The mission of the *Columbia Social Work Review* is to provide a forum for the exchange of innovative ideas that integrate social work practice, education, research, and theory from the perspective of social work students. Founded by students at Columbia University School of Social Work in 2003 as the *Columbia University Journal of Student Social Work*, this academic journal provides an opportunity for students in the field of social work to share their unique experiences and perspectives with fellow students, faculty, and the larger social work community.
Editorial Board…………………………………………..Page 4
Editorial Letter…………………………………………..Page 5
Advisory Board and Acknowledgments…………………..Page 6

Undoing the Damage: Working with LGBT
Clients in Post-Conversion Therapy
by Jessica Horner…………………………………………..Page 8

Funding America’s Nonprofits: The Nonprofit
Industrial Complex’s Hold on Social Justice
by Jennifer Ceema Samimi………………………………..Page 17

Utilizing Exercise and Nutrition in the Treatment of
Chronic Disease: Community-Based Models
by Jake T. Kim…………………………………………….Page 26

Mental Health Courts: An Interface Between
Social Work and Criminal Justice
by Leslie Roberts………………………………………….Page 36

A Case for Evidence-Based Practice
by Tara Batista…………………………………………....Page 45

Contributors…………………………………………….…Page 54

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Editorial Letter

Welcome to the Columbia Social Work Review! In our inaugural edition we continue the tradition of the Journal of Student Social Work to bring you new perspectives on social work.

This past year has been full of challenges across the globe: the devastating earthquake in Haiti, war in many countries, and the continued economic crisis, to highlight just a few. In light of these challenges, we invite social workers to reassess our collective work and join with others to enact creative and collaborative solutions to the world’s challenges. The articles within these covers depict opportunities for such practices.

Jessica Horner shows us in “Undoing the Damage: Working with LGBT Clients in Post-Conversion Therapy” the challenges that appear at the intersection of identity and faith for many people in the LGBT community. She highlights what social workers need to be aware of when individuals seek services after post-conversion therapy. Jennifer Ceema Samimi shows us, in “Funding America’s Nonprofits: The Nonprofit Industrial Complex’s Hold on Social Justice,” that social justice organizations must be cognizant of their funding sources and how these sources impact their ability to fulfill their mission statements. In “Utilizing Exercise and Nutrition in the Treatment of Chronic Disease: Community-Based Models” Jake T. Kim reminds us that exercise and nutrition are fundamental in preventing chronic disease. Yet, he points out the barriers that certain communities face in accessing these basic necessities for optimal health. In “Mental Health Courts: An Interface Between Social Work and Criminal Justice,” we learn from Leslie Roberts that alternatives are necessary in our criminal justice system, where people in need of mental health services are not marginalized but receive justice in court. Finally, Tara Batista challenges social workers in “A Case for Evidence-Based Practice” to examine their interventions and suggests that evidence-based practice is the most appropriate response to client needs.

We hope that you enjoy this first edition of the Columbia Social Work Review. The following articles add to the critical way in which we should examine our roles and our profession.

Sincerely,

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Undoing the Damage: Working with LGBT Clients in Post-Conversion Therapy

Jessica Horner

As a mecca of diversity, New York City is one of the epicenters for the lesbian, gay, bisexual, and transgender LGBT community. As such, LGBT identified clients present in New York’s counseling and mental health agencies with a cross section of issues unique to the LGBT community. One of these issues is the deleterious effects LGBT-individuals face after an experience with conversion therapy. Conversion therapy aims to alter a person’s sexual orientation away from homosexuality and into heterosexuality or celibacy. Clients seeking counseling after an experience with conversion therapy present distinct practice challenges that require special consideration in treatment. These clients may experience both sexual and spiritual identity crises, symptoms of depression and anxiety, hopelessness, sexual dysfunction, and symptoms of post-traumatic stress. Integrative solution therapies, grief work, community-based interventions, and trauma work offer healing strategies for treating LGBT clients after conversion therapy.

One associates the practice of conversion therapy with a time when homosexuality was a diagnosable mental illness. Many contemporary clinicians readily classify such practices as unethical and therefore conclude that they are rare in occurrence. Furthermore, prevalence rates of conversion therapy are unclear and vary geographically. Individuals suffering from the adverse effects of conversion therapy appear in diverse urban areas such as New York City’s lesbian, gay, bisexual, and transgender (LGBT) affirmative agencies, indicating that it is still a relevant concern for the LGBT community and mental health practitioners serving these populations.

Though we generally consider those who undergo conversion therapy to be bisexual, gay men, or lesbians, transgender individuals have also experienced conversion therapy since not all transpersons identify as heterosexual. Consequently, conversion therapy may affect anyone in the LGBT community.

As an historically underserved sexual minority population subjected to homophobia and transphobia, LGBT clients present with symptoms of depression, anxiety, and post-traumatic stress disorder. These symptoms are the result of overt aggression, physical assault, living with limited civil liberties, microaggressions, and the overall unaccepting social climate of an inherently homophobic society. Embedded in these societal oppressions is the practice of conversion therapy in which a licensed clinician, priest, rabbi, or other spiritual advisor works with the LGBT-identified client to “convert” the individual to a heterosexual, or at least a celibate, lifestyle. In opposition to conversion therapies, the National Association of Social Workers Committee on Lesbian, Gay, and Bisexual Issues (NCLGB) firmly asserts:
Lesbians and gay men often are pressured to seek reparative or conversion therapies, which cannot and will not change sexual orientation…NCLGB believes that such treatment potentially can lead to severe emotional damage…no data demonstrates that reparative or conversion therapies are effective, and in fact they may be harmful.

(NCLGB, 2000, p. 1-2)

With this statement in mind, this paper explores evidence-based approaches that affirm and support both the sexual and spiritual identity of the LGBT-identified client seeking mental health services after conversion therapy. Such approaches are referred to as “integrative solutions” (Gonsiorek, 2004). The following case example highlights many of the traumatic experiences unique to LGBT populations involved in conversion therapy.

**Consequences of Conversion Therapy**

M.H. arrived disheveled and exhausted for counseling services during walk-in hours at a LGBT community center in New York City. LGBT community centers often serve as sanctuaries for LGBT individuals who have experienced trauma by providing them with counseling and case management services. M.H. arrived at the center hoping the agency could help him find somewhere to stay. His affect was flat, and he held his head in his hands as he explained that he was 21 years old and running away from home. His parents, particularly his father, abused him for being gay. His mother and father called him derogatory names and often hit him. In tears, M.H. disclosed that his parents sent him to a Christian conversion counselor who tried to “turn him straight” and also verbally assaulted him. He wanted desperately to move away from his parents but lacked the resources to live on his own. Through his tears, his face remained flat and unanimated as if he were resigned to giving up. He confirmed this sentiment when he stated that he no longer cared whether he lived or died. Unfortunately, the conversion therapy movement profoundly impacted M.H., and the issues he encountered are highly relevant to those working in social services with LGBT populations.

Some consider conversion therapy a phenomenon of the past, but many LGBT clients who seek various types of counseling still encounter ideas and therapies that attempt to convert an individual’s sexual orientation, especially in the context of religion. Conversion therapy, also referred to as reparative therapy, began with the idea that LGBT individuals are “sexually broken” (Kort, 2008; Haldeman, 2002b). Despite the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders in 1973 by the American Psychological Association, these therapies persisted, justified by theological arguments that define homosexuality as a moral transgression. In an attempt to rectify this perceived transgression, conversion therapists used abusive aversion techniques with their clients, which included electric shocks to the hands and genitals when exposed to homosexual material, encourage-
ment of heterosexual activity such as sex and dating, and the teaching of skills to manage homosexual tendencies. Clients who experienced such therapies present unique practice challenges for mental health providers because conversion techniques are frequently associated with religious conviction (Kort, 2008; Gonsiorek, 2004).

A client seeking services after conversion therapy may be in a state of emotional and/or spiritual crisis. Clients seeking counseling after an experience with conversion therapy present with increased levels of depression, low self-esteem, and suicidal ideation and intention (Nicolosi, Byrd, & Potts, 2000). They frequently feel intense shame and self-loathing from internalized homophobia (Carroll, 2010). Furthermore, some consider the infliction of conversion therapy upon an LGBT individual a type of hate crime and sexual minorities endure devastating and long-lasting effects from hate crimes (Rose & Mechanic, 2002). Other studies confirm chronic depression and low self-esteem in post-conversion clients, as well as sexual dysfunction and significant relational issues (Haldeman, 2002b).

In addition to psychological consequences of conversion therapy, individuals experience a series of concrete losses. Clients may feel that they have “failed” at conversion therapy and, as a consequence, may be ostracized by family, community, and work, all of which are significant and potentially incapacitating losses (Haldeman, 2002b). This sense of failure and loss can contribute to debilitating feelings of guilt (Haldeman, 2002b). Clients not only experience the identity trauma of intrinsically homophobic conversion therapy, but also experience another level of psychological pain when they consider themselves failures for not having the ability to change their sexual orientation.

When conversion therapy fails to change one’s sexual orientation, it eliminates any hope for change a client may have had prior to the conversion therapy. Consequently, clients enter post-conversion therapy attempting to manage the aforementioned issues, and they may also endure dangerous levels of hopelessness.

Clients who seek counseling and mental health services after conversion therapy survived psychological manipulation and possibly physical trauma. They may have suffered some threat to and/or crisis of identity. The identity component of the trauma adds another level of complication to clinical work in mental health counseling, especially when the client cannot decouple spiritual and sexual identity. Historically, the controversy around conversion therapy centered on the ideological debate of whether or not it should exist. Even some mental health practitioners who are not necessarily proponents of conversion therapy argue that client self-determination ranks as a priority over the ethical considerations of the treatment (Carroll, 2010; Haldeman, 2002a). Therefore, many practitioners who honor client choice above other ethical standards believe individuals should have access to conversion therapy.

