelines are now being promulgated in other areas of the human services such as child and family services. Sometimes the guidelines are based on research findings. Often research is not available and, therefore, the guidelines are based on professional consensus.

Evidence-based practice

Evidence-based practice seems to me to be a term that is increasingly used to capture ways in which all of these products and processes can be moved into practice. However, as I have described elsewhere (Mullen, 2002) evidence-based practice has taken on two rather different meanings. First, an evidence-based practice is considered any practice that has been established as effective through scientific research according to some set of explicit criteria. For example in 1998 a Robert Wood Johnson Foundation consensus panel concluded that research findings identify six evidence-based treatment practices for the treatment of persons with severe mental illness: assertive community treatment (ACT); supported employment; family psychoeducation; skills training and illness self-management; and, integrated dual-disorder treatment. To be considered an evidence-based practice four selection criteria were used: the treatment practices had been standardized through manuals or guidelines; evaluated with controlled research designs; through the use of objective measures important outcomes were demonstrated; and, the research was conducted by different research teams. Accordingly, we can say that evidence-based practices or best-practices were identified for the treatment of persons with severe mental illness through efficacy trials meeting these four criteria.

In contrast to this usage of the phrase evidence-based practice a second popular meaning is the one often attributed to David Sackett who in 1996 described evidence-based medicine as “ --- the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.” (Sackett, 1996, 71) Subsequently, Sackett notes that evidence-based medicine is the "integration of best research evidence with clinical expertise and patient values" (Sackett 2000, 1). In this second meaning evidence-based practice is a decision-making process in which judgments are made on a case-by-case basis using best-evidence.

SCIE’s guides

It is in this context of evidence-based practice that SCIE’s best practice guides seem to me to fit. As I understand these guides they are designed to provide information to practitioners that will support the practitioner’s decision making, yet they do not present prescriptions for assessment or intervention. Accordingly, it is possible that they will be found useful by practitioners, individually and in teams. If they are found useful such best practice guides would be an important resource for improving the quality of social care services. However, since they are a new approach to providing information to support best practices their value cannot be assumed without careful evaluation. If through an evaluation process best practice guides can be refined and strengthened they hold considerable promise for supporting practitioners engaging in evidence-based practice.

My consultations this week at SCIE have underscored the importance of the work that SCIE is engaged in today. I am struck by how much has been accomplished in just over a year. This is even more impressive when considering that so little systematic attention has been given in the past to improving the use of knowledge in social care around the world. Furthermore, I am aware of no other national centre focused on the question of the character of knowledge in social care, how that knowledge is distinct from knowledge in other areas of practice, and how best to facilitate knowledge use for quality outcomes that are important to users and carers. Those of us in other countries will be watching developments at SCIE over the next several years since SCIE is clearly grappling with issues of international importance to the social care field.

I see SCIE's practice guides as the embodiment of much of what SCIE is about. While much work occurs at SCIE in the areas of information gathering, information synthesis and promoting the development of new knowledge, ultimately the test of all of this must be formed into some product that can be disseminate and used in practice so as to facilitate quality outcomes. Whether these products are called "best practice guides", or more simply "practice guides", or "guidelines" is a matter of what SCIE determines it wants to communicate to potential users.

Suggestions for evaluation of SCIE's guides

Because of the importance of these guides as a key expression of what SCIE hopes to achieve and its performance judged by, it is important that they be carefully developed, re-developed, disseminated, and evaluated. And, because there is bound to be uncertainty about what form they should take and how they can be delivered to maximize their use and benefit, their evaluation will need to be structured so as to enhance their refinement and reshaping in light of what is learned. Accordingly, I see the evaluation as needing to be cyclical and ongoing, providing for feedback and redesign.

It also strikes me that there is an important question to be raised about what the evaluation should examine, or what is the object of study, so to speak. Is the guide the content of what appears on the computer screen? If this is the guide then what is being evaluated is akin to an electronic book that is distributed to a range of users. Or, is it SCIE's intent to establish a learning environment or process in which the guide content is only a part? I expect the answer is that SCIE's intent here is to create a more knowledgeable group or team of social care practitioners and that the entity to be evaluated is not the guide itself, but rather processes associated with using the guide in teams of providers embedded in organizations that support learning. If this is the case then an evaluation that focuses too narrowly on the electronic guide as product and object of evaluation would be of little use. Rather, what would be needed would be an evaluation that examines the processes and contexts of guide use as viewed through a systemic, contextual, organizational lens. This may sound like a lot of jargon, but I think the distinctions are important to the character of the evaluation that is undertaken and to what can be learned from the evaluation.

