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Exploring the efficacy of evidence-based practice within public mental health agencies

Hannah Kaye Norton

EXPLORING THE EFFICACY OF EVIDENCE-BASED PRACTICE WITHIN PUBLIC MENTAL HEALTH AGENCIES

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

This research project's aim was to explore the efficacy of evidence-based practice within public mental health agencies. The method to do this consisted of nine face-to-face interviews of various clinicians over a three-week period. The interviews demonstrated a wide range of knowledge, skills, and opinions regarding evidence based practice within public mental health agencies. Utilizing the data from each of the interviews, the researcher was able to suggest interpretations of the results, and in turn make suggestions for the future of social work practice, policy, and research. It is hoped that this research project will not only create additional dialogue surrounding evidence-based practice, but also push for a more clear understanding of evidence-based practice and its implementation in public mental health agencies.

ACKNOWLEDGMENTS

I would like to acknowledge my fiancé, who made all of this possible and always gave me unconditional love and support. I thank my son, for being an amazing newborn throughout this process. I would also like to acknowledge my family for cultivating my drive for knowledge and helping others, and my friends for always standing by me. I would like to acknowledge my cohort and professors, who have become like family the last two years. Lastly, I want to acknowledge the assistance of the graduate advisory committee in the completion of this research project.

DEDICATION

To my son, the light of my life. You make every day more and more amazing, and are more special to me than you could possibly imagine. Thanks for being such a great little man and letting mommy finish school.

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CHAPTER ONE

INTRODUCTION

Problem Statement

Mental health is a booming field within the social services realm. It is estimated that 26.2 percent or 57.7 million adults over 18 years suffer from a diagnosable disorder within any given calendar year (National Institute of Mental Health, 2009). Approximately 12 million adults receive outpatient treatment every year; with only 19.4 percent receiving treatment in outpatient mental health centers. Given California's adult population of 27,383,716 (Barker et al., 2004), almost 7,174,533 persons suffer from mental illness. Of those people, approximately 1,492,302 seek outpatient treatment, with 445,198 adults seeking outpatient mental health treatment from county mental health programs (California Health and Human Services Agency, 2007). In Riverside County alone, there are about 1,516,572 adults (U.S. Census Bureau, 2008), with around 315,446 seeking mental health treatment, and 94,003 receiving care within the county. These figures display a high frequency of people seeking mental health care and also demonstrate an

inherent need for effective, practical, and cost-effective mental health treatments.

In the 1800's, charity organization societies (COS) began to multiply throughout the United States, with the help of Mary Richmond, a woman who established several of these organizations. These organizations utilized "friendly visitors," who would assess and work with consumers (Popple & Leighninger, 2008). Settlement houses also spread in the late 1800's partly in thanks to Jane Addams. These organizations were actually settlements within impoverished neighborhoods that would offer help to the residents. By the early 1900's, social workers were trying to move toward professionalism. This was inundated by Flexner, who wrote a paper in 1915 on the deficits within social work practice. Social work practice continued to expand throughout the 1900's, first becoming involved in mental health in as early as WWI, when caseworkers would treat veterans. This continued to increase and expand social work practice, eventually producing a broad sector of roles and practices. Today social workers utilize a generalist model of practice, yet specialize and become experts in any field with which they practice (Popple & Leighninger, 2008).

Practice Context

At the core of social work practice are social work values and ethics. These values and ethics center on client protection and valuation (National Association of Social Workers, 1996). More specifically, these values and ethics ensure that clients of social workers are afforded the best interventions and practice methods possible. It is of utmost importance, therefore, to ensure the evidence-based practice will enable social work clinicians to provide the best possible practice for their clients and consumers. This topic directly affects the clientele and populations that social workers work with and encounter daily.

Currently, there is much dissonance within the social work mental health community as to whether evidence-based practice is a positive direction for social work to move toward; however, implementation has become mandatory in many agencies. Widely researched interventions, including but not limited to cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), and others have become staples in mental health agencies. Texts, articles, and books written by people within the mental health field recommend these techniques

often, however also repeatedly express concern over the research effectiveness and the lack of positive outcomes when used with broadly defined clientele (O'Hare, 2005).

Policy Context

Likely as a result, in part, of much needed, cost-effective treatments, social work has recently experienced a push toward implementation of evidence-based practice in mental health settings. The surgeon general urged evidence-based practice to be used within the mental health field in 1999 (U.S. Department of Health and Human Services, 1999). In 2004, California passed Proposition 63, which enabled an increase in funding and resources to county mental health agencies (California Department of Mental Health, 2004). Each county was required to submit public mental health initiatives that would draw out what they are going to do with the extra funds (California Department of Mental Health, 2004). In Riverside County, for example, a final revision was passed in 2006. This plan included several different program initiatives, specifically calling for extensive use of evidence-based practice within the programs (Riverside County Department of Mental Health, 2006). Explicit evidence-based practice were to be

identified and explored. Deeply embedded within the entire plan was the use of particular evidence-based practice. These evidence-based practice interventions included multidimensional family therapy, multidimensional treatment foster care, wraparound, cognitive behavioral therapy, SMART programs, and integrated recovery service center (Riverside County Department of Mental Health, 2006).

Purpose of the Study

There has been little research as to how evidence-based practice is being implemented, how it restricts or expands clinicians best practice methods available, and whether the methods are disadvantageous or beneficial to mental health consumers. As a result, this study will address the implementation of evidence-based practice and explore the ways in which it has been done, as well as determining how clinicians and directors of public mental health agencies view the progress. The purpose of the study is to answer if the recent implementation of evidence-based practice within public mental health agencies disadvantages the consumers.

Presently, scholars within the field of mental health social work are arguing over the efficacy and feasibility of evidence-based practice. Some contend that evidence-based practice is vital for social work as a professional field and as an empirical way in which to provide consumers with best possible practice (Gibbs & Gambrill, 2002; Mullen & Streiner, 2006). Others assert that evidence-based practice competes with social work values and devalues practitioner expertise and client needs (Webb, 2001; Gray & McDonald, 2006). Even with current skepticism, there is little public debate over evidence-based practice in social work or even in mental health in general. Evidence-based practice has become mandatory for many public agencies, with the promise of funding and sustainment. For these reasons, professional and scholarly research, review, observation, and discourse are essential.

Currently, in public mental health settings, manualization of interventions has become popular. At times, these manuals are poorly written and filled with grammatical errors. That, coupled with an inferred overuse of certain interventions, could be guiding public mental health agencies toward experiencing difficulties

in providing clients with the best possible care. On occasion, otherwise acclaimed evidence-based practice interventions are ineffective with certain clients. With only certain evidence-based practice interventions available, will this eventually limit available interventions to clients or leave them with individually ineffective options? This study plans to bridge the present gap between evidence-based practice and best practice for the consumer.