Working in tandem with sexuality and spirituality creates precarious clinical situations for the practitioner. Researchers highlight the fact that the saliency of spiritual identity and the need for a spiritual belief system often exceed those of sexuality, and a practitioner who suggests “an abandonment of
their spiritual traditions in favor of a more gay-affirming doctrine” may also inflict psychic damage on the client (Haldeman, 2002a, p. 263). Haldeman (2002b) reiterates in another article that religious beliefs can define the self as much as or more than sexual orientation. For some, positive associations with religion, such as comfort, family connection, and routine, are lost with acceptance of sexual orientation, a loss that the practitioner must acknowledge and respect. Furthermore, acknowledgment of sexual orientation does not always automatically earn acceptance into the LGBT community. Some LGBT clients complain that, “it is easier for some individuals to come out as lesbian or gay men in their communities of faith than it is to come out as spiritually or religiously oriented in the LGB community” (Haldeman, 2002a, p. 262). The practitioner must not assume that a client can easily “give up” a religious community in exchange for the LGBT community.

Implications for Practice

Integrative solution therapies propose that mental health clinicians respect all the components of a client’s identity and assist the client in making room for a variety of aspects of identity in their overall self-schema (Gonsiorek, 2004). The therapist does not seek to indoctrinate the client into the LGBT-affirmative community, but rather intends to illuminate the ways in which social forces coalesce to devalue, invalidate, and sometimes oppress gender and sexually non-conforming individuals. Frequently, significant loss may be associated with these truths. For example, a client’s deeply embedded schema that everything about her religion is true and good will be compromised with the acknowledgement that this fundamentally “true and good” community has also oppressed her in some way. Therefore, grief work will be necessary for such clients (Haldeman, 2002b). After the client acknowledges the pain of her losses, she may need to deal with internalized homophobia, guilt, and shame. Haldeman (2002b) advises:

Neutralization of shame takes place by examining a self that has been firmly embedded in a socio-cultural environment that did not value the self for who it was, but that required it to change (or hide) in order to be acceptable…this is not a problem of the self, but of the social environment.

(p. 121)

Creating an environment that simultaneously affirms and validates both spiritual and sexual identity requires illustrating for the client a concept of the self within a socio-cultural environment. Collectively, some of the integrative solution practice goals for working with clients after conversion therapy include acknowledging and validating pain and loss, neutralizing shame, and encouraging clients to live for themselves rather than the social institutions that pressure them to conform to a certain standard (Haldeman, 2002b).

The literature highlights other important practice considerations when
working with LGBT clients participating in post-conversion therapy. For example, LGBT-identified individuals who attempt conversion therapy commonly believe that their homosexuality resulted from inadequate or inappropriate bonding with one or both parents, that they are morally corrupt, or that homosexuality represents a failure in adequate psychological development (Carroll, 2010; Kort, 2008; Haldeman, 2002a; Haldeman, 2002b). Such clients often need varying amounts of psychoeducation following conversion therapy. The practitioner must address these beliefs without denigrating religious conviction or disparaging the client for her potential belief in such statements. Furthermore, practitioners must be absolutely comfortable with addressing and discussing sex with their clients in order to ensure they have the most accurate information with which to protect themselves. In particular, therapists need to comfortably address the topic of sex because of the way in which trauma and sexual orientation have impacted the client’s formation of identity.

In many ways, LGBT clients in post-conversion therapy suffer a double assault to their identity formation. They entered, or were coerced into, conversion therapy because their spiritual and/or self-concept clashed with their sexual orientation. Unfortunately, the trauma experienced in conversion therapy further disturbs a client’s sense of self on a less conscious level. For example, traumatic memory remains highly accessible to an individual and, consequently, autobiographical knowledge organizes itself into a new, salient, cognitive schema created by the trauma memory; it may be interpreted as a feature of one’s personal identity (Berntsen & Rubin, 2007). Furthermore, trauma creates highly accessible memories which, according to the availability heuristic, cue the victim to overestimate the frequency of the traumatic events. Not only will a client organize any or all knowledge of self into the cognitive schema created by the trauma of conversion therapy, she may expect to be hurt and traumatized again when re-entering treatment after an experience with conversion therapy. Consequently, the client may shut down, be defensive, suicidal, highly anxious, and/or experience symptoms of post-traumatic stress disorder. Knowing and expecting the cognitive effects of trauma equip the practitioner for work with LGBT clients in post-conversion therapy.

The implications of these findings for work with individuals in post-conversion therapy are extensive. The social worker and/or mental health practitioner must consider trauma, spiritual and sexual identity, and any presenting clinical pathology. Distinguishing pathology from the negative effects of a lifetime of internalized homophobia contributes to the complexity of treatment considerations. However, a practitioner has the opportunity to do meaningful and important work by simply providing a client with information incongruent with their maladaptive schema, which commences the process of forming new, healthier, and more adaptive schema (Berntsen & Rubin, 2007). Therefore, a significant component of practice with post-conversion clients involves providing them with schema-deviant material through a series of corrective emotional experiences. Unconditional positive regard, valuing all features of a client’s identity, and resisting impulses both to coax her into openly embracing her sexuality and to compel her to integrate into the LGBT community all provide
Undoing the Damage

the client with some level of remedial emotional experience, thus increasing
the likelihood that she will remain in treatment and achieve some healing. In
order to achieve a safe environment, the clinician must recognize her own het-
erosexual and gender-normative privilege (if she does not identify as LGBT),
and acknowledge the grief that comes with losing heterosexual privilege in the
community after unsuccessful conversion therapy (Kort, 2008). Other ap-
proaches to trauma work, discussed below, are particularly relevant to work
with post-conversion therapy clients.

Healing Trauma

Judith Herman (1992) adopts a feminist perspective on trauma theory
and practice. Herman describes many of the features characteristic of a trauma-
tized individual. One feature includes “re-living” the trauma in thoughts, ac-
tions, and dreams. This phenomenon is particularly relevant in working with
clients after conversion therapy. For example, many clients who have under-
gone conversion therapy report persistent sexual dysfunction. For clients who
received aversion stimuli, such as electric shocks, sexual intimacy brings back
the moment of conversion therapy trauma, and she may be unable to continue
any sexual activity. This repetitive intrusion produces debilitating effects.
When she coins the “dialectic of trauma” phenomenon, Herman describes the
converse of intrusive re-living experiences in which the traumatized individual
vacillates between states of complete numbness and amnesia of the trauma, to
states of overwhelming sensitivity and re-living of the event. Practitioners
working with individuals in post-conversion therapy should recognize this dia-
lectic vacillation and cultivate awareness of the danger and emotional distress
involved in both of these states. According to Herman, the emotional/re-living
state could produce complete inhibition in the client, creating a variety of un-
safe situations ranging from self-harm, substance abuse, and unsafe sex.
Numbness and complete lack of feeling may lead to extreme isolation and the
development of symptoms of depression, both pertinent concerns for individu-
als who identify as LGBT.

Herman (1992) also discusses the way in which trauma affects faith
and sense of community, both critical factors involved in working with clients
in post-conversion therapy. She asserts that to repair the connection between
the traumatized person and the community, the community must concurrently
acknowledge the harm inflicted on the individual and take action in response to
the inflicted harm. Herman states that “these two responses – recognition and
restitution – are necessary to rebuild the survivor’s sense of order and jus-
tice” (p. 70). This may present a particular challenge to clients in post-
conversion therapy. In many cases, the community that inflicted the harm on
the individual will neither publicly acknowledge the damage nor take responsi-
bility or action to make amends. In order to achieve recognition and restitution
for the traumatized client, the practitioner must investigate resources that help
satisfy these needs. For example, a client forced under threat of expulsion by
her religious community to engage in conversion therapy has the opportunity

13 Columbia Social Work Review, Volume I
to gain recognition from inclusion in a LGBT-affirmative religious setting. Unfortunately, such resources are difficult to access even in densely populated urban areas because homosexuality is still highly stigmatized within and outside of the context of religion, but the practitioner should remain aware of potential avenues for achieving recognition and restitution within a community.

The best opportunity for recovery from trauma is in interpersonal relationships, rather than in isolation (Herman, 1992). In this way, the survivor rebuilds and repairs the psychological functioning that was jeopardized by the trauma. In discussing the significance of allowing a client to remember and mourn losses, Herman delivers wisdom particularly suited to those who have survived conversion therapy:

[The survivor] often comes into conflict with important people in her life. There is a rupture in her sense of belonging within a shared system of belief. Thus she faces a double task: not only must she rebuild her own “shattered assumptions” about meaning, order, and justice in the world but she must also find a way to resolve her differences with those whose beliefs she can no longer share.

(Herman, 1992, p. 178)

A client seeking LGBT-affirmative treatment after an experience with conversion therapy may confront overwhelming psychic tension in trying to “resolve differences” between conflicting systems of belief. This poses particular challenges for the clinician who may gravitate to theological solutions for the client either by trying to alter the client’s system of belief or by trying to find different interpretations of those beliefs. Instead, the clinician must assist the client in deciding which beliefs to cherish and which doctrines to mourn. Herman (1992) describes multiple features of trauma, such as re-living and intrusion of the event into daily life, and the importance of community in healing from the trauma. The aforementioned treatment considerations pertain to affirmatively supporting a LGBT client post-conversion therapy and providing critical tools for working with any traumatized individual.