Another important question to be examined in future evaluations pertains to the level of prescription provided in guides. I don't think this is a settled issue, so information collected in an evaluation will need to be gathered so as to help answer this question. In America, and I gather in the UK as well, we have seen a remarkable growth in the development of highly prescriptive statements called "practice guidelines", such as generated in the United States by the Agency for Health Care Research and Quality, the American Psychiatric Association, and many other research and standard setting bodies. In the UK such guidelines have been generated by NICE as seen in the schizophrenia guidelines recently disseminated. In contrast the two guides disseminated by SCIE seem purposively to have avoided prescription of this sort. I think there are important questions to be examined in an evaluation pertaining to the benefits and harms associated with varying levels of prescription in social care guides. At one extreme one could ask why guides would not prescribe when the knowledge supporting a specific course of action is firm. Is it just and ethical to leave to discretion what has been clearly demonstrated to be the proper course of action?

However, a counterargument is that no matter how firm the research evidence, practitioners operate in specific contexts with individual users, and need to use judgment and discretion as they apply knowledge. Accordingly, the danger of prescriptive guidelines is that they will mechanize social care, stripping it of necessary professional judgment and discretion. Furthermore, if knowledge is to be applied in organizational contexts and in individualized situations, the idea of practice guidelines of general applicability would be misleading. The bottom line here is that I think an evaluation of SCIE's guides will need to grapple with this question empirically as well as conceptually.

A related but somewhat different sort of question has to do with what is very popular now in America, namely "translational research". I gather this term is used in the UK as well, but perhaps not yet so much in social care. Essentially, this distinction has to do with how confident we can be generalizing from research findings that emanate from studies conducted in highly controlled settings to what might happen in messy real world situations. In

America priority in health and mental health research is shifting toward translational research under initiatives often labeled with terms such as moving research into practice. The idea of translational research is related to the issues I raised about how prescriptive guides should be, because oftentimes the research supporting practice guidelines has been conducted in controlled studies that may be of questionable external validity, or of unknown real world validity. Can such guidelines be faithfully implemented in real world social care organizations? If so, will the outcomes be the same? It seems to me that an evaluation of SCIE guides would do well to find ways of addressing this issue.

Because of these and other important questions it seems to me that SCIE's evaluation of its practice guides will need to tackle a number of important questions, sequentially and methodologically, over a two to three year period. Using what we are referring to in America as a social intervention research framework, or what you may be calling a developmental framework, it is important to begin evaluating current guides so that they can be redesigned and improved based on feedback from those using the guides. This would include a range of methods to gain information about experiences with accessibility and use by a limited number of partner organizations. Based on this information the two current guides will need to be redesigned and future guides will need to be built upon what has been learned. The next set of questions will need to address generalizability across a larger number of social care providers operating in diverse contexts taking into account complexities of how the guides are integrated into complex decision-making processes. Based on these evaluations, I expect that previous guides will need to be redesigned and those on the drawing boards will need to take account of this new information. Of course, the most important questions must await a third and final evaluation phase, that is questions addressing the troubling "so what" area. Here the evaluation will need to probe into questions of the extent to which use of the guides has resulted in both positive and negative change and impact on users in ways that affect valued outcomes. Because SCIE will be heavily invested in finding desirable outcomes, this third phase evaluation will need to be reasonably well controlled, with structured checks and balances to assure a measure of objectivity. And, of course the ultimate questions will have to do with cost and benefit. If the guides are found to produce large impacts at small cost this would be a happy finding for all concerned. But, if as has typically been found in the past the outcomes are small to modest, and the costs are substantial, then an argument will need to be made that the outcomes are durable and that even small gains can, over time, accumulate so as to justify the costs.