This study will specifically investigate public mental health agencies within Riverside and San Bernardino Counties in California. The study will be exploratory, so qualitative interview methodology will be utilized. To fully explore and examine this problem, this study will utilize qualitative methods, including face-to-face interviews. Directors of agencies will be interviewed to assess how the agencies determine which evidence-based practice interventions are available for the clinicians to use. Individual clinicians within the agencies will also be interviewed, to provide a candid experiential profile of how evidence-based practice is affecting their practice and their clients.

The purpose of the study is basically to explore in depth how evidence-based practice implementation is occurring within public mental health agencies. There has been little done to do this currently, and it is hoped that the resulting discourse and open discussion from this study will allow professionals and consumers alike to advocate for best possible practice. Specifically, it will clarify how clinicians feel their practice is affected. It is hoped that clinicians will be able to provide a more or less objective view on their interventions used, practice outcomes, and client satisfaction and recovery before and after evidence-based practice.

Significance of the Project for Social Work

Social work clinicians should be able to tie their practice to ethics, values, evidence, and theory; however, this does not appear to always be the result of evidence-based practice implementation. The National Association for Social Work recognizes specific values and ethical guidelines that social workers are to follow (1996). This study will enable an educated discussion as

to how evidence-based practice fits in with those values and ethics.

Social work is also highly directed by the recovery model. First proposed by consumers, the recovery model is a process by which consumers attain the ability to hold productive roles within society (U.S. Department of Health and Human Services, 1999). It is individualistic and less based on elimination of symptoms than it is on personal function (U.S. Department of Health and Human Services, 1999). This study will also allow for a discussion of how evidence-based practice is a suitable accompaniment to the recovery model of social work practice.

In the Surgeon General's report, it is also mentioned that consumers need to know there are effective treatments available, and utilize mental health services when needed (U.S. Department of Health and Human Services, 1999). This study will further the goal of improving access to public mental health services, as well as improving consumer trust in the mental health system. Finally, in line with the Surgeon General's call to continued expansion of mental health knowledge research (U.S. Department of Health and Human Services,

1999), this study will explore and expand the knowledge of evidence-based practice; therefore, it will orient researchers and clinicians alike toward best available practices for consumers within the mental health community.

Social work agencies have restrictions on funding and available practice. It is their responsibility to provide clients with interventions that are not only likely effective but also cost-effective for the agency. At times, this can present a conundrum. Through efficient research that encompasses appropriate methodology, agencies can more effectively provide their clients with said interventions in a way that is in line with their funding resources. Furthermore, agencies have the responsibility to advocate for their clients rights. This includes advocacy at a level where policy changes and pushes for relevant research can take place. This study will provide additional information for agencies to consider in their practical regulations and practices.

Social work practitioners receive their limitations from the agency within which they work. Yet, they are the individuals that encounter clients on a daily basis, and are able to evaluate program efficacy most efficiently.

This study values their opinions as expert judgments, and anticipates providing insight for other clinicians within social work practice. Micro level practitioners have the ability to stimulate change within their organizations and professions. This unique position also creates a level of accountability to clients, families, and outside resources. This study will facilitate discussion between social workers and their agencies.

Consumers of social work services will also be able to sense the effects of this study. The population of mental health consumers is a disadvantaged and vulnerable group. Experiencing the support, encouragement, commitment, and collaboration of social work mental health professionals will not only persuade more consumer participation in mental health services, but can also provoke a sense of trust and competence. Additionally, mental health consumers are historically impressive with self-advocacy. This study will give them more tools with which to continue to do so.

This study follows the generalist intervention method in social work. By researching whether evidence-based practice within public mental health agencies disadvantages clients, it focuses on three steps

of the method, including: assessment, implementation, and evaluation. The study will delve into the ways in which agencies have implemented the policy suggestions for evidence-based practice. It will also investigate agency and clinician evaluation of this implementation. Lastly, the study proposes to look at how agencies and clinicians have assessed client and agency needs, as well as externally assessing the needs of the agency and the clinicians within the agency.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter will outline the current literature on evidence-based practice within the mental health field. It will not only deliver a historical account of evidence-based practice within mental health social work, but also summarize current arguments for and against its implementation. Specifically, this chapter aims to develop a basic understanding of evidence-based practice with definitions, commentaries, studies, and articles from established and recognizable experts within their respective fields. It also intended to point out the lack of studies done on implementation, its fit within social work, and specific problems with evidence-based practice in social work.

The History of Evidence-Based Practice in Social Work

Social work has a long history. However, it is only more recently that research and practices based on evidence have become more predominant within the field. In the 1970's, the effectiveness of social work was first

questioned by Joel Fischer (Gray & McDonald, 2006). Since then, evidence-based practice has been used as a tool to improve efficacy, especially within the last decade (Webb, 2001; Furman, 2009). It has also been utilized to develop a professional status within social work, as it has been documented that many clinicians within the field rarely use research in their practices (Yunong & Fengzhi, 2009).

As a result of efficacy contention, in 1999, the Surgeon General specified that evidence-based practice be utilized within the mental health arena of practice (U.S. Department of Health and Human Services, 1999). The Surgeon General's report established that there were many well researched modes of intervention. It contended that while consumers work toward recovery they deserve empirically based intervention delivery (U.S. Department of Health and Human Services, 1999). Moreover, the report urged for a superior knowledge base driven by research (U.S. Department of Health and Human Services, 1999).

A report from the New Freedom Commission on Mental Health, and published by the U.S. Department of Health and Human Services (DHSS) cited the surgeon general's 1999 report, stating that it suggested the implementation

of evidence-based practice in mental health as an opportunity for consumers to receive best available practices (2005). Since, there have been many barriers and obstacles that the public sector has had to overcome. This is viewed as a quality based improvement for mental health services which needs initiatives and a supportive infrastructure to succeed. This report not only listed possible barriers, but also policy changes and options (New Freedom Commission on Mental health, 2003).

While the government has pushed for evidence-based practice, a strict definition of what exactly that is has yet to be found. Definitions of evidence-based practice are contended by scholars, professors, and practitioners alike. Some assert that evidence-based practice is a procedural framework or set of skills and techniques that have been found to be successful with clients (O'Hare, 2005). Clinicians must be able to utilize these skills to construct an effective helping relationship (O'Hare, 2005). This definition, while seemingly broad, would likely be more accepted by many within the social work mental health community. It is unrestrictive, and negates many of the criticisms of implementation of evidence-based practice that will be discussed later in

this chapter. Still others have argued that evidence-based practice is a formula that should be used within practice. Thyer (2006) stated that evidence-based practice is a series of steps one must use. One must formulate a question, look for all legitimate and applicable evidence, make a decision based on clinical expertise and client values and circumstances, and then evaluate your efficiency and outcomes. His chapter viewed each component as necessary, and explained how to implement them into your practice (Thyer, 2006).