Conclusion

Though M.H. and I met only once, strong interpersonal factors emerged during this meeting. M.H. maintained a defensive and guarded posture, sitting with his legs double-crossed and his arms tightly crossed around his abdomen. He rarely made eye contact and covered his face so I could not see his tears. He also repeatedly apologized for crying. Such acute discomfort was difficult to witness, and my primary goal during the intake session was to provide constant reassurance, validation, and a sense of safety in the hopes of creating a mini-corrective emotional experience that would be just enough to bring him back for continued services. In an attempt to be as affirmative as possible, I made the mistake of openly judging the community and family from...
Undoing the Damage

which he came, and I rushed to reassure him that he had a place in the LGBT community. As discussed, the literature reveals the danger in using such a tactic. In my concern for his well-being, I was extremely eager to whisk him away from his abusive family and community into the LGBT community with which he may not yet, or ever, identify. The outrage one feels for the devastating effects such overt hate and discrimination produce may be one of the most difficult emotions for clinicians working with clients post-conversion therapy. It triggers an impulse to “rescue” or “save” the client which, ironically, are some of the same verbs used by conversion therapists to justify their work. This is a sobering realization.

Future research must explore the ways in which social workers and other mental health practitioners can empower individuals who seek treatment after an experience with conversion therapy. Greater attention to the subject would help contradict the erroneous belief that conversion therapy no longer exists since homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders. Clients who survived conversion therapy suffer a myriad of psychological symptoms ranging from depression and anxiety to PTSD and sexual dysfunction. They may be in spiritual and emotional crisis, experiencing shame, low self-esteem, relational issues, and the loss of family and/or community.

The biggest challenge for practitioners in treating the symptoms of clients exposed to conversion therapy lies in the fact that clients need guidance in resolving the tension between their religious conviction and their sexuality, a very precarious task for the clinician. Integrative solution therapies that attempt to make room for all aspects of oneself (spiritual, sexual, and otherwise) offer some hope for LGBT individuals seeking treatment after an experience with conversion therapy. Integrative therapies also strive to bring awareness to the client of how environmental and social forces contribute to their pain and experiences with homophobia, and they aim to acknowledge and validate pain and loss, neutralize shame, and teach clients to live for themselves rather than for institutions. Trauma and grief work also assist in this process. As demonstrated in the case of M.H., these issues are deeply ingrained and may even be life threatening at times. Despite some social progress, conversion therapy exists and practitioners must be prepared to adequately serve LGBT individuals; they deserve the same non-judgmental, affirmative, and evidence-based therapies as their heterosexual counterparts.

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Funding America’s Nonprofits: The Nonprofit Industrial Complex’s Hold on Social Justice

Jennifer Ceema Samimi

Private nonprofits are increasingly relied upon to provide social services in the United States. As these nonprofits professionalize and look to the government and foundations to fund their work, communities may be deprived of services they need in order for the agendas of funders to be carried out. By examining the rise of the nonprofit as an institution in the United States, this article examines how social justice has been separated from social service provision by the system that has come to be known as the Nonprofit Industrial Complex.

People working for social justice in the United States today are limited by the dysfunctional funding system that sustains most nonprofits. A significant number of people who believe in and work for social justice are employed in the nonprofit sector: an industry that requires organizations to compete for government and foundation funding. Known as the Nonprofit Industrial Complex (NPIC), this system forces nonprofits to professionalize, wherein they must focus on maintaining their funding sources rather than fulfilling their mission.

When organizations participate in the NPIC and perpetuate this cycle of sacrificing mission for funding, they disenfranchise their constituents. Such organizations become more concerned with remaining in business, and goals rooted in social justice become of secondary importance. Though lesser known, alternatives to this system do exist, whereby social justice need not be sacrificed for funding. It is important to examine these alternatives and to use them to evaluate the current nonprofit funding system.

Funding versus Social Justice

The latter part of the 20th century saw the American government devolving as it transferred its traditional responsibilities and processes for service provision to other levels of government, private companies, and nonprofit organizations (Kettl, 2000). The government no longer was the primary provider of social services in America. At the same time, community groups increased their capacity in the service provision domain. However, in order to receive funds from the government or private foundations to provide these services, these groups today are required to legally incorporate as nonprofits.

When funders have agendas that are inconsistent with the mission of the organizations that they support, organizations then risk becoming predisposed to mission drift. Mission drift is a term used to describe instances where an organization moves away from its mission, which in turn leads to a loss of the original reasons for their organizational establishment (Moore,
The concept of mission drift questions whether the organization maintains its original values and goals, exposing it to a potential compromise of its contribution to the community it serves.

Mission drift has the potential to result in tensions between staff and others involved in the organization, wasted resources, and loss of revenue (Moore, 2000; Dees & Anderson, 2003). The possibility of mission drift directly challenges nonprofits to find a balance between seeking social justice and seeking funding. Understanding how nonprofits developed in America is important in illustrating the establishment of the NPIC, and subsequently realizing how the NPIC resulted in the divergence of service provision and social justice.

Nonprofit Organizations and Social Justice:
A Brief History

In the United States today, social service delivery is commonly associated with nonprofit organizations; a relationship that originated during the country’s colonial period. In Making the Nonprofit Sector in the United States: A Reader, David C. Hammack (2000) outlines how religious groups during colonial times espoused a doctrine that “required assistance to be offered to those in need” (p. 19). The colonists implemented the British Poor Laws, which established a distinction between those who were unable to work due to their age or physical health and those who were able-bodied but unemployed. Those who were deemed unable to work were assisted with cash or other forms of assistance from the Colonial government. Those deemed able to work were sent to workhouses (Axinn & Stern, 2008). This concept of a “deserving poor” informed the development of service provision.

The Puritans established Harvard College as a place to educate ministers in 1643. In doing so, the religious group issued what was probably the first American fundraising appeal of its kind (Hammack, 2000). As the foundation of the social service industry began to establish its roots in religion against the backdrop of colonialism, the link to funding was also established. However, the idea of social justice, with a focus on the poor, was the target of service provision. Colonial notions of social justice were explicitly pursued by, and related to, the needs of the white settlers in America.

With the American Revolution came the constitutional separation of church and state. The newly established American nation state increased rights for white male citizens, as well as property rights for organizations (Hammack, 2002). These factors, along with a rise in egalitarianism, resulted in increased civic participation of citizens. With this growing social equality came the phenomenon of nonprofit schools, libraries, orphanages, and clinics in seeking out private sponsorship (Hammack, 2002; McCarthy, 2003).

Until 1800, no organization existed that fit today’s concept of a nonprofit. Over the next 100 years, most nonprofit work occurred within religious contexts as religious groups and churches played a central role in American community life. By 1900, schools and religious institutions were the largest
nonprofit employers. However, even with the addition of individuals employed by private colleges, orphanages, old age homes, publishing houses, museums, and other nonprofit organizations, the total was still estimated at less than 1% of the labor force (Hammack, 2002).

Throughout the 19th century there was no federal system for recognizing nonprofits, and it was at the discretion of local authorities to allow groups legal status. States had the permission of, and were often encouraged by, the federal government to reject requests from groups seeking nonprofit status. Minority groups that sought to change the existing power structure and establish social justice for their communities were often denied permission to form nonprofits by the government in an effort to maintain religious, racial, and gender norms. The established missions of many groups that did manage to achieve nonprofit status were likewise limited by the political stronghold on accepted forms of social leadership (Smith, 1997). Catholics, for example, were prevented from obtaining charters in many states due to a perception that upon their formal establishment, these organizations would be subsequently controlled by the pope (Carey, 1987).

Stifled by the governance of the strict system that limited access to financial support that might be available to contemporary nonprofits, early American nonprofits were only able to increase their income when local authorities allowed resources to be accessed. States were able to undermine access to resources by denying requests for charters, which also denied minorities the ability to challenge the status quo. Thus, as service providers continued to define themselves as a group, social justice advocacy efforts were limited because certain populations were excluded from access to resources through nonprofit fundraising. From 1900 until the 1960’s, nonprofit employment grew to about 3.7 percent of the labor force, which was in part due to the establishment of nonprofit nonsectarian universities and medical centers, which were not affiliated with religious institutions (Hammack, 2002).

Further growth of the nonprofit industry was limited during the first half of the 20th century for several reasons. The formation of New Deal programs, which were designed to employ citizens directly by the government through government agencies, did not provide funding for private welfare agencies (Brown & McKeown, 1997). The New Deal dramatically expanded the government’s role in the provision of services, including the establishment of unemployment compensation and Aid to Families with Dependent Children; two programs that still exist today (Axinn & Stern, 2008).

In addition to limiting the funding of existing organizations, many people were not allowed to establish nonprofits due to prejudice and restrictive traditions, for instance, existing religious discrimination in the north and segregation in the south. Additionally, some Americans faced political and financial constraints; for example, women were not able to gain control of these types of funding resources despite having gained the right to vote (Anderson, 1988; Gamble, 1995; McCarthy, 1990; Scott, 1992).

The devolution of the federal government has resulted in the government’s reliance on for-profits and nonprofits to provide a variety of goods and services.
services, including welfare services (Kettl, 2000). The transition of social welfare provision from the public sector to the private has led the government to develop and utilize a complicated system that consists of contracting intergovernmental funding through grants and loans, other funding regulations, and a series of mandated bureaucratic administrative methods (Mosher, 1980). Today, most domestic programs and agencies to which Congress allocates specific budgets, are managed through an indirect relationship between the federal government, for-profits, and nonprofits (Kettl, 1993).