Because there are many unanswered questions about the use of guides in practice I think that it is important for SCIE to not only develop practice guides for social care, but also to make sure that the guides are evaluated so as to gain information about access, use, and changes brought about by the guides pertaining to attitudes, practice behaviors, organizational processes and structures and impact on users.

Thank you for your attention and I look forward to a lively debate about these and other issues that I may have overlooked and should have identified.

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Practitioner Adoption and Implementation of Evidence-based Effective Treatments and Issues of Quality Control

Edward J Mullen and W F Bacon

Prologue

Recently we overheard a clinician complaining that New York State had announced a practice guideline for the treatment of autism. The clinician was unhappy because the guideline proposed an approach to treatment that she did not favor. Her assessment was that the guideline had been endorsed because the method it proposed had research support whereas her favored approach had not been empirically evaluated. She believed that she would be forced to use the guideline since her social agency would require practitioner conformity. She believed the agency would not be reimbursed by the state unless the proposed treatment method was used. With such strong negative feelings toward the guideline we wondered how likely it would be that she would implement the new guideline even if adopted by the agency.

This example raises a number of issues pertaining to practitioner use of practice guidelines. First, the typical practitioner has an established approach to practice, or style if you like. Each practitioner's style has been molded by a complex combination of personal attitudes, preferences, beliefs, training and experience. Simply publishing a new practice guideline is not likely to affect such a practitioner's work with his or her clients.

Second, assuming that a practitioner is open to using a new guideline, additional knowledge and skill will be required to effectively use the guideline. How will such knowledge and skill be provided, especially in social agencies with limited resources where time for anything but essential services is in short supply?

Third, how can practitioners weigh and draw conclusions about the relative merits of alternative interventions when some have been empirically evaluated and others have not been empirically evaluated? While interventions that have been put to the empirical test and have failed that test provide the practitioner with some reason to abandon a favored approach, in the majority of cases such negative evidence is absent. Practitioners may wonder why they should abandon an approach that has not been shown to be ineffective simply because another approach has some degree of research support.

Fourth, the very notion of guidelines for the treatment of particular disorders may not sit well with some social work practitioners. While Thyler (this volume) is no doubt correct in his contention that disorder-based categorizations do not necessarily assume a medical, biologically oriented model of causation, such categorizations certainly do encourage a view of treatment as symptom reduction. Social workers may be inclined to think of their clients more broadly, perhaps in terms of general outcomes to be achieved, as suggested by Proctor and Rosen (this volume). The outcomes selected as targets of change may have rather little dependence on diagnostic category.

Finally, in complex social agencies how can guidelines best be disseminated, critically assessed and sustained among a diverse group of practitioners with varying perspectives and often from different professional groups?

This paper addresses the topic of practice guidelines in the context of evidence-based practice. The focus is on practitioners.

Introduction

Central to implementation of evidence-based effective treatments is the use of practice guidelines. This paper addresses the use of practice guidelines by social work practitioners. Clinical practice guidelines have been described by the Institute of Medicine as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances” (Field & Lohr, 1990). For at least a decade professional organizations and governmental agencies have formulated practice guidelines for various clinical conditions such as depression and schizophrenia (American Academy of Child and Adolescent Psychiatry, 1994; American Psychiatric Association, 1993, 1994, 1997; United States Preventive Services Task Force, 1994). These guidelines prescribe how clinicians should assess and treat clients. Sometimes the guidelines are based on research findings. Often research is not available and, therefore, the guidelines are based on professional consensus. While the past decade has witnessed a marked growth in the production and dissemination of practice guidelines in medicine, psychiatry and psychology, until recently there has been little attention given to practice guideline development and use by social workers and social agencies. How relevant are these guidelines to the functions of social work practitioners and social agencies? Are additional guidelines needed which are of specific relevance to social work practitioners? How might social work practitioners react to and use, externally as well as internally developed guidelines? What technologies are needed to assist practitioners in identification and responsible use of practice guidelines? Furthermore, since most currently available guidelines are general statements intended to guide practice, how can social work practitioners apply such broad guidelines in individual case situations?