With the recent integration of research and evidence-based practice into social work, definitions, theory and implementation have not yet met in harmony. The remainder of this literature review will reveal the dissonance within the social work mental health community regarding evidence-based practice, and demonstrate the gaps in current applicable research.

Support for and Against Evidence-Based Practice

Gibbs and Gambrill asserted that evidence-based practice is simply a way in which to integrate evidence with client values (2002). They stated that there are many misconceptions about evidence-based practice and its

implementation. Some practitioners misunderstand the approach while others object on ethical, realistic, or philosophical grounds. The article gave cited counterarguments to each misconception, including the inherent integration of clinical expertise and client values and needs in evidence-based practice as an counter-argument to opponents that said evidence-based practice does not value clinical expertise or client values and needs. It also explained that evidence-based practice may increase costs and is completely possible in practice, contrary to popular opinions that it is only implemented to cut costs and is impossible to apply. Furthermore, the authors showed that evidence-based practice is not currently being taught in schools to standard, or being used properly in practice by individual clinicians. They put the weight of implementation on the shoulders of the practitioner.

Many other scholars are in favor of evidence-based practice in social work. While Mullen and Streiner suggested that some recent criticisms are legitimate, they explained and suggested ways in which to view evidence-based practice that are implementation friendly. They suggested that clinicians should be trained to find

research efficiently, and not take evidence-based practice to mean "proof." Overall, they were optimistic for the implementation of evidence-based practice within social work (Mullen & Streiner, 2006).

Similarly, McNeil wrote an article that breaks down current barriers to implementation evidence-based practice in social work, yet kept an overall positive outlook on its eventual execution. He reviewed current criticisms of evidence-based practice, from philosophical to methodological. He reviewed current philosophies on reality, including positivism and postmodern realism. While positivism lends itself to a one-reality view, realism can be too all encompassing, especially when looking at past injustices such as the holocaust, racism, and others. McNeil found, therefore, that neither fits perfectly with social work values, and using the criticism of positivist philosophies toward evidence-based practice is not fair or reasonable. This article also delved into methodological approaches to research, namely qualitative and quantitative. The author stated that while qualitative research provides a more focused, overall outcome, quantitative provides important, specifiable outcomes. Both are integral to

social work, and one should not be favored over the other overall. Finally, this article covered the difficulties, yet the importance of keeping an up to date knowledge base on current research. It is of great value to develop readily accessible analysis of evidence-based practice, employ more doctoral level social workers who can act as "knowledge brokers," and further incorporate evidence-based practice into social work education.

Other scholars assert that evidence-based practice is highly correlated with the financial stressors on the public sector (Webb, 2001). Webb proposed that evidence-based practice is somewhat of a paradigm shift in social work, and undermines the values by which it was created; furthermore, it also lacks current critical scrutiny (2001). He delved into which outcomes evidence-based practice measure. He linked heuristics and actions with social work practice, while demonstrating that social workers cannot simply practice with facts alone, as evidence-based practice suggests. Webb implied that evidence-based practice undermines the individual identity and oversimplifies social work practice by suggesting that interventions can be judgment and value-free (Webb, 2001).

Similarly, Holosko and Leslie asserted that evidence-based practice has difficulty integrating itself into social work (1998). They went into more detail about the problems with implementation of evidence-based practice research (1998). Specifically, how social work is unique in its research needs, the issue of research outcomes not including day-to-day practice, and social work organization structure impediments (Holosko & Leslie, 1998).

Other scholars point definitional issues as the issue with implementation. Gray and McDonald (2006) suggested that adhering to the ethical undertones of evidence-based practice may be more practical for social workers than to abide by the limitations that evidence-based practice can exert. The authors purported that evidence-based practice is social work's way of asserting itself as a profession and allowing itself expertise. They used agency theory to demonstrate how social work has become a product of the public health industry it serves. They also asserted that the ethics inherent in social work practice are critical thinking frameworks by which clinicians already do best by their clients. These authors did not argue against

evidence-based practice, but suggested a more loosely defined or carefully refined form (Gray & McDonald, 2006).

Furman (2009) also criticized evidence-based practice in his article, "Ethical considerations of evidence-based practice." One possible problem with evidence-based practice, he stated, is an overreliance on knowledge, meaning that social work may lose its human focus. Evidence-based practice studies rarely include affects on client empowerment and freedom. Another problem is created by the reliance on researching only what is easily measurable. This inherently prefers micro approaches over long term macro approaches to clients and communities. Lastly, the helping relationship that social workers develop with their client is often an important predictor of client outcomes. Evidence based research focuses on interventions and modes of practice that sometimes lose sight of the significance of this relationship. Overall, an approach that centers on outcomes instead of processes loses sight of social work as it originated, and can lead to agencies that are overly routinized instead of client centered (Furman, 2009).

Adams, LeCroy, and Matto also argued that research problems are an issue in implementing evidence-based practice in social work (2009). They wrote that evidence-based medicine is based on symptoms and highly focused outcomes (2009). Yet, social work, a highly individualized field that is based on a person-in-environment perspective, has come to adapt this medical model in the form of evidence-based practice. While outcome research has shown certain methods of practice to work more efficiently than others, this can be biased, as the modalities researched are the ones easily replicated and measured. It should not be assumed that those interventions not mentioned in literature pertaining to evidence-based practice are "bad practice," but practices not researched. This is especially true given the possible bias in research funding and methodology. Evidence-based practice not only de-emphasizes theory and the changing relationship, but has trouble within its definition. Lastly, evidence-based practices sanctioned by agencies can limit mental health providers in the best-practice services they provide, as well as their ability to gain much needed professional competence (Adams, LeCroy, & Matto, 2009).

Related to the looming issue of research, Lalayants and Tripodi (2009) published a study on the methodology of social work research, and the resulting issues with generalizability. Their article replicated an earlier exploratory study by Nurius and Tripodi. The authors used three major social work journals, from the years 1996-2005. Utilizing content analysis, and then random sampling, the authors classified the type of research conducted, and then did a quantitative analysis on the generalization methods those studies used. The authors found that many studies did not utilize random sampling or sample/ population generalization. While this study found an increased use in generalizability, it still demonstrated the need for using better, more standardized methods of generalizability in social work research. This directly supports the previous complaints of evidence-based practice research not being wholly applicable or appropriate to social work.