The Imposition of the NPIC on the Pursuit of Social Justice

While there is no single definition of a nonprofit organization, a framework for understanding American nonprofits throughout history is evident by an agency’s possession of six organizational characteristics: nonprofits are formal organizations, they are private entities, they do not distribute profits, they are self-governing, they are voluntary, and they provide a public benefit (Hammack, 2002). Nonprofits are fundamentally different from corporations in two major ways; their funds are donated, not “earned,” and they are assumed to meet a need that serves the public good (Internal Revenue Service, 2008). Nonprofits also operate under a mission statement, which serves to formally establish the goals and functions of an organization by defining what it does, whom it serves, how they do it, and where it does its work (Meshanko, 1996).

In 2005, there were over one million nonprofits in the United States, and as of 2010 nonprofits are the seventh largest economy in the world (Cohen, 2005; National Council of Nonprofits, 2010). Nonprofits today include organizations that represent diverse causes and groups. Private hospitals, theater spaces, environmental organizations, human rights groups, advocacy groups, think tanks, and professional associations are all examples of nonprofits. For nonprofits to receive donated funds they must register as 501(c)(3) organizations (Internal Revenue Service, 2009). Recognition as a 501(c)(3) allows nonprofits to access grant money from foundations, corporations, and the government without paying income tax.

When government funding is not enough for programs to respond to community needs and provide services, nonprofits often rely on foundations for funding their activities. However, foundations are complicit in the development of the NPIC and nonprofits’ divergence from social justice. Today there are over 75,000 foundations in the United States, who provided an estimated total of over 45.6 billion dollars in 2008 alone (Foundation Center, 2009).

While foundation funding could represent an alternative to government funding so that social justice aims could be achieved without limitations, grants from foundations also come with an unfavorable set of requirements that must be met. Particular grant requirements may fit with the mission and work of the organization; however, an organization may feel compelled to modify its programs, and sometimes even its mission statement, in order to fit into the requirements of the grant application.
Funding America’s Nonprofits

Paul Kivel, a social justice educator, activist, and writer, examines the consequences of the nonprofit system through the lens of his work with domestic violence and abuse survivors in his essay “Social Service or Social Change” (2000). Kivel writes about how funding bodies have power over community leaders, stating that “the ruling class co-opts leaders from our communities by providing them with jobs in non-profits and government agencies, consequently realigning their interests with maintaining the system” (p. 21). Kivel’s depiction is of a society that prevents community leaders from confronting the root causes of social inequities while struggling to provide services to those who are exploited and oppressed by institutions. He asks, “Do our efforts to provide human services maintain or even strengthen social inequality?” (p. 2).

While service delivery alone holds merit, an unfortunate consequence of this system and its funding structure is its failure to recognize social justice (Kivel, 2000). Kivel writes “When temporary shelter becomes a substitute for permanent housing, emergency food a substitute for a decent job... we have shifted our attention from the redistribution of wealth to the temporary provision of social services to keep people alive” (p. 12). Unfortunately, this is the typical evaluation of nonprofits as band-aid services that are unable to exact real change focused on justice for all.

Kivel describes his idea of a “buffer zone” created by the rich to “prevent people at the bottom [of the economic ladder] from organizing to maintain the power, the control, and, most important, the wealth they have accumulated” (p. 13). The buffer zone provides three functions: to avoid chaos by “taking care” of people at the bottom [of the economic ladder]; to keep hope alive among the poor; and to control those who want to make change. The buffer zone and its functions are a result of an over-reliance of nonprofits on government and foundations as funding sources.

Kivel’s buffer zone is a depiction of the NPIC. This system is built on a series of relationships between the State, owning classes, foundations, non-profit organizations, social service organizations, and social justice organizations. Unlike nonprofits, grassroots movements like those described below do not rely on traditional funding sources, and thus do not operate within the NPIC framework. As a result, these grassroots movements become best equipped to more seamlessly promote social justice, as well as to address the structural causes at the root of social service provision.

**Alternatives to the NPIC**

In the article “On Our Own Terms...10 Years of Radical Community Building with Sista II Sista” four representatives of Sista II Sista, an organization that works with young women in New York, discuss the implications of avoiding foundation funding and what that meant for their ten-year existence (Burrowes, Cousins, Rojas, & Ude, 2007). Sista II Sista facilitated a group process that led to the decision to do away with paid staff and only engage in grassroots fundraising techniques. Sista II Sista concluded from their discus-
sions that there are ways for social justice to be realized through nonprofit work. “We are not saying that all foundations are bad….We are also not of the belief that 501(c)(3)'s are bad….We are trying to figure out different ways to live our values and model our vision” (p. 39). When groups challenge the NPIC, the question shifts the focus from whether or not it is possible to realize social justice within the current system to an examination of how the system can be adjusted so that it might work for everyone.

The Grassroots Institute for Fundraising Training (GIFT) is one resource for people seeking to reconcile working within nonprofits and believing in social justice. GIFT seeks to “promote the connection between fundraising, social justice and movement-building” (Grassroots Institute for Fundraising Training, 2010). GIFT trains people working for social justice how to sustain their organizations in a way that they depend on the financial support of their community, not outside funders or government grants. They encourage organizations to build a large donor base that will invest not only financially in an organization but that the organization will be held accountable in providing services that the community needs. Organizations like GIFT offer practical solutions for moving away from and toward a systematic shift in the way social justice organizations are funded.

Conclusion

People working for social justice today bear the burden of carrying on past social movements while working within the NPIC, a system that necessitates taking on managerial structures that force services and fundraising apart. Nonprofits in the US are rooted in origins of colonization and oppression. Social justice focused community-based initiatives would be possible if funding sources did not compromise their mission. Broad, public dialogue regarding the nonprofit structure and the 501(c)(3) in particular, is lacking, and the priorities of philanthropy need to be questioned. Without prioritization of social justice, new leaders will be forced to take on the contradictions and dilemmas regarding how funding restricts organizational activities, how nonprofit governance relates to the working class people at the heart of the organization, and how hiring and promotion policies can result in individualistic competition (Tang, 2007).

The NPIC’s separation of social justice and social service provisions has silenced the people most directly affected by issues of injustice, and it privileges educated employees and board members of nonprofits. Constituents should be more than just the recipients of service delivery “products.” They should invest in the sustainability of the organization, not leaving funders to determine the organizational agenda. When nonprofits internalize the locus of control, they are less likely to participate in mission drift and are more accountable to their constituents. Diversified funding allows an organization to retain the autonomy necessary to maintain the control of the organization within the community, ensuring that avenues to work towards social justice remain open.
Funding America’s Nonprofits

Notes

1 In this paper, the term social justice refers to a concept that is concerned with ensuring equal rights and opportunities for all people. Both nonprofit organizations and efforts extended by individuals and groups in pursuit of social justice will be examined and referenced.

2 This definition is paraphrased from the website of Incite! Women of Color Against Violence. The full definition can be found at http://www.incite-national.org/index.php?s=100

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Funding America’s Nonprofits

Utilizing Exercise and Nutrition in the Treatment of Chronic Disease: Community-Based Models

Jake T. Kim

The prevalence of chronic diseases in America has increased substantially within the last few decades, increasing the cost of healthcare by billions of dollars. In addition, these diseases have a higher incidence rate for low-income populations who may have greater difficulty accessing adequate resources or appropriate treatments. There has been a growing body of literature supporting the use of community-based exercise and nutrition interventions. Community-based interventions emphasize social supports and personal empowerment for behavioral change. Given the chronic and growing nature of these diseases, this paper will examine community-based exercises and the surrounding elements which facilitate and hinder behavioral change.

Chronic diseases\(^1\) are the most common, expensive, and preventable healthcare challenges in the United States today (Centers for Disease Control and Prevention, 2009). Globally, low-income populations\(^2\) have higher rates of chronic illness than the general population, resulting from common lifestyle trends and a lack of resource availability. The prescriptive nature of traditional interventions for prevention and management of chronic disease fails to support sustainable behavioral change. The failure of current health interventions is compounded by economic and societal emphases on consumption, which sabotage individuals’ efforts and opportunities to improve their health through exercise and diet. Alternatives, including empowerment-based community intervention models, have been found to facilitate behavioral change among members of low-income populations (Hinkle, 2008).

Social workers are equipped with knowledge and skills that prepare them to play a pivotal role in facilitating behavioral change among members of low-income communities. Since the beginning of the profession, social workers have worked with disadvantaged groups to empower individuals and mobilize communities. Attention to cultural nuances and the unique needs of diverse communities have been at the forefront of the profession. Community-based interventions for diet and exercise are ideal areas for social workers to mobilize communities to increase support and self-efficacy in people’s behavior change for better health.

The Cost of Chronic Disease in America

Current concerns regarding the need for prudent and effective healthcare interventions underscore the importance of addressing long-term and preventable illness. The prevalence of chronic disease continues to increase and the cost of care is predicted to rise substantially due to the expensive interventions and treatments necessary for addressing chronic illness. Recent estimates
Chronic Disease: Community-Based Models

by the Henry J. Kaiser Family Foundation (2009) indicate that general healthcare costs surpassed 2.2 trillion dollars in 2007. Traditional interventions for chronic illness, such as surgery or medication, can be risky, have high costs, and most importantly, fail to address the behavioral issues that maintain or contribute to disease. The adequate management of chronic illness requires behavioral modifications to break long-standing lifestyle patterns that can sustain an individual’s decline in health. For long-term behavioral change to be effective, individuals suffering from chronic disease must understand how lifestyle choices and behavior impact their health. Furthermore, the aid of community support mechanisms has been studied as an effective strategy for long-term behavioral change (Arkowitz et al., 2007). Without alternatives to traditional treatment models, chronic disease will continue to escalate healthcare costs and Americans, especially those in low-income communities, will continue to struggle with their health.