How will the move toward practice guidelines impact on professional boundaries and shape the functions of social work practitioners and social agencies? In organizations where practitioners from different mental health professions work together will practice guidelines developed by one professional group dominate the work of allied professional groups? Which professional groups will be knowledgeable about and disposed to use practice guidelines and which will not? What effect might these varying attitudes have on practice? What do we know about how social agencies and social work practitioners are responding to the move toward practice guidelines?

Although practice guidelines have been promoted for several decades in medicine and psychology (see Howard & Jenson, this volume), little has been written about practice guidelines in the social work literature. The May 1999 issue of Research on Social Work Practice, which has a special section on practice guidelines and clinical social work, is a notable exception (Howard & Jenson, 1999a, 1999b; Jackson, 1999; Kirk, 1999; Richey & Roffman, 1999; Steketee, 1999; Wambach, Haynes & White, 1999; Williams & Lanigan, 1999). The articles in this section address many important aspects of practice guidelines but the authors are relatively silent on the question of how agencies and practitioners view this development. A review of the literature beyond social work journals indicates that little has been written about the practitioners' views. Little is known about the use of guidelines in social work practice and how social worker practitioners view the use of guidelines.

Agency practitioner survey

Because of this lack of information about the practitioners' views we conducted a practitioner survey regarding practice guidelines. The survey respondents were from a large, urban voluntary mental health/social service agency noted for the high quality of its services and training programs. This agency offers a continuum of mental health and social services, both residential and community-based. Masters level social workers are the primary providers of service although the staff is multidisciplinary including psychologist, psychiatrists and other mental health professionals. This agency employs approximately 500 direct service professionals.

The survey examines practitioner awareness of practice guidelines, specification of guidelines known about and used by individual practitioners; practitioner attitudes toward the use of guidelines, and their preferences for guidelines based on expert consensus and/or based on empirical research findings. Because we assumed that some practitioners would be unfamiliar with what we meant by practice guidelines the survey included the following explanatory text: "Recently professional organizations and government agencies have promulgated practice guidelines for various clinical conditions such as depression and schizophrenia. These guidelines prescribe how clinicians should assess and treat patients. Guidelines are now being promulgated in other areas of the human services such as child and family services. Sometimes the guidelines are based on research findings. Often research is not available and, therefore, the guidelines are based on professional consensus. We are interested in your views regarding this development."

Based on the findings of this survey additional research is being conducted pertaining to these questions with a national sample of social work mental health practitioners who are members of NASW (n=150 drawn from a random sample provided by NASW of 1,000 practitioners). These surveys and their findings are presented in Mullen and Bacon (1999) and Engstrom, Fletcher, Gangwich, Bacon, Borges and Mullen (forthcoming). Relevant conclusions and implications for the development and use of practice guidelines are summarized next.

Viewed from the perspective of how practitioners working in organizations such as the one surveyed in this study view practice guidelines and other aspects of evidence-based practice we draw a number of conclusions.

The three mental health professions represented in the Mullen and Bacon (1999) survey were strikingly different in their knowledge of practice guidelines. Psychiatrists appeared to be relatively well informed about relevant practice guidelines, whereas social workers were poorly informed, typically not even aware of the meaning of practice guidelines. Psychologists were somewhere in between.

Once social workers were told what practice guidelines are, they generally reported an openness to their use. However, when practitioners were asked whether they would prefer guidelines that represented research evidence or those that represented professional consensus, the social workers stated a preference for guidelines based on professional consensus. This contrasts with the views of the other practitioners, who more strongly valued guidelines based on research evidence.

The social workers' apparent devaluing of research evidence as a basis for practice guidelines was consistent with their reported attitudes toward research in general. Consistent with previous research, the social workers surveyed by Mullen and Bacon (1999) reported low levels of utilizing research findings or research methods in their practices. Psychiatrists and to a lesser extent psychologists reported regularly using research-based findings and methods of assessment. Many social workers did not read the research literature or even other professional literature. Psychiatrists read this literature frequently.

So where do social workers turn for guidance on practice issues? Mullen and Bacon (1999) found that social workers were heavy users of consultation, much more so than the other professionals who functioned more autonomously. Social workers reported frequently seeking guidance and direction from supervisors and other consultants who are viewed as repositories of knowledge based on experience and spokespersons for organizational policy.