Theories Guiding Conceptualization

There are a few theories within social work practice that guide this project's conceptualization. This section will focus on two such theories, namely systems theory

and ecological theory. Each of these theories can be considered at a macro level of social work practice, and integrated into the focus and design of this project.

Systems theory dictates that communities are comprised of a variety of subsystems, including but not limited to families, individuals, churches, and businesses. These systems communicate with larger environmental suprasystem whose parts include such as subsystems as counties, nations, and states, as well as politics (Hardina, 2002). Change in one part of the political, economic, or social system can be a catalyst to all other systems involved. The systems exist to create and maintain stability, maintenance, and adaption to the surrounding environment (Hardina, 2002).

Systems theory can be utilized when thinking about public mental health agencies. They are merely subsystems within the larger suprasystem of communities, politics, and individuals. When something changes in one system, such as funding and economic stability, smaller systems like public mental health agencies must change and adapt their practice to maintain stability. Similarly, when the public mental health agencies adapt and change, so do the smaller systems within the community. Individuals may

have changed accessibility to mental health programs, and will alter the way in which they approach mental health treatment. Resources like shelters and food banks will deal with other systems, such as the public mental health agencies and individuals and families more or less effectively.

One way to conceptualize systems theory in accordance with evidence-based practice implementation is to look at mental health policy and government funding. The suprasystem of government are affecting the interventions and funding of public mental health agencies. This, in turn, affects community member accessibility to resources in the community, as well as the ease with which consumers can access mental health agencies. Furthermore, the ways in which they are able to receive services are also different.

Ecological theory is another theory with which one can conceptualize this research project. This theory purports that natural changes within the environment are inevitable, and takes into account ecosystem variables such as land use and availability, population density, resources, individuals, housing structures, the surrounding social structure. These changes can be due to

movement of the population and resources, and occur to maintain ecological stability (Hardina, 2002). Competition for resources and adaption to change create a Darwinian survival of the fittest model within the environment (Hardina, 2002).

When conceptualizing evidence-based practice in mental health, one can utilize ecological theory. With all parts of an environment competing for scarce resources, some must change and adapt to current situations or die out. This is true for the current state of public mental health. Funding monies and political support for mental health has waxed and waned with the economic and political ideological changes in the United States. Similar public mental health agencies compete for the funding and support that is available, therefore bowing to whatever the higher power government decrees. Other groups, such as the clinicians and clients, must adapt to whichever policies are initiated. This is true for evidence-based practice, where agencies have agreed to implement evidence-based practice to secure funding. Clinicians must adapt their practices, and individual consumers must also adapt the way in which they expect to access mental health services. Another way to envision

the way in which evidence-based practice implementation relates to ecological theory could be that public mental health systems have adapted and improved their services to clients. They are continuing to survive, despite dire economic conditions, because of their dedication to best and cost-effective practices.

Both of the previously explained theories point to change, power, and adaption as core values within social work systems. They can aid in visualizing how evidence-based practice fits into the larger environment of mental health services, social work, politics, communities, and government.

Summary

Literature in the social work field regarding evidence-based practice is overall lacking and not unified. More research is needed to assess evidence-based practice within the social work mental health field, as well as its efficacy with clients and within agencies. Specific holes within literature include lack of a definitive definition of evidence-based practice. Moreover, research methods appropriate to all models of intervention need to be developed and used. Finally,

implementation and execution of evidence-based practice needs to be assessed and evaluated to provide a holistic view of evidence-based practice in mental health social work.

CHAPTER THREE

METHODS

Introduction

This chapter outlines the methods used for this research study. The study design and procedures is addressed and defined. A focus on data collection procedures utilized and the ways in which human subjects are guaranteed protection is also addressed. Limitations and strengths of the study will be mentioned, along with the way in which data accrued was analyzed and refined.

Study Design

The purpose of this study was to explore the local implementation of evidence-based practice within public mental health agencies. More specifically, this study assessed how implementation and utilization of evidence-based practice within public mental health agencies affects consumers. By utilizing qualitative methods, this study focuseed on macro and micro functions of evidence-based practice within public mental health agencies. This enabled the researcher to more fully investigate the ways in which evidence-based practice has been implemented in public mental health. Face-to-face

interviews not only have enabled the interviewer to fully assess participant reaction, but also allowed for clarity, individual differences in comprehension, and an individualized experience to foster candid participation. Furthermore, it allowed a focused and in-depth format through which to gather as much information about the topic as possible. Face-to-face interviews were appropriate as there has been little research done in this area, and therefore, surveys and scales have not yet been developed with reliability and validity. Still, there are some limitations to utilizing a qualitative design. It invites interpretive bias and can be less representative than a larger quantitative design.

Sampling

The sample of this study consisted of a population of nine current and former public mental health clinicians coming from within the Inland Empire. The sampling population was determined by convenience and snowballing methods. The mental health professionals utilized varied in age, gender, experience, and ethnicity. This was so as not to limit the study

population, and also to keep the study as reliable and valid as possible.

There were practical limitations to this study. First, the sampling method used was convenience snowball sampling. This was less reliable, and therefore less generalizable to other localities. Another challenge encountered with sampling was the sample size. Only nine interviews were conducted, limiting reliability and generalization. The study aimed to promote discussion about the topic, broaden applicable research available to clinicians, and provide supplementary data to already limited similar research. It did not aim to be representative of every public mental health agency throughout the country, or clinicians in general.

Data Collection and Instruments

The researcher of this study collected data by way of face-to-face interviews with current and former clinicians over a period of three weeks. The interview guide, Appendix A, is attached. Since no applicable guide exists, these questions were prepared with the utmost sensitivity to culture, application, reliability, focus and validity. This guide focused on determining how

agencies choose which evidence-based practices are utilized within practice. Furthermore, it attempted to discern what clinicians think about evidence-based practice implementation, and how it affects their clients. It was intended to be loosely defined, allowing for individual interpretation, perception, and context. The interview guide was organized in a way that encourages clinicians to examine their own experiences in relation to the questions asked, and answer thoughtfully and honestly. It also asked demographic questions to better understand the context of interview answers and the sample population in general.

Procedures

Data in this study was gathered in a way that is consistent with qualitative studies. Clinicians were solicited based on convenience and accessibility. Participation was encouraged and a list of individuals able to participate was created. Those individuals were encouraged to participate with a gift card from Starbuck's in the amount of $5.00. Once eligibility and approval was established, appointments for interviews were made with selected clinicians. The primary

investigator, Hannah Norton, conducted interviews in a timely manner, over a period of three weeks. The interviews took place within agencies, in the offices of the subjects being interviewed. Contact information was asked for, for follow-up and clarification purposes.