Self-Efficacy and Empowerment

Scientific studies support self-efficacy and empowerment-based models in bettering health outcomes through improved diet and exercise. Involvement in exercise can empower an individual, “...through the self-efficacy mechanism,” state Ozer and Bandura (1990). Empirical evidence demonstrates how equipping people with knowledge, skills, and resilient self-beliefs can alter their lives and they can begin to believe that they have control over their lives. Alsop et al. (2006) state that the empowerment model “...hypothesizes that interventions to improve agency and enhance opportunity structures can increase a person’s capacity to make effective choices [and] this in turn can bring about other development outcomes” (p. 1). Ozer and Bandura utilized a mastery model for physical training and found that there were increases in self-efficacy in community-based exploratory studies with women and adolescents (Ozer & Bandura, 1990; Guthrie, 1995; Zivin et al., 2001).

One study conducted by Folta et al. (2009) found that a greater sense of self-efficacy in overweight and obese older women lowered cardiovascular risk through participation in a community-based program. In a comparable study concerning incidences of heart health in individuals, Luszczynska and Sutton (2006) found that those with a history of one or more heart attacks had a greater likelihood of adherence to an exercise program and reported higher levels of self-efficacy. In their study, Wellman et al. (2007) found that 620 participants showed significant physical and psychological improvements from their community-based exercise and nutritional program. Munro et al. (2004) observed that the implementation of a community-based exercise program was more cost-effective than medical interventions regardless of the lower exercise participation rates, highlighting the effective nature of the nutritional component of such health interventions.
Financial Benefits of Self-Efficacy and the Community-Based Model

Evidence from several studies show that community-based exercise and nutritional programs can predict substantial cost-savings. Ackermann et al. (2003) found that a group of individuals participating in a community-based exercise intervention experienced fewer hospitalizations compared to those who received standard medical treatment. In the study, those who exercised more than once per week had a total annual healthcare cost of 1,057 dollars per person less than the control group (Ackermann et al., 2003). In another example, Roux et al. (2008) evaluated and compared community-based exercise interventions for chronic disease and found that they were cost-effective based on a variety of statistical simulations. Clearly, community-based exercise and diet interventions show promising results, yet people in low-income communities face many barriers in accessing these interventions.

The Role of Institutions

Traditionally, centralized institutions such as hospitals served as a primary resource for addressing health concerns, providing a range of acute to chronic care. The centralization of specialized knowledge and expertise in hospitals, at times, can remove patients from their home communities. In hospital settings, it is common for doctors to recommend exercise and a healthy diet as supplemental aids for chronic disease management. However, comprehensive exercise and nutritional change require an incorporation of the behavioral patterns and motivations of the client. The particular needs of the client must ultimately be acknowledged by both the prescriber of a program and the receiver of care, which go beyond the primary general suggestion of a medical professional, and calls for secondary supports to fulfill the recommendation (Arkowitz et al., 2007).

In America, restaurants also play a key institutional role in hindering the success of diet and nutrition interventions. Representing a link between nutrition and a community, restaurants facilitate consumption. According to Glanz et al. (2007), survey responses from the executives of several national dine-in chain restaurants indicate that the high costs of carrying healthier ingredients with a short shelf-life and lower demand make it less profitable to offer healthy alternatives. The result of the cost efficiency of more sustainable, but less healthy ingredients, is the availability of an abundance of processed and preserved foods through these widely accessible chain restaurants to a mass market. Drewnowski (2004) states that energy-dense foods, usually made with sugar substitutes and laden with fat, are profitable for companies not only due to their lower production costs, but also because they have become a necessity to those who cannot afford to pay for healthier, more expensive alternatives. Some consequences of these economically-driven behaviors are evidenced in the high rates of obesity and type II diabetes in the United States among low-income populations (Drewnowski, 2004).
The Role and Benefits of Exercise

According to the Centers for Disease Control and Prevention (2009), exercise reduces the risk for cardiovascular disease, type II diabetes, and various cancers; strengthens bones and muscles; protects the body from potential physical injuries such as falls; and, it improves individuals’ moods and psychological state (Linenger, Chesson, & Nice, 1991). Furthermore, increased muscle density – a result of exercise – improves metabolic rates, physical function, and guards against muscle wasting (Baker et al., 2001). Exercise also lowers depressive symptoms for those suffering from chronic disease such as diabetes (Golden et al., 2008). Exercise has also proven to produce a reduction in delinquent behaviors among adolescents (Zivin et al., 2001), relieve trauma in those suffering psycho-sexual abuse, and have positive results in women with eating disorders and substance abuse problems (Guthrie, 1995).

Further, exercise has resulted in better balance, coordination, and a general sense of well-being in older adults (Kutner et al., 1997). Continued exercise fosters positive physiological and psychological benefits (Paluska & Schwenk, 2000). In addition to the benefits of general physical activity, traditional and holistic approaches to exercise such as yoga and martial arts increase an individual's sense of self-mastery, decrease anger, and generate a sense of inner-peace (Binder, 2007). Despite the evidence demonstrating the benefits of exercise, many people living in low-income communities are unable to access these benefits.

Existing Community-Based Models

There is a growing body of literature supporting the use of community-based exercise and nutritional interventions; however, the widespread applicability of these programs requires further study. Randomized clinical trials link the effectiveness of community-based interventions with fewer hospitalizations, shorter inpatient stays, and decreased healthcare costs (Ackermann et al., 2003). Community-based exercise and nutritional interventions have also shown improvements in physical and psychological functioning after a debilitating illness (Harrington et al., 2010).

A community-based exercise and nutritional model facilitates access to the physiological and psychological benefits of exercise to individuals that may be excluded by socioeconomic factors. A program in rural Oregon is an example of the success of a community-based exercise and nutritional program for a low-income population (Berkes, 2009). This program lacked the specialized equipment or dedicated space found in most commercial gyms or the specialists found in hospitals, but through the use of a supportive and cohesive community, the participants developed a healthier lifestyle. Similar results were found in a rural Montana community-based exercise program with the use of a women's fitness boxing class (Ritter, 2009). These programs took place in the community and used the social supports of the participants to encourage and create a sense of empowerment. As per the empowerment model...
(Alsop et al., 2006), these two interventions assumed that the strength for positive development came from a collective effort by the members of the community channeling strength toward a productive outcome. Although these programs have shown significant promise in the rural setting with low-income populations, more research needs to be conducted to understand the applicability in urban settings.

There has been a growing number of successful community-based exercise and nutritional programs targeting chronic disease. Roux et al. (2008) compared seven different community-based exercise programs and found that they were all cost effective and exhibited positive results. Some of these programs placed greater emphasis on social support and community-wide campaigns while others utilized the community but strengthened skills through individualized attention (Reger et al., 2002; Young et al., 1996; Kriska et al., 1986; Lombard et al., 1995). Additional programs focused on outreach and education (Knowler et al., 2002) and another program encouraged an active lifestyle within the community (Linenger et al., 1991). The success of these programs can be attributed to the specificity and applicability to the target populations.

Cultural Competency

Effectively utilizing exercise as a tool for supporting individual health and well-being should be viewed as akin to the process of learning a language, rather than a focus on the end-goal outcome. Learning a language requires consistent and patient practice and a supportive community that nurtures practice and development. Fluency in exercise skills is not immediate, and it cannot be purchased. In addition, as with language, learning and understanding exercise requires comprehension and understanding throughout the process. As such, individual needs and cultural understanding along with existing community factors as well as supports must be taken into consideration when developing community-based exercise interventions.

Studies have indicated that African Americans living in urban environments are less likely to exercise when compared to a group of white Americans living in urban environments, indicating that differences in cultural background are relevant to the feasibility of community-based exercise models (Lavizzo-Mourey et al., 2001). The findings of the aforementioned study may be the result of the ineffective selection of exercise interventions for the targeted community. In addition, the study revealed that older African Americans were less likely to engage in exercises using weights and preferred to workout in groups (Lavizzo-Mourey et al.). The implications of such findings substantiate the call for culturally competent programming, and reinforce the applicability of a community-based model given the evident preference for group exercise. The study also provides implications for the role of social workers with regard to their common professional capacity for supporting cultural sensitivity in program implementation (NASW, 1999). Regardless of the source of the service provision, the development of community-based models should include
Chronic Disease: Community-Based Models

the consideration of community cultural factors, as well as foundational knowledge of individual and community norms and preferences, in order to ensure the successful implementation of a program.

Conclusion

A shared focus on personal empowerment through the use of community resources is an effective alternative to traditional medical interventions in the successful management of chronic disease across communities. These programs have a proven efficacy in rural, low-income communities and have likewise shown great promise for low-income populations in urban settings. The high cost of chronic disease reinforces the utility and feasibility of community-based interventions and supports the plea for their wider application in national efforts to reduce health risks and increase healthy lifestyle options for people living in poverty. Social workers play a pivotal role in community-based interventions, as community organizing is a key component of the National Association of Social Workers’ Code of Ethics. Social workers can provide support through interventions that mobilize community resources, develop effective programs, and evaluate and disseminate the programs’ results. A collective effort toward mobilizing communities to apply exercise and nutrition models to their health-management schemes would greatly benefit the country and reduce health risks for current and future generations.

Notes

1 In this paper, the term chronic diseases will be used to represent type II diabetes, obesity, and cardiovascular diseases.

2 The term low-income populations will be used in this paper to refer to people living below the official poverty line, as designated by the U.S. Census Bureau (2009).