Given the low use of research methods and infrequent reading of professional literature it is not likely that social work practitioners will be influenced significantly through these routes. Rather, supervisors and consultants seem to be the most promising conduit for knowledge regarding practice guidelines and other forms of evidence-based practice for social workers.

A subgroup of the surveyed social work practitioners deviated from this norm, appearing to function more autonomously through behaviors more like those of the psychiatrists in the sample. These social workers expressed preference for evidence-based guidelines and they reported higher frequencies of reading research articles and professional publications. It is likely that they use supervisors and consultants differently as well. This subgroup of research-oriented social workers may be important resources for dissemination of evidence-based practice knowledge within social work organizations. It is likely that their training has provided them with research skills of relevance to practice.

These findings have implications for technologies needed to assist practitioners in identification and use of evidence-based practice guidelines; for quality control and accountability; and, for education. The remainder of this paper addresses these implications.

A Technology for Adapting Practice Guidelines to Social Work Practice

The first author's earlier work on personal practice model development (PPMD) proposed a process for individual practitioner use so that broad summary generalizations and practice guidelines could be applied to their own personal practice situations (Mullen, 1978, 1981, 1983a, 1983b, 1988). The approach had evolved from work at the University of Chicago. Because outcome studies had raised questions about the effectiveness of conventional social work interventions, we looked to the interdisciplinary literature to find evidence of interventions that had been found to be effective. Together with graduate students we sifted through the literature, attempted to form summary generalizations about what had been found to be effective, and drew out prescriptive implications in the form of practice guidelines.

However, since our purpose was not simply to codify the results of research, but rather to move the findings into practice application the process was further developed to include this integration of research with other aspects of the practitioner's intervention processes. Accordingly, information derived from research findings, theory, professional and personal experience, values and ethics, and view of professional mission and function were integrated into working models which were designed to guide each practitioner's work with their clients. The PPMD approach contextualizes individual practice guidelines. Guidelines were integrated into an understanding of professional function and mission, professional and personal values and ethics, theory and experience. This process produced a set of working practice guidelines, which were explicitly linked to an integrated practice model. The grounding for each guideline was specified as to its source (e.g., empirical research, theory, experience, values, ethics, professional mission and function). Also, for empirical guidelines the level of evidence supporting each guideline was explicated.

Together with our students we analyzed the process we had gone through to arrive at PPMs. This process was then taught to first year students at the University of Chicago who implemented it in class and field. The PPMD process was further refined and elaborated based on this experience. When developed in the 1970s practitioners using the PPMD approach faced a scarcity of information regarding effective interventions. To locate information regarding effective interventions the practitioner had to sift through extensive library references. And, this needed to be an ongoing process to keep a model current. Now the situation is quite different. Information technology has simplified these tasks, meta-analyses have proliferated, outcomes research has come of age, and summary generalizations and practice guidelines are ever present. While the task of finding information has been simplified, the task of adapting that information to individual social work practice situations has become more complex. This challenge remains.

What can be learned from the PPMD approach of relevance to practitioner's use of practice guidelines today?

Perhaps most importantly, the PPMD approach suggests that practice guidelines, whether developed on the basis of consensus or empirical research, cannot be applied without appropriate context. Individual guidelines must be considered in relation to intervention models that address other relevant dimensions of social work practice (e.g., professional mission and function, professional and personal values and ethics, theoretical understanding, experience).

In addition, general practice guidelines cannot be applied to individual situations without considerable adaptation. Proctor and Rosen's (this volume) suggestion that moderator variables be explicitly incorporated into practice guidelines surely represents an important step toward creating guidelines that actually give guidance under a wide variety of circumstances. However, no guideline can anticipate all the variables operating in a complex clinical situation. Moving from practice guidelines to individual case-situations will always require professional judgment and skill, based on accumulated clinical experience.

Moreover, as guidelines proliferate it is increasingly clear that available guidelines are not always consistent with one another. Thus, individual practitioners must have the resources to identify and to resolve inconsistencies. The PPMD approach suggests some other sources of information that may be available and useful in such efforts.