Protection of Human Subjects

It is of the utmost importance that the currently employed clinicians are comfortable and completely protected. Every effort was made to sustain the protection of human subjects utilized within this study. Confidentiality and anonymity of all subjects was protected, as names were not utilized, and interview notes were coded for privacy. Names and data could not be connected, which ensured anonymity of each participant. Furthermore, responses were not linked with agency names or agency data. This information was stored on an external hard drive in the house of the primary investigator. Once the study was completed, all data was erased from that hard drive. An informed consent statement outlining the purpose as well as a description of the study, confidentiality, duration, audio taping and voluntary participation was given prior to each

interview. It addressed any risks and benefits foreseeable to participation in the study and how to contact the investigator for the results. This document is attached.

Data Analysis

Data analysis for this study included qualitative analysis techniques, including transcription, coding, and interpretation. All data from the face-to-face interviews was transcribed verbatim. A constant comparison was used while coding and tallying interviews initially, enabling the researcher to identify coding categories and then assign codes to each category. The researcher also used a journal to document and record the codes with their meanings and definitions. A second-level coding was used to interpret the first-level coding. This allowed the researcher to discover relationships within the data set, including differences and similarities. The researcher not only recorded and coded manifest content, but also latent content within the interviews. Description of the data coded was furnished, utilizing frequency. This data analysis process was conducted in a way that limits

researcher bias and subjectivity. Analysis focused on objectivity and consistency.

Summary

The intent of this chapter is to present and explain the methods of this study. Study design, sampling, data collection, procedures, protection of human subjects, and data analysis specific to this study were all proposed and discussed in detail. Each methodology facet mentioned was employed in a way that ensured participant protection and limited researcher bias. Furthermore, every precaution was made to ensure that this study is deemed as reliable and valid as possible within the limits of its design. This was done without proposing that the study will be generalizable to the entire public mental health system.

CHAPTER FOUR

RESULTS

Introduction

This purpose of this chapter is to outline the results of this study. There were a total of 9 interviews conducted, over a three-week period. This chapter will not only demonstrate the variance in demographic data collected, but also introduce the results of coding the interviews. The interview guide will be divided into two sections, including demographic data and research questions. The first five questions of the interview guide are demographic in nature, and include questions about age, education, experience, gender, and current job held. The last sixteen questions are the research questions. These questions ask the clinicians interviewed about their experiences with evidence based and non-evidence based practices, their experiences with their agency regarding evidence based practices, and the clinicians' personal opinions regarding the efficacy of the interventions they use.

Presentation of the Findings

Demographic Results

The first three interview questions addressed age, gender, and level of education/licensure. Of the clinicians interviewed, there was a range of different ages, the youngest being 23, and the oldest 68. The majority (five) of the clinicians were in their 30's and 40's, three were in their 50's, and one in their 60's. There was only one clinician in their 20's. There were six females and three males interviewed. All of the clinicians had attained their master's degree, either in social work or psychology with an emphasis in marriage and family therapy. Three of the clinicians had gone on to acquire their doctorate degree in addition to their master's. Six interviewees had a current license to practice in California, and one held a PPS (Pupil Personnel Services) credential.

The following two questions asked about the clinicians' years of experience and current job held. The fourth question on the interview guide addressed how many years of clinical experience the clinicians had acquired throughout their careers. Two reported having over 20 years of experience, five others had 5-8 years

experience, and two had less than five years experience. The mean amount of years of experience for the clinicians interviewed was 11.8 years. The fifth and last demographic question asked what the current job of the clinician was. Two of the clinicians were currently employed in academic settings, two were hired into supervisory roles, and five identified as clinical therapists.

Research Questions Results

The last sixteen questions addressed evidence-based practices from an agency and clinician viewpoint. The questions were asked the same way and in the same order to avoid any researcher bias. There were several themes that came up when the researched conducted the coding of the interview information. The following pages will address some of these themes, as they are related to the research project. Some of the results from the questions have been consolidated in this chapter for the sake of organization and later discussion.

Two of the questions asked were aiming to find out which client populations these clinicians are working with, and if they had worked with those populations before. Four of the clinicians interviewed answered that

they worked with "chronically and severely mentally ill adults," and this was the only population they have ever worked with. Two others worked primarily with children currently, but had worked with adults previously. Three participants answered that they worked with both children and adults in crisis throughout their careers.

The first theme that became apparent when coding the interviews was the way in which the agencies determined which practices were available for the clinicians to utilize. Eight of the nine clinicians interviewed reported that their agency determined which interventions were available via the county policy and regulation. Other means of determination that came up were research and insurance regulations. One clinician was quoted as saying "I think the biggest thing was, honestly, insurance regulations," (1, personal communication, March 2010), when speaking of how her particular agency determined how she was to act and intervene in certain situations. Six clinicians felt like they were able to use a range of interventions and had discretion as to which they used. Four felt they were unable to be flexible in which interventions they used and how they used them. One of those clinicians was quoted as saying:

> When I was hired I was hired only into the evidence based program so there wasn't a lot of room for me to do free interventions, or more in what my modality would be or what I'd feel comfortable with. (3, personal communication, March 2010)

The clinicians were asked which interventions they used, or were allowed to use now, as well as which interventions they had used, or were allowed to use in the past. All nine clinicians reported that they had used cognitive behavioral therapy (CBT) as an intervention both before evidence-based practice had been implemented at their agency and currently. One of these clinicians made the following point regarding CBT and evidence-based practice:

> We know that cognitive behavioral therapy is easily measurable. Therefore, it is one of the most commonly researched, and evidence-based practices. Other interventions are more difficult to measure; um, narrative therapy or object relations therapy is harder to measure and so it gets less attention; it's less researched. The way research is done affects which interventions are considered

evidence-based. (4, personal communication, March 2010)

Five of the clinicians also described using expanded versions of CBT in their practice, including mindfulness CBT and trauma-focused CBT. The recovery management program was identified as an evidenced based intervention that five of the clinicians were able to utilize now. Three of the clinicians said they were also encouraged to use dialectical behavioral therapy (DBT) in their practice.