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Chronic Disease: Community-Based Models


Chronic Disease: Community-Based Models


Mental Health Courts: An Interface Between Social Work and Criminal Justice

Leslie Roberts

Mental health courts (MHCs) are emerging as a critical element in the nationwide effort to counter overcrowding in the US prison system and more adequately address the plight of offenders who are diagnosed with a mental illness. The goals of MHCs, an example of problem-solving courts, are to improve the quality of life for those involved in the criminal justice system, link clients to community treatment resources, and reduce recidivism and crime rates in a more cost-effective manner than within the traditional criminal justice process. This article provides a brief history of MHCs, including the rationale behind their initial implementation, an overview of their clientele and process, a review of the role social workers play, arguments for and against their broader introduction, and specific research recommendations to better ascertain their current and future effectiveness. Although MHCs are still too nascent to draw broad conclusions about their rates of efficacy, early results are promising.

Over 7.3 million (1 in every 31) adults in the United States are under criminal justice supervision, and for the first time in the nation's history, the adult incarceration rate is 1 in 100 (Warren, 2008). Between 1997 and 2007, the country’s prison population almost tripled. The Department of Justice recently estimated that more than half of all individuals who are incarcerated have been found to have mental health problems (James & Glaze, 2006).

All too often, the US penal system, whose stated goal is to protect society and punish those who have committed crimes, has instead taken the place of community mental health services and in-patient psychiatric units by housing large numbers of people living with mental illness. For instance, in 2008, the Los Angeles County Jail System housed 1,400 people who required daily mental health services, effectively making it the largest mental institution in the country (Montagne, 2008). The size and scope of the issue makes it all the more difficult to devise a workable strategy for the mentally ill that does not bust budgets.

The need for MHC can be directly connected to the deinstitutionalization of psychiatric hospitals roughly 40 years ago, a social movement aimed at releasing patients living with mental illness from deplorable conditions in state psychiatric hospitals and transitioning them to community mental health centers to provide quality treatment. Although this goal was commendable, the subsequent lack of funding for continued community mental health actually left this population without oversight (Fields, 2006).

Advocates in the US concurrently began to clamor for reductions in
criminal health courts, and politicians consequently sent more people convicted of crimes to jail, including many non-career criminals living with mental illness who were in need of proper psychiatric care. The policies this decision has engendered have led to overcrowded jails, a prohibitive rise in the cost of incarceration, and the ever-present likelihood of recidivism, which played a central role in the creation of the “revolving door” of criminality (Delcka, 2001).

As the number of people in the criminal justice system steadily increases and financial resources become even more scarce, those living with mental illness become less likely to receive the treatment they require. In fact, adults living with mental illness are arrested for the same behavior twice as often as people who are not diagnosed with a mental illness (Teplin, 2000). Therefore, the size and scope of the issue makes it all the more difficult to devise a workable strategy that is fiscally responsible. To wit, 47 percent of federal inmates and 42 percent of jailed inmates with diagnosed mental illness have served three or more prior sentences (James & Glaze, 2006).

These issues evoke equally strong sentiments from victims’ rights groups and criminal justice advocates. Among the rehabilitative responses that have provoked rigorous debate are MHCs. This paper will provide a comprehensive overview of MHCs and discuss the benefits and drawbacks of this alternative form of sentencing. Finally, the paper will provide a series of large and small-scale recommendations for social workers and researchers.

What is a Mental Health Court?

The main goals of an MHC are: to provide necessary mental health treatment, decrease recidivism, increase public safety, and reduce legal and incarceration costs. Judges, prosecuting attorneys, police officers, defense attorneys, and family members can all refer participants. Most MHCs use a model that re-routes participants into community mental health treatment instead of the traditional criminal justice system. In some courts, pending charges can be deferred as a judge monitors the person’s adherence to the structure of the MHC. Other MHCs require a guilty plea in order to become a client.

MHC staff members include judges, attorneys, social workers, bailiffs, case managers, and court liaisons who have been trained in mental health. This multi-disciplinary team works collaboratively to develop treatment plans and sanctions for those who do not comply. This team also finds community-based mental health providers for additional care, incorporates substance abuse treatment, and locates housing and public benefit agencies. Partnering with all of these service providers builds a lasting support system for the client.

Mental Health Court Clientele

Each MHC utilizes different criteria to determine its participants; there is no nationally recognized standard. Interestingly, research has demonstrated that felony offenders in alternative-sentencing programs remain in treat-
ment longer, successfully complete or “graduate from” those programs at higher rates, and are much less likely to commit crimes post-completion provided they remain under court supervision (Rempel & DeStefano, 2001). The reasons for these higher success rates are two-fold: (1) Felony offenders are mandated to treatment, where they must remain for longer periods of time; and (2) The stakes are higher since failure to complete the program will likely result in a long prison sentence (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005).

The History and Rationale of MHCs

The US has yet to properly answer a fundamental question about its penal system: Are prisons meant to rehabilitate or simply house inmates? There are numerous reasons behind the recent significant increase in the number of mentally ill offenders. Inmates are often released without proper access to necessary medications or referrals for adequate psychiatric care. In addition, there has been a general decline in access to inexpensive psychiatric services and public hospital beds (Watson, Hanrahan, Luchins, & Lurigio, 2001). Together, issues like these conspire to push people living with mental illness away from the treatment they require and toward anti-social behaviors they might not be able to control.

The first MHC opened its doors in Broward County, Florida in 1997 in an attempt to address the issues of individuals diagnosed with mental illness residing among the broader prison population (Watson et al., 2001). The court evolved from a taskforce established three years earlier by a local judge and public defender, who were searching for specific solutions to the interrelated problems of the increasing number of inmates with mental illness and overcrowded jails. Taskforce members consisted of community mental health treatment providers, hospital administrators, a spokesperson for the public defender, representatives of the state’s attorney, and county sheriff officers (Watson et al., 2001).

By linking people with a mental illness to alternative forms of incarceration, many MHC advocates view these courts as a form of therapeutic jurisprudence, since they are expected to engender positive long-term lifestyle changes that avert a life of crime. The concept of therapeutic jurisprudence holds that “the law should be used, whenever possible, to promote the mental and physical well-being of the people it affects” (Slate & Johnson, 2008, p. 432).

Therapeutic jurisprudence seeks to focus attention on an often-neglected variable necessary for mental health law and practice (Wexler, 1993). The expectation of proponents of therapeutic jurisprudence is improved psychiatric stability for offenders, which is believed to eventually translate into better public safety, since these inmates should be less likely to commit crimes after release from prison. Therapeutic jurisprudence advocates argue that MHCs are an effective alternative to incarceration, since they target an underserved population but are not an easy way to avoid lengthy prison sentences.
Mental Health Courts

MHCs also offer practical benefits: they are less costly than incarceration. Recent research regarding an MHC in Allegheny County, Pennsylvania found that it saved 18,000 dollars per person verses the traditional criminal justice system, translating to 3.6 million dollars in annual savings (Ridgely et al., 2007). Given current governmental budgetary pressures, this is no small issue. Studies show that state prisoners with mental health illness served four months longer than prisoners without mental health issues (James & Glaze, 2006).

Recent research has demonstrated that clients who are involved in MHCs progress longer without a new criminal offense and are much less likely to be arrested for a violent offense than offenders who are forced to navigate the traditional criminal justice system. Those who graduate the MHC have lower rates of recidivism and commit fewer violent crimes even after direct supervision has ceased (McNiel & Binder, 2007).

The Mental Health Court Process

Although the specific process of entry into a MHC varies from court to court, there are significant similarities across the 250 currently in operation across the US. Post-arrest intake specialists at a jail assess an offender’s mental state and competency. If the intake officer, offender, prosecuting attorney, defense attorney, family member, or arresting officer report any symptoms of mental illness, a social worker, psychologist, or psychiatrist immediately performs a more thorough assessment. If an examiner deems the individual mentally ill and recommends him for participation, the case is eligible for transfer to an MHC. All cases are reviewed thoroughly by the MHC team, which makes a final, collaborative admission decision.

As noted earlier, in some courts, once an individual is recommended to the court, he must plead guilty to charges to secure his/her spot. This “guilty” plea is a useful tool: If a participant absconds, misses appointments, or does not follow-through with their treatment plan, the previous guilty plea means they will be sentenced immediately as they would have in the traditional criminal justice system.

The court’s clients must pass a number of different stages with full compliance to graduate. There is no nationally recognized number of stages, although most of the 250 MHCs in the United States typically compel clients to complete three to four stages (Vleet, Hickert, Becker, & Kunz, 2008). The duration of each stage differs on an individual basis and from court to court, although all require full compliance before completion. Compliance means attending all court-mandated counseling sessions and hearings, avoiding additional trouble with the law, and passing random drug tests. With the completion of each stage successful clients are rewarded with incentives that include a reduced frequency of court appearances, placement on the “Rocket Docket,” which allows them to appear before the judge at the beginning of status hearings and leave court earlier than others (Vleet et al., 2008), certificates of completion, and small gifts such as movie certificates or candy. It is hoped that
these benefits incentivize clients to continue to work hard and successfully complete the program (Gonnerman, 2004).

Over time, a client is given increasing freedom to ease his transition back into society and to ensure that he can effectively cope outside of a structured environment. A judge’s level of personal involvement is often critical. The judge is the final arbiter of a client’s performance and is therefore in a unique position of determining an individual participant’s success or failure.

**Mental Health Courts: The Positives and Negatives**

When assessing the efficacy of MHCs, it is critical to remember that its clients are living with mental illness and in need of treatment. Many have received little to no psychiatric care prior to incarceration. Consequently, access to treatment is theoretically life-altering, particularly if the client accepts and responds to care and stays with counseling and prescribed medications after graduation. Community mental health professionals, who are highly skilled in psychiatric settings, typically provide regular treatment for clients rather than court staff. When necessary, the mental health professionals can recommend to the judge that clients be provided in-patient psychiatric treatment.