The PPMD approach also makes explicit the need for constant refinement of any practice model. Implementation of interventions based on specific guidelines needs to be monitored and evaluated, with revisions incorporated as necessary. This critical step is represented in the fourth of Proctor and Rosen's (this volume) proposed components of practice guidelines, relating to the explication of gaps in knowledge.

Finally, accountable use of guidelines requires a well-developed dissemination and implementation process. Social work practitioners need to be educated for accountable use of practice guidelines and social agencies need to provide systems supportive of accountable use. As demonstrated by the survey findings, while some practitioners may be capable of developing models based on reading and critical review of the research literature this is beyond most social workers as they are currently educated. Rather, for the majority of practitioners evidence-based guidelines will need to be communicated through supervision, consultation, and in-service training. Those few social workers who are oriented toward and skilled in the use of evidence-based practice may need to become resources for other practitioners within agencies. Social agencies will need to be the conduits for evidence-based practice including guidelines. Since practitioners want to be effective, agencies will need to emphasize the utility of evidence-based practice including guidelines for effective practice.

Because good guidelines can be misused, or not used at all, mechanisms to ensure quality control and accountability are necessary to make certain that guidelines have the best possible impact on practice.

Quality control and accountability

Issues of quality control and accountability can be considered in at least three ways.

- Standards should be developed and applied for assessing the quality of practice guidelines prior to their dissemination.
- Clinicians and clients should be provided with frameworks for assessing the quality, relevance and consequences of the application of specific guidelines.
- Those responsible for monitoring the quality of practice implementation should use systematic monitoring procedures that include collaboration with social agencies and practitioners.

Standards should be developed and applied to assessing the quality of practice guidelines prior to their dissemination

In their review of practice guidelines published in the peer-reviewed medical literature between 1985 and 1997 Shaneyfelt, Mayo-Smith and Rothwangl concluded that many guidelines “do not adhere well to established methodological standards. While all areas of guideline development need improvement, greatest improvement is needed in the identification, evaluation, and synthesis of the scientific evidence” (Shaneyfelt, Mayo-Smith & Rothwangl, 1999). Their list of methodological standards is useful and directly applicable to social work. Twenty-five standards are grouped into three areas:

- guideline development and format (e.g., guideline purpose is specified, specification of external review method);
- evidence identification and summary (e.g., method of identifying scientific evidence is specified, benefits and harms for specific health practices are specified);
- formulation of recommendations (e.g., role of value judgments by developers is specified, role of patient preferences is specified).

In their editorial comment Deborah Cook and Mita Giacomini wonder whether Shaneyfelt, et al’s quality criteria are necessary or equally appropriate for all guideline areas (Cook & Giacomini, 1999). The point is that while a set of standards may be of general use, it is important to apply them flexibly. Both the editorial and the original article stress the need for greater “transparency” of guideline reporting as well as more rigorous peer review prior to guideline publication.

Quality could be improved prior to guideline dissemination through measures such as the development of guideline standards for social work and the use of these standards by those producing and disseminating guidelines (e.g., journal reviewers and editors, professional organizations). Proctor and Rosen (this volume) offer a minimal set of standards, but as they point out their proposed standards are quite similar to those proposed by the psychiatric profession. However, as the previously described practitioner survey makes clear, social workers do not consume research in the same ways that other mental health professionals do, nor are they likely to use or react to practice guidelines in the same ways. Thus, in order to be effective, guidelines for social work practice must be held to standards that reflect the reality of the way social workers acquire and develop practice knowledge. Presentation and dissemination must be carefully considered and may be decisive in determining whether a guideline is actually used, which is a necessary (though not sufficient) condition for a guideline's effectiveness.

Clinicians and clients should be provided with frameworks for assessing the quality, relevance and consequences of the application of specific guidelines

The previously described PPMD approach addresses quality control and accountability at the practitioner level by providing a framework whereby practitioners are expected to make explicit the practice guidelines used in their practice. These guidelines are to be developed based on systematic and critical assessment of research findings, practice-derived knowledge, theory, values and function. This framework requires practitioners to monitor and assess implementation of their practice guidelines, making revisions based on experience. The methodology is composed of five interrelated steps: (a) identification of substantive findings concerning intervention variables and their effects on clients; (b) identification of the quality of the evidence; (c) development of summary generalizations specifying the substantive findings, the limiting conditions, and the quality of evidence; (d) deduction of practice guidelines; and (e) specifying an evaluation plan for assessing the effects of practitioner interventions based on the practice guidelines. In the PPMD approach practitioners develop explicit frameworks that can be critically examined not only by the practitioners themselves, but also by clients, supervisors and others to whom practitioners are accountable. Because it is explicit, the model also permits revision based on feedback and new information. This approach is consistent with views recently expressed by Guyatt and colleagues.