Of the evidence-based interventions that clinicians were able to utilize now, four of those interviewed said that those interventions were more effective than the non-evidence based interventions they used previously. In addition to identifying if the evidenced-based practices were effective for the clients they saw, the clinicians were also asked if the interventions were appropriate for those clients. Seven of the nine participants agreed that evidence-based interventions were appropriate for the clients they encounter. One of the participants explained, "Yes, um, for example, recovery management was designed with the population of schizophrenia, bipolar and depression in mind" (3, personal communication, March

2010). Two of the clinicians interviewed felt that the interventions were too narrowly focused, and at times inappropriate for the clients they served. Four of the clinicians said that the evidence-based interventions worked better than the non-evidence-based interventions they had used. Three of the clinicians disclosed that the evidence-based interventions seemed to work as well as the non-evidence based interventions they used. One clinician was quoted as saying,

> I think that with the way things are now with reliance on the medical model and reliance on diagnostic categories or particular syndromes or problems, we are beginning to collect evidence that certain interventions work better with certain problems. For some disorders there is clear evidence… but the fact that there is some good evidence for some of those, doesn't mean that we have good evidence on even 80% of what is in that book. (4, personal communication, March 2010.

The remaining two interviewees declared that it was difficult to tell if the interventions were more or less effective. In relation to the currently utilized evidence-based interventions, each clinician was also

asked which non-evidence based interventions they had used in the past. All but one of the clinicians interviewed identified non-evidence based practices that they used previously. The most commonly reported treatments included narrative therapy, psychodynamic and long-term therapy and gestalt therapy. One clinician reported, "Yeah, but for sure the interventions I've always used have always been CBT. Occasionally I've used the empty chair, which is more gestalt. But other than that I honestly have not used any other techniques other that cognitive behavioral" (5, personal communication, February 2010).

All nine clinicians reported that their agencies evaluated the interventions they used, but only three said their agencies used evaluation prior to evidence-based practices. Two of those clinicians said that their agency used random case assessment to acquire the information to evaluate. Five others admitted that they utilized client report when evaluating individual progress, prior to evidence-based practices. One clinician spoke about the experiences they had with evaluation prior to evidence-based practice implementation:

> ...before being in evidence based programs I was dealing with hospital discharges. Really high risk; suicidal ideation, cutting and stuff like that. So it was basically the frequency of the behaviors; if they were occurring and obviously if they had diminished or they didn't happen anymore we considered that completing their goal. (7, personal communication, February 2010)

All nine participants said they formally evaluated their clients' progress after evidence-based practice implementation. Four described a county intranet system in place that required clinicians to log in timely formal consumer evaluations and clinician reports on progress. This was best described by one of the participants,

> Right now the recovery management program we are on, every three months we complete an assessment; the client completes an assessment as well as the clinician. We log the results on Image-net and that is to determine fidelity. (4, personal communication, March 2010)

Six of the clinicians also admitted to utilizing self-report and clinician discretion in identifying if treatment interventions were working or progress was

being made. Several (five) clinicians admitted that they, or their agency used goals in treatment planning to measure client progress.

The interviewees were asked if there were any other interventions that they thought their clients could benefit from. All nine participants thought that their clients could benefit from interventions that were not available due to the implementation of evidence-based practice. The most common answer came from six of the clinicians interviewed. The intervention mentioned was processing or long-term psychodynamic approaches. One of the participants summarized their answer,

> We have findings that people say, well they got better. It's a manifestation of crisis theory. They return to their previous level of function but they still have all these underlying issues and dysfunction going on in their lives. Some serious problems are not amendable to short term treatment and we are inflicting that model on everybody, almost. (4, personal communication, March 2010)

One participant didn't believe there were any other interventions that should be used with the clients they encountered, "I honestly don't think there are any

others. I'm really an advocate after using it the past five years of CBT" (5, personal communication, February 2010).

Summary

This chapter has reported the data collected from the interviews. Both the demographic and research questions from the interview guide were addressed, and results from each were described. This data will be further discussed and interpreted in chapter five.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the results of the research done for the purpose of this study. It introduces possible interpretations of the data collected, and eight themes that became apparent throughout the interview and coding process. This chapter will also address the faults of the study, and how it may be done better in the future. It proposes recommendations for social work practice, policy, and research. This study is applicable to both macro and micro practice; therefore, the results have presented the researcher with many implications as far as where and how further research could be done and how evidence-based practices could be better implemented in policy. The researcher also proposes how individual clinicians could become better aware of and more aptly implement evidence-based modalities within their practice.

Discussion

County Policy

Several themes became apparent in the coding process. When the clinicians were asked how their agencies determine the interventions they can utilize with clients, they answered that county policy was the major determinant. This could be interpreted various ways. First, this could mean that the clinicians are unaware of federal and state policies. Furthermore, they may not be keeping up with current research on evidence-based practices. It could also mean that the clinicians did not know how their agencies decided which interventions to use, and were guessing.

Interventions Available

The interview participants were also asked which interventions their agency had determined available for use. Despite the implementation of evidence-based interventions, most clinicians felt they still had discretion with what interventions they used with their clients. Yet, when asked, they admitted only a handful of interventions they have available for use. The clinicians overwhelmingly mentioned CBT as a technique that was encouraged. One clinician did not realize that

evidence-based interventions other than CBT were available. One could suggest that this means that CBT is touted as reliable and practical. The clinicians may also be more comfortable utilizing the modality of CBT, and therefore use it more often than other modalities of treatment. Furthermore, if the clinicians valued an eclectic approach, but thought their agency did not encourage this type of practice, they may have simply answered what was politically correct, and not necessarily what they were actually doing. Some may interpret the widespread use of CBT as a research issue, in that CBT is a highly measurable intervention, and therefore, more easily researched. Agencies could be more inclined to utilize CBT because it is highly evidence-based, and also because it makes evaluation easier for the agency because it is more easy to measure.

Flexibility

Interesting enough, while some of the clinicians felt they had flexibility in their practice, others reported that they did not have flexibility in which interventions they used. This ambiguity could be seen as a lack of knowledge about which evidence-based interventions are currently available for use. It may

also mean that the clinicians were complacent in that they did not use other interventions, or were more comfortable in what they had available to them.

Efficacy

Some clinicians reported that the evidence-based interventions were more effective than the other interventions they had used, while others said it was difficult to tell if they were more effective or not. This ambiguity could be explained as a result of pressures to utilize evidence-based practice, and clinicians' knowledge of the "right" answer. They may have felt that evidence-based interventions were supposed to be better, so they answered that they were. The clinicians could be using different methods of evaluation for their interventions, which could explain the opposing views of evidence-based practices.