Ongoing arguments about who deserves to participate in these programs continue, as there are no national standards for admission. Other questions include whether MHCs can legally force clients to use legal psychotropic medications and how to codify proper sanctions for non-compliant behavior (e.g. jail time, community service, additional courtroom appearances, or dismissal). Some mental health professionals question whether MHCs violate a client’s rights if he is forced to take prescribed medications and/or is remanded to prison for failing to effectively deal with a debilitating mental illness. In addition, some criminal justice advocates believe MHCs engender an unwelcome stigma for clients as both criminals and mentally ill. Conversely, victims’ rights advocates argue that many clients are not committed to getting better but are instead finding a way to evade prison.

**Mental Health Courts and the Social Work Interface**

Given social work’s ethical obligations to criminal justice, its unique stance on social justice, respect for human dignity, and commitment to disenfranchised/vulnerable populations, social workers are uniquely qualified and well suited to make significant contributions to individuals and families involved in the criminal justice system (National Association of Social Workers, 1999).

Social workers play a number of critical roles in a MHC. Clinical directors, who typically have a graduate degree in social work, oversee a team of social workers with forensic experience who conduct initial evaluations. Social workers also serve as treatment coordinators who maintain daily contact with clients and also mental health providers who follow up on treatment plans and
Mental Health Courts

create reports for the judge to track a client’s progress. They are also charged with the day-to-day responsibilities of providing clients with the skills to lead productive lives and to provide for their basic needs, including substance abuse treatment, psychiatric treatment options, housing, food, and medical care. MHCs are an opportunity for social workers whose interests lie in criminal justice, mental health, and social service systems to influence an emerging enterprise that is setting new standards and creating new solutions.

Unfortunately, as the social work profession has evolved, it has largely abandoned the field of criminal justice and corrections; neither the National Association of Social Workers (NASW) nor the Bureau of Labor Statistics lists how many social workers currently or have previously worked in corrections. In addition, the NASW does not regard corrections as one of its eight specialty practice methods (NASW, 1999).

The social work field’s Code of Ethics mandates that social work professionals maintain a commitment to social justice (NASW, 1999). Unfortunately, the lack of criminal justice curriculum in master-level social work programs is keeping future social workers from gaining the skills to address an area of critical need, considering many students will work with clients affected by crime, corrections and the justice system. Recent studies indicate among the 95% of Council on Social Work Education-certified MSW programs that had field placements in the criminal justice arena, over half were specific to law and social work and therefore did not include work within criminal justice settings (Epperson, Roberts, Tripodi, Ivanoff, & Gilmore, 2009).

Research Conclusions

Researchers and advocates on all sides should remember that this is still a relatively new initiative and documenting the performance of one MHC should not be generalized to all. Therefore, researchers must be careful to allow the MHC initiative broad adoption before beginning to draw meaningful conclusions.

Specific Research Recommendations:

- Delay evaluations until a court has been fully implemented and procedures have been standardized for measurement purposes.
- Ensure validity of the design. Assess the effectiveness of a court by using other innovative legal approaches dealing with clients who are mentally ill and implement treatment other than typical processing. For example, compare MHCs to other interventions, including mandatory treatment as part of probation/parole requirements, pre-trial diversion or assignment of a mental health advocate (Almquist & Dodd, 2009).
• Collect information on the characteristics and percentages of clients who are eligible but choose not to participate or reasons clients were deemed ineligible for the MHC.

• Provide a clearer picture of the people, court systems, and communities most suited for a MHC, explaining clearly why one community or client population might have better outcomes.

• Determine whether MHCs improve criminal justice outcomes by linking participants to effective treatment, increased public safety, reduced recidivism, and reduction of correction costs.

(Almquist & Dodd, 2009)

Until we can begin to draw conclusions about the broader efficacy of MHCs, judges and prosecutors must continue to vigilantly assess the viability of each potential client, the failure to do so, given the possibility an offender might commit additional crimes, could possibly derail the entire initiative. MHCs offer an alternative to the criminal justice system, beyond standard plea agreements or trials by jury, which might not be the proper course of legal remedy for some offenders. As with virtually anything, MHCs will rise or fall largely on the actions of those who populate them, from judges, to lawyers, to social workers and, most crucially, to clients.

Because initial evidence shows that MHCs are more cost-effective and provide generally better client outcomes than traditional justice settings, adoption is likely to become more widespread over the coming years. Therefore, social workers, policy makers, and researchers must devise ways in which to more fully involve themselves, ensure broader utilization, and make the entire concept better and more workable for both clients and professionals.

References


Mental Health Courts


Evidence-Based Practice

A Case for Evidence-Based Practice

Tara Batista

Evidence-based practice (EBP) has enjoyed increasing popularity in the field of social work. However, not everyone is enthusiastic about this movement. This paper defines EBP, attempts to clarify common misconceptions about EBP, and organizes and analyzes some of the criticisms of EBP so that the field of social work can move onto a more productive debate about its legitimate strengths and limitations.

Evidence-based practice (EBP) has increased in prevalence in the field of social work and enjoys a strong body of supporters. However, not everyone is enthusiastic about this shift. Indeed, one need not look hard to find resistance to this movement from the field and even from schools of social work that teach EBP. Some practitioners contest that their authority, expertise, and reflective judgment should not be replaced by a mechanistic evidence-based decision-making process and are skeptical about the practicality of such a research-based approach. Other social workers and researchers feel that EBP is too narrow to encompass the dynamic nature of complex social problems. Still others worry that EBP may inadvertently restrict the development of novel interventions. This paper attempts to clarify common misconceptions about EBP and to organize and analyze some of the criticisms of EBP so that the field of social work can move to a more productive debate about its legitimate strengths and limitations.

What is Evidence-Based Practice?

EBP is “the conscientious, judicious and explicit use of the current best evidence in making decisions about the care of individuals” (Gibbs & Gambrill, 2003, p. 453). EBP is conscientious in the sense that it should be ethical, effective, and honest. It is judicious because the decision to incorporate a piece of evidence into practice should be considered and prudent. Using the current best evidence means that practice and policy decisions are based on evidence that utilizes the most rigorous methodology possible and is subject to updating. EBP should also be explicit in its transparency. This means practitioners and policy makers are expected to share the evidence with their clients or constituents and consider client feedback in the decision-making process. Clients also feed into the decision-making process through qualitative research on client views and experiences, and satisfaction surveys. Through this collaborative process, practitioners incorporate clients’ values as a key part of their decision-making. Therefore, EBP must be a comprehensive approach that integrates client values and preferences with practitioner knowledge, expertise, and judgment. There are a variety of diagrams like the one below that illustrate the inclusive EBP model.
The definition and model above describe using the “best external evidence.” Determining what constitutes the best evidence depends on the type of question. For questions concerning effectiveness, EBP advocates refer to a hierarchy of evidence where the best external evidence sits at the peak as demonstrated below in Figure 2. This hierarchy places systematic reviews of randomized controlled trials (RCTs) and meta-analysis at the top, and personal testimony and expert opinion at the bottom with many other methods of evaluation in between such as: cohort studies, case-control studies, and case reports. If there are no systematic reviews or RCTs conducted on a specific research topic, the evidence-based practitioner moves down the hierarchy until an appropriate study design can be found.

Evidence-Based Practice

Figure 2

As a holistic approach, EBP adheres to a hierarchy of the best, current, and available evidence while incorporating client and practitioner values, yet it should be emphasized that EBP is a process that actually includes several steps. These steps consist of: (1) Converting information needs into answerable questions; (2) Searching for the best evidence to answer the questions; (3) Critically appraising the evidence for validity and usefulness; 4) Applying the results of this appraisal to policy/practice decisions; and 5) Evaluating the outcomes (Gibbs & Gambrill, 2002). As both a process and an approach, an example of EBP can be found in Gibbs and Gambrill’s text which follows a social worker through the five steps described above (2002).

A social worker at a nursing home learned that the facility might be shut down in 60 days by state inspectors. All 135 residents would have to move. (Step 1: Answerable Questions) The social worker wondered: “What is the effect of relocation on mortality rates in elderly residents of a nursing home?” and “If relocation is necessary, what is the most effective way to relocate elderly residents?” (p. 455). (Step 2: Evidence Search) She conducted an online literature search using seven different relevant databases. (Step 3: Evidence Appraisal) After reviewing abstracts to identify well-designed studies, she found a review summarizing 11 studies that addressed both of her research questions. Two of these studies were single-group pre-posttest studies, two were posttest only, seven were pre-test/posttest with a control group, and one was a RCT. The general results of her research indicated that “inter-institutional relocations are stressful but usually not life-threatening” (p. 456) and much of the stress can be reduced by consulting with nursing home residents in preparation for a move. The studies described different preparation

techniques such as taking residents and families on tours of the new facility and asking them for input on the color and location of their rooms. (Step 4: Apply Results) The social worker presented her findings at a staff meeting which better prepared the staff in the event of relocation. (Step 5: Evaluate) Fortunately, the residents did not have to relocate; however mortality rates and other undesirable outcomes could have been measured after a move to see if the preparation was effective.

This example incorporates the definition, steps, and comprehensive approach of EBP. The story effectively demonstrates how EBP can and should work. Although seemingly straightforward and reasonable, EBP has actually proven to be quite controversial. Common criticisms in the literature concerning EBP can be allocated to four main categories: limitations of EBP based on misconceptions, inapplicability critiques, practicality arguments, and philosophical critiques. This list is not exhaustive, as delineating every single criticism of EBP is beyond the scope of this paper.