Guyatt, Sinclair, Cook and Glasziou (1999), writing for the Evidence-Based Medicine Working Group and the Cochrane Applicability Methods Working Group, note that "clinical decisions are likely to improve if clinicians are aware of the underlying determinants of their actions and are able to be more critical about the recommendations offered to them" (Guyatt et al., 1999, p. 1842). They note that practice management decisions are a function of evidence and preference including both practitioner and client values. Accordingly, quality control and accountability must provide for client and practitioner judgments and discretion. They suggest that rather than presenting practitioners with rigid guidelines which they are then held accountable for implementing, what may be needed is the presentation to practitioners of information of relevance to practice decision areas with specification of implications for action under differing value scenarios. They note that practice decisions involve "framing a question, identifying management options and outcomes, collecting and summarizing evidence, and applying value judgments or preferences to arrive at an optimal course of action" (Guyatt et al., 1999, p. 1836). Therefore, practitioners need frameworks for assessing available information and recommendations. Guyatt, et al. provide a framework for use by individual practitioners designed to support systematic review so as to avoid bias. This framework stresses the application of "scientific principles to the collection, selection, and summarization of evidence, and the valuing of outcomes" (Guyatt et al., 1999, p. 1837). Making available to practitioners such frameworks can support quality control and accountability at the practitioner level.

Clients should also be provided with frameworks for monitoring and assessing practice guidelines. The practice of publishing reports of practice guidelines for consumers should facilitate quality control and accountability. Furthermore, once social agencies and practitioners make explicit their preferred intervention methods by way of guidelines and models, including their evidentiary base, clients will be better informed and, consequently better positioned to make informed judgments about which agencies and practitioners to use.

Those responsible for monitoring the quality of practice implementation should use systematic collaborative monitoring procedures

In an era of managed care it goes without saying that standard setting, accreditation and funding organizations play a significant oversight role. These groups can be expected to increasingly monitor social work practice with an eye toward fostering implementation of best-practices, use of favored practice guidelines and engagement in outcomes measurement (Mullen & Magnabasco, 1997). However, it is important that such monitoring be done collaboratively, involving social agencies and practitioners in the process. Such a collaborative process will increase the probability that agencies and practitioners will use resulting feedback in subsequent quality improvement efforts (Hess & Mullen, 1995).

Development and dissemination of practice guidelines do not assure accountable implementation. Studies are needed of how practice in social work agencies conforms to practice guidelines and other evidence-based methods. Our survey findings suggest that at present guidelines are not explicitly used in social work practice. It is likely that this will change as guidelines are developed for social work. However, little is known about how practitioners will react to dissemination of guidelines, or how faithfully guidelines will be implemented. Most important, the effectiveness of guideline-based and other forms of evidence-based practice need to be assessed through collaborative evaluation and monitoring procedures.

Implications for Social Work Education

We conclude with observations about changes needed in the education of social work practitioners. The survey findings reported here further underscore the fact that social work education is not preparing for autonomous practice. Social workers need to be prepared to take responsibility for frequent and critical reading of the professional literature, including reports of practice research. Knowledge is changing too rapidly for social workers to rely primarily on what had been taught during their few years of professional education.

Furthermore, social workers need to be prepared to use systematic assessment instruments and designs so that they are capable of gathering reliable and valid data regarding their clients. And, information gathered through frequent reading and systematic assessment will be useless unless practitioners are provided with critical thinking skills that will lead to responsible use of the information.

Our survey findings indicate that many social workers are unusually dependent on supervisory guidance when compared with other professionals studied. Currently, social work education and agency practice reinforce this dependence. If social work practitioners are to move forward toward evidence-based practice significant changes will be required in how social workers are educated as well as in how social agencies view their practitioners' autonomy.