Evaluation

When the clinicians were asked about personal and agency evaluation, they all admitted that the agencies currently used evaluation. However, only some said their agency used evaluation prior to evidence-based practice implementation. This could be interpreted as a lack of knowledge about agency procedure prior to evidence-based

practice implementation. These answers could mean that agencies are now more transparent regarding their operations in evaluation, or that agencies are now held more accountable for the services they render. In regards to individual clinician evaluation, most reported that they used client report, but some said that they utilized goal setting as a means of evaluation and measurement. This demonstrates the range of evaluation methods, and could reflect agency flexibility when it comes to clinician evaluation. These answers could also be interpreted as a lack of standardization or direction when it comes to evaluation of self on the clinicians' part. It could also demonstrate a lack of knowledge of evaluation methods. It may also represent evaluation as low-priority for individual clinicians.

Non-Evidence Based Interventions

When the clinicians were asked if they believed their clients could benefit from other, non-evidence based interventions, they overwhelmingly said "yes." However, one clinician did not believe there were other appropriate interventions. These answers could be interpreted a number of ways. First, it could demonstrate a lack of creativity on the clinician's part, for not

integrating some of these other interventions into their evidence-based practice. The clinicians may feel a lack of ownership over the future of social work practice and not feel a need for innovation, as they are not initiating research surrounding the interventions that they would like to use. Their answers could also mean that they do not necessarily know which practices their agencies would allow them to use. Lastly, these answers could be interpreted as laziness or a lack of creative charting on the clinician's part. If their agencies expect them to be utilizing certain interventions, they could weave those interventions into their practice, and chart towards those particular practices, rather than these other modalities they wish they could use.

Psychodynamic Therapy

The most widely touted non-evidence based intervention that clinicians would like to use was psychodynamic/processing therapy. There are a number of ways in which one could interpret this. First, this may mean that clinicians are overwhelmingly more comfortable with psychodynamic methods. It could also mean that psychodynamic treatment is difficult to measure, and therefore more difficult to research. It may mean that

clinicians are already utilizing psychodynamic techniques in their treatment, but do not want to admit to being eclectic. Finally, it may suggest that experience has shows clinicians that psychodynamic methods are integral to mental health treatment. This answer may also have implications for how clinicians are educated or how schools are teaching psychodynamic methods.

Ambiguity

Overall, there was a general theme of ambiguity regarding evidence-based practice. The clinicians were not cohesive regarding which interventions they used, how well they worked, or how they were evaluated. Furthermore, they expressed very different expectations and degrees of satisfactions with evidence-based practices. This may a general ambiguity regarding the very definition of evidence-based practice, as was discussed in chapter 2. It may also simply mean that evidence-based practice is a new concept, and not widely appreciated. Finally, it may be interpreted as evidence-based practices seen as a fad, or temporary trend in practice. This explain why clinician's do not feel responsible for learning more about and researching evidence-based practices.

Limitations

In hindsight, there are many practical limitations to this study. First, some of the questions on the interview guide were redundant; specifically, those questions regarding agency and individual clinician evaluation seemed to be repetitive. These questions could have been consolidated. Also in regards to the interview guide, some of the questions were assumptive of prior clinical experience. Since not all of the clinicians interviewed had long-term experience, the questions about practice before evidence-based practice implementation had occurred were not applicable. It would have been beneficial to have clinicians with more years of experience. This would have enabled a more apt comparison of pre- and post- evidence-based practice implementation. Most importantly, sample size and sampling method were definite limitations of this study. The sample consisted of only 9 participants, and they were found by a convenience method of sampling. These two factors reduce both internal and external validity of this study.

Recommendations for Social Work Practice, Policy and Research

After discussing and interpreting the main themes of this research project, some implications for social work research, practice, and policy have become apparent. First, this study has demonstrated the need for more research regarding evidence-based practices. More specifically, it demonstrates the need for more cohesive research, and a real necessity for a definitive description of what evidence-based practice is and which interventions it encompasses. Finally, it shows that there are other interventions that may be affective, but do not have the research backing them to be considered evidence-based. Creative methods of evaluation are needed to more accurately research the legitimacy of a wide array of interventions and not just those easily measurable. This study has also shown that clinicians need to be more involved in social work policy. It seems that evidence-based practice is a positive direction for social work practice, as it is a form of "best practice." However, policy could create a definition of evidence-based practice that could be utilized by all agencies, individuals, and researchers. Finally,

practitioners should become more educated on evidence-based practice in general, as well as individual modalities of evidence-based practice. This study has shown that clinicians should have a responsibility for providing their clients "best practice," and having a broad knowledge base is integral to doing so. Furthermore, expertise is a social work value. It is, therefore, a social work clinician's responsibility to be an expert in what they do. Right now, evidence-based practice is synonymous with "best practice," and integral to the operation of public mental health agencies.

Conclusions

This chapter introduced the themes that were found in chapter four. Utilizing context, prior knowledge, the literature review, and the first-hand data of the interviews, the researcher was able to detect possible interpretations of the data collected. This chapter also brought forth many ideas for both macro and micro social work practice. It also demonstrated how studies in the future may improve upon this study's design.

This study focused on a current "hot-topic" within social work micro practice. Its aim was to explore the

efficacy of evidence-based practices within public mental health agencies. The study accomplished this by interviewing clinicians with first-hand knowledge and experience of evidence-based practice implementation in public mental health agencies. It is hoped that this study will open more dialogue regarding evidence-based practice. Professional and academic discussions regarding how one could define evidence-based practice, how interventions should be researched, and how evidence-based practice policies should be implemented are vital to the advancement of "best practice," social work in the mental health field, and the social work community in general.

APPENDIX A

INTERVIEW GUIDE

Interview Guide

1. What is it your age?
2. What gender do you identify with?
3. What level of education and licensure have you attained?
4. How many years of clinical experience do you have?
5. What is your current job?
6. How does or did your agency determine which interventions you use with clients?
7. Which evidence based interventions has/had your agency determined available for use?
8. How does/did the agency evaluate the interventions they use?
9. Did the agency evaluate interventions prior to the utilization of evidence-based practice?
10. What types of clientele do/did you most commonly work with?
11. Have you worked with this client population before?
12. What interventions have you used in the past with clients that were not considered evidence-based?
13. Did you measure the efficacy of these interventions? How?
14. What were the outcomes with non-evidence-based practice interventions used with your clients?
15. Which evidence-based practices do/did you use with your clients?
16. Are/were you allowed flexibility in which evidence-based practices you use with your clients?
17. Do you think the specific evidence-based practice interventions you are/were allowed are/were appropriate for the clientele you encounter?
18. Do you feel your clients could/could have benefit/ed from other, non-evidence-based interventions?

19. How do you (or your agency) evaluate the evidence-based practices you utilize with clients? What are/have been the outcomes?