Limitations Based on Misconceptions of Evidence-Based Practice

Many criticisms are based on misinterpretations of EBP. Two main criticisms that fall under the umbrella of misconception critiques are: EBP is too narrow and too simplistic in its approach. Critics believe it is too narrow because it relies heavily on RCTs and that it is too simplistic because it imposes universal “cookbook” solutions that dictate intervention application without sufficient regard to individual and situational factors.

A Narrow Approach

EBP is often described as over-emphasizing the “gold standard” of RCTs. A few of the many examples of criticisms regarding RCTs are demonstrated in the following statements: “The orthodoxy of experimental manipulation and RCTs is dangerous when applied unthinkingly to health promotion,” or, “randomized comparisons can yield biased assessments of true effects of interventions,” and “randomized designs have, like all designs, important limitations” (as cited in Chalmers, 2003, p. 8).

It is true that “EBP favors methods that critically appraise claims so that we do not misinform ourselves and our clients” (Gibbs & Gambrill, 2002, p. 464). EBP uses RCTs because they are the optimal evaluative design for measuring intervention effects. With questions about whether an intervention produces the desired outcome, “non-experimental approaches … routinely lead to false positive conclusions about efficacy” (Sackett et al., 1996, para. 8). RCTs, and especially systematic reviews of several randomized trials, are considered the “gold standard” because they rely on an experimental design and are therefore more likely to inform than mislead (Sackett et al.). RCTs accomplish this in two ways: 1) Through randomly allocating participants to comparison groups to abolish selection bias and 2) Through the use of a control
Evidence-Based Practice

group so that we know it is the intervention that is causing the change instead of external lurking variables. Systematic reviews are also at the top of the hierarchy because they are “typically more rigorous,” “exhaustive in the search” strategy, “transparent” and “less grandiose in claims of effectiveness” (Gambrill, 2003, p. 13-14). In short, depending on the research question, certain kinds of evidence are more accurate, useful, and reliable than others.

Although RCTs are ideal when applied to questions concerning causality and effectiveness, EBP recognizes the limitations, biases, and applicability of each research approach, including RCTs. This understanding is illustrated in EBP textbooks, articles, and instructional manuals. The curriculum describing EBP clearly states that it is not restricted to RCTs. It involves identifying the best external evidence in order to answer important clinical questions (Sackett et al., 1996). Different research designs are applicable to answer different types of questions. For example, “to find out the accuracy of a diagnostic test, we would use cross-sectional studies of patients who might have the relevant disorder, not a randomised trial” (Sackett et al., para. 8).

Often, RCTs cannot and need not be used at all; nor does EBP require it. For example, researchers would not use a RCT to test the effectiveness of parachutes even though proof of their effectiveness is based largely on anecdotal evidence and observational data. In fact, Pell and Smith conducted a systematic review titled “Parachute Use to Prevent Death and Major Trauma Related to Gravitational Challenge” (2003) and were shockingly unable to identify any RCTs. There are also instances where researchers cannot use randomization. This is especially true in the arena of program evaluation where government and nonprofit agencies do not allow randomization for ethical or political purposes, or researchers are contracted to evaluate existing programs that have not employed randomization. In fact, the vast majority of the social work evidence base consists of quasi-experimental or observational research.

The confusion among critics about the role of RCTs in evidence-based social intervention lies in the failure to distinguish the purpose of using one research design over another (Chalmers, 2003). The key question to ask is: “Can researchers manipulate the factors?” For example, to understand the effects of divorce on child development, a researcher would not use a RCT because it is a contextual question and the researcher cannot manipulate the variables (i.e. the researcher cannot make one half of the children’s parents divorce). After conducting primary cross-sectional research or reading studies of child development, the researcher might be able to form a theory. The theory can then lead to intervention ideas. These intervention ideas can be tested in three stages. The first stage is a pilot or feasibility study. If feasible, the intervention can then be investigated using a RCT in a tightly controlled efficacy study, then later in a “real world” effectiveness study (Carroll & Onken, 2007). Furthermore, the RCT can be combined with qualitative methods and mediator and moderator analyses to elucidate the processes and mechanisms that explain why, how, and for whom the intervention works. In other words, there is actually no need to pick one design over another. In fact, mixed-method approaches are becoming increasingly popular in evidence-based social interven-
In short, EBP incorporates an array of different kinds of evaluation methods based on the best available evidence that can answer the specific type of question asked to solve a particular problem. It is too simple to focus on the flaws of RCTs or any particular evaluation method. EBP does not “unthinkingly” apply experimental methods to promote any intervention. It is understood that biases and limitations are an inevitable part of any methodology; however, EBP attempts to choose an appropriate method that reduces bias as much as possible.

A Simplistic Approach

There is a common fear that EBP will replace practitioner expertise by dictating solutions to professionals that ignore their values and preferences and those of their clients. This is based on the misunderstanding that EBP takes a “cookbook” approach or uses a one-size-fits-all model. This recipe for potential disaster does not consider the actual definition of EBP and the steps and diagram described earlier. Practitioner’s expertise decides whether research evidence applies to the individual client at all, and if so, how it should be implemented into practice while keeping the client’s voice in mind. Those who employ EBP argue that external evidence can inform, but not replace, individual clinical expertise (Sackett et al., 1996). As the earlier diagram illustrates, EBP is intended to be a comprehensive and empowering strategy that integrates the best, current, available evidence with practitioner expertise and client preferences.

The “cookbook” misconception suggests that EBP poses one certain solution for each individual problem. As Newman, Moseley, Tierney, and Ellis (2005) explain, “contrary to popular belief, evidence-based practice is not about searching for a ‘right answer’ because there rarely is only one right answer” (p. 5), in social work and social policy. Additionally, EBP actually makes no statement on the individual level. Systematic reviews and RCTs assess the probability of an outcome occurring on an aggregate level. In other words, EBP “cannot deliver certainties, just increase probabilities” (Newman, Moseley, Tierney, & Ellis, 2005, p. 5).

An Approach Inapplicable to Social Interventions

There is a belief that the problems social work and social policy address are too complex and dynamic to apply the formulaic process of EBP (Plath, 2006) and that while EBP might work for medical interventions, it will not work for social interventions. However, evidence-based social interventions are not new. In fact, social work has a long history of using scientific research evidence to guide practice, dating back to the turn of the twentieth century (Gibbs, 2002). In the 1930s social scientists in the United States were trained in experimental methods, and evaluations of social interventions were carried out by independent investigators. Between the early 1960s and late
Evidence-Based Practice

1980s, RCTs emerged as the ideal method for assessing a wide range of public policy interventions (Oakley, 1998). One of many examples of EBP in action is a recent systematic review that evaluated the effectiveness of sexual abstinence-only HIV prevention programs in high-income countries. The review found that these programs had no effect on the HIV rate (Underhill, Montgomery, & Operario, 2007). In response to the evidence, the US Congress reassessed funding for these programs. Another example of the successful implementation of EBP is when professionals delivering an education and training program for high school dropouts agreed to a RCT to assess its effects, in spite of their concern that it might fail to find any beneficial effects of their work. The results of the trial were positive and led to a 15-site expansion serving hundreds of disadvantaged youth (Chalmers, 2003).

These examples demonstrate that rigorous scientific methods and appropriate design choices can be used to successfully evaluate social interventions. Critics who claim that EBP is not applicable to social interventions because we “cannot quantify the human experience” (Chalmers, 2003) are right: The human experience may not be quantifiable, but the effectiveness of specific interventions is.

An Impractical Approach for Real World Practitioners

There are many practical reasons practitioners do not incorporate EBP into their daily routine. These include lack of resources, time, training, and evidence. Practitioners are often busy with overwhelming caseloads, managing several job titles. They may feel that they have more pressing tasks to accomplish than to become researchers on the side (Newman, Moseley, Tierney, & Ellis, 2005). Although this argument is legitimate, social work practitioners are professionally obligated to use evidence to inform their practice if they seek to adhere to a code of ethics.

Incorporating evidence into practice is not just ethical, but practically speaking, EBP actually saves time and money. EBP can help practitioners to identify the most effective interventions. Systematic reviews summarize RCTs so practitioners do not have to search, find, and read each one and then try to evaluate their collective effectiveness. Additionally, developments in information technology have greatly accelerated the process by which information can be searched, identified, obtained, and updated. Practitioners no longer have to spend hours attempting sophisticated searches because “the average length of time to conduct an electronic search [is] between 5.5 minutes -7 minutes 6 seconds” (Gibbs, 2003, p. 18). Furthermore, a simple search of Google Scholar can provide useful results. As previously demonstrated in the example of the social worker in the nursing home, incorporating EBP into decision-making does not necessarily entail a lengthy research process.

Even when practitioners have time to search, they may feel they lack the skills to navigate the vast amount of available information. To exacerbate this problem, schools of social work in the United Kingdom and United States have not dedicated adequate attention to instruct students how to search for and
locate pertinent research from online databases (Newman, Moseley, Tierney, & Ellis, 2005). Although this is a legitimate problem, it is far from insurmountable. Simple searches of the most important and relevant databases are achievable by any practitioner with access to a computer and the internet (Newman et al.). Additionally, practitioners can refer to several user-friendly guides on how to search and can also seek assistance from reference librarians for sophisticated searches.

Where practitioners have the time and skill to conduct searches, there may not be enough evidence to establish which interventions work. In the case when there is no evidence for an intervention, or the evidence is scarce, practitioners should report their findings, use their best judgment, and be open to alternatives (Newman et al.).

**Philosophical Criticisms**

Perhaps the most legitimate criticism of EBP is philosophical in nature. Organizational Theory professor Jim Mandiberg warns, "Evidence-based practice is anti-