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ANNEX

Agency for Health Care Research and Quality (AHCRQ) Evidence-based Practice Centers (EPIC-I & EPIC-II). In the United States the federal Agency for Health Care Research and Quality (AHCRQ) has invested heavily in evidence-based practice. For example AHCRQ funded twelve Evidence-based Practice Centers for five years in the United States and Canada (EPIC-I). Recently AHCRQ has announced plans to fund an additional twelve to fourteen, five year centers (EPIC-II). This initiative is described on the AHCRQ web site.

In 1997, the Agency for Health Care Policy and Research, --- launched its initiative to promote evidence-based practice in everyday care through establishment of 12 Evidence-based Practice Centers (EPCs). The EPCs develop evidence reports and technology assessments on clinical topics that are common, expensive, and/or are significant for the Medicare and Medicaid populations. With this program, AHCPR became a "science partner" with private and public organizations in their efforts to improve the quality, effectiveness, and appropriateness of clinical care by facilitating the translation of evidence-based research findings into clinical practice. --- The EPCs will review all relevant scientific literature on assigned clinical care topics and produce evidence reports and technology assessments, conduct research on methodologies and the effectiveness of their implementation, and participate in technical assistance activities. Public and private sector organizations may use the reports and assessments as the basis for their own clinical guidelines and other quality improvement activities (Agency for Healthcare Research and Quality, 2002).

Translating Research into Practice Initiatives (TRIP-1 & TRIP – II). The AHCRQ has also established its translating research into practice initiatives (TRIP I & II) which funded fourteen projects in 1999 and another thirteen in 2000. The objective is to examine innovative, sustainable and reproducible strategies for translating research findings pertaining to effective practices into direct health service practice through collaborative partnerships (Agency for Healthcare Research and Quality, 2001).

Implementing Evidence-based Practice Project

In the Implementing Evidence-based Practice Project, funded by the Robert Wood Johnson Foundation, SAMSHA, NASMHPD, the goal has been to identify evidence-based practices supported by research findings (six identified in mental health) and to identify, develop and evaluate strategies for implementing the identified evidence-based practices in real clinical settings in seven states. The focus has been on developing toolkits and stakeholders in phase I; and, in phase II, evaluating efficacy and fidelity of implementation.

Conferences and Professional Meetings

National Level Conferences

Conferences and professional meetings are highlighting evidence-based practice. At the national level the Agency for Health Care Policy and Research hosted a conference in 1998 on translating evidence into practice which focused on evidence-based medicine, changing clinical behavior, the internet and implementation, meta-analysis, and legal issues.

http://www.ahcpr.gov/clinic/trip1998/index.html

The National Association of State Mental Health Program Directors (NASMHPD) hosted a conference in 2002 focused on the theme of "Moving Towards Evidence-Based Systems of Care".

http://nri.rdmc.org/2002Agenda.html

As a follow-up to this conference another is planned for 2003, also on evidence-based practice. The focus of these conferences has been on the meaning of evidence-based practices, the types of practices deemed evidence-based, levels and types of evidence required, and insights about implementation.

http://nri.rdmc.org/conference/proposals.pdf

State Level Conferences

In addition to the national level activities across the United States many individual states are hosting similar conferences to foster evidence-based practice in state funded systems of care. One of the most aggressive is New York State. For example, in 2001 the New York State Office of Mental Health (OMH) convened a statewide conference on best practices which examined issues regarding implementation of evidence-based practice as well as reports regarding the six evidence-based practices being promoted in services to the severely mentally ill in the United States.

http://www.omh.state.ny.us/omhweb/aboutomh/Videos.html

These examples of national and state level activities indicate that the level of recent activity in the United States focusing on evidence-based practice has been considerable. The activities in the United States may be expected to contribute to the many international developments as well as activities in other countries such as the noteworthy accomplishments of the Cochrane

Collaboration, the Campbell Collaboration, and the many evidence-based practice centers in the United Kingdom and continental Europe. I conclude with thoughts regarding implications of this move toward evidence-based practice for social work practice and education.

Stakesin FinSoc-ryhmän työpapereita ISSN 1455-9064

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