20. Do you think that the evidence-based interventions you use now are more or less effective than the interventions you used before with your clients?

21. Which interventions do you think your clients could benefit from that are not available due to evidence-based practice implementation, based on your experience?

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

The study in which you are being asked to participate in is designed to investigate the effects of evidence-based practice implementation in public agencies. This study is being conducted by Ms. Hannah Norton, a Master of Social Work graduate student under the supervision of Professor Thomas Davis, School of Social Work, California State University, San Bernardino. This study has been approved by the Social Work Human Subjects Sub-Committee of the Institutional Review Board, California State University, San Bernardino.

PURPOSE: The purpose of the study is to investigate the effects, if any, of the implementation of evidence-based practice within public agencies.

DESCRIPTION: You are being asked to take part in a face-to-face interview. You will be asked a few questions about your background, your thoughts on evidence-based practice from your experiences, and the agency you work/worked for.

PARTICIPATION: Participation is totally voluntary and refusal to participate will involve no penalty or loss of benefits to which you are entitled. You may discontinue participation at any time without penalty.

CONFIDENTIALITY: The information you give during the interview will be recorded. Your answers will not be linked to your name or your agency.

DURATION: The interview will last approximately 30 minutes.

RISKS: There are no foreseeable risks to your participation in the research.

BENEFITS: As a reward for your full participation in this study you will be rewarded with a $5.00 gift card to Starbucks.

VIDEO/AUDIO/PHOTOGRAPH: I understand that this research interview will be audio recorded. Data from the interview will be confidential, coded, and interpreted initials ( )

CONTACT: If you have any questions about this project, please contact my research supervisor, Dr. Thomas Davis, Associate Professor, School of Social Work, California State University, San Bernardino, 5500 University Parkway, San Bernardino, CA 92407, tomdavis@csusb.edu, 909-537-5839.

RESULTS: The results of this investigative study will be available at the Pfau Library, California State University, San Bernardino after September 2011.

X: _____ Date _____

REFERENCES

Adams, K., LeCroy, C., & Matto, H. (2009). Limitations of evidence-based practice for social work education: unpacking the complexity. *Journal of Social Work Education, 45*(2), 165-186. Retrieved from http://vnweb.hwwilsonweb.com.libproxy.lib.csusb.edu/hww/results/results_single_fulltext.jhtml;hwwilsonid=DLUG4DKCIVZSLQA3DIKSFGOADUNGIIV0

Barker, P. R., Epstein, J. F., Hourani, L. L., Gfroerer, J., Clinton-Sherrod, A. M., West, N., & Shi, W. (2004). *Patterns of Mental Health Service Utilization and Substance Use among Adults, 2000 and 2001* (DHHS Publication No. SMA 04-3901, Analytic Series A-22). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Retrieved September 28, 2009 from http://oas.samhsa.gov/mhtx/toc.htm

California Department of Mental Health. (2004). *Mental health services act*. Retrieved from http://www.dmh.ca.gov/Prop_63/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf

California Health and Human Services Agency. (2007).*Statistics and Data Analysis*. Retrieved September 28, 2009 from http://www.dmh.ca.gov/Statistics_and_Data_Analysis/docs/Statewide_Production_Rpt/CSIannualreport_FY0506_FINAL_1.pdf

Furman, R. (2009). Ethical considerations of evidence-based practice [Editorial]. *Social Work, 54*(1), 82-84. Retrieved from http://libproxy.lib.csusb.edu/ login?url=http://search.ebscohost.com/ login.aspx?direct=true&db=ulh&AN=36048926&site=ehost-live

Gibbs, L., & Gambrill, E. (2002). Evidence-based practice: counterarguments to objections. *Research on Social Work Practice, 12*, 452-476. doi:10.1177/ 1049731502012003007

Gray, M., & McDonald, C. (2006). Pursuing good practice? The limits of evidence-based practice. *Journal of Social Work, 6*(1), 7-20. doi:10.1177/ 1468017306062209

Hardina, D. (2002). *Analytical skills for community organization practice*. New York: Columbia University Press

Holosko, M., & Leslie, D. (1998). Obstacles to conducting empirically based practice. In J. S. Wodarski, & B. A. Thyer (Eds.), *Handbook of empirical social work practice: Vol. 2. Social problems and practice issues* (pp. 433-451). New York: John Wiley & Sons, Inc.

Lalayants, M., & Tripodi, T. (2009). A review of generalization methods used in empirical social work research. *International Journal of Social Welfare, 18*, 333-341. doi:10.1111/ j.1468-2397.2008.00634.x

Mullen, E., & Streiner, D. (2006). The evidence for and against evidence-based practice. In A. Roberts & K. Yeager (Eds.), *Foundations of evidence-based social work practice* (pp. 21-34). New York: Oxford University Press.

National Association of Social Workers. (approved 1996, revised 1999). *Code of Ethics of the National Association of Social Workers*. Washington, DC: Author.

National Institute of Mental Health. (2009). *Statistics*. Retreived from http://www.nimh.nih.gov/health/ topics/statistics/index.shtml

New Freedom Commission on Mental Health. (2003). *Achieving the promise: transforming mental health care in America*. Rockville: DHHS Pub. No. SMA-03-3832

O'Hare, T. (2005). *Evidence-based practices for social workers*. Chicago: Lyceum Books, Inc.

Popple, P., & Leighninger, L. (2008). *Social work, social welfare and American society* (7th ed.). Boston: Pearson Education. (Original work published 1990)

Riverside County Department of Mental Health. (2006). *Riverside County mental health services act.* Retrieved from http://mentalhealth.co.riverside.ca .us/opencms/english/mhsa /Revised_Plan_1_10_06_pdf_1.pdf

Thyer, B. (2006). What is evidence-based practice? In A. Roberts & K. Yeager (Eds.), *Foundations of evidence-based social work practice* (pp. 35-46). New York: Oxford University Press.

U.S. Census Bureau. (2008). *Riverside County, CA.* Retrieved September 28, 2009 from http://quickfacts.census.gov/qfd/states/06/06065.html

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health

Webb, S. A. (2001). Some considerations on the validity of evidence-based practice in social work. *British Journal of Social Work, 31*(1), 57-79. doi:10.1093/ bjsw/ 31.1.57

Yunong, H., & Fengzhi, M. (2009). A reflection on reasons, preconditions, and effects of implementing evidence-based practice in social work. *Social Work, 54*(2), 177-181. Retrieved from http://libproxy.lib .csusb.edu/ login?url=http://search.ebscohost.com/ login.aspx?direct=true&db=rzh&AN=2010240854&site =ehost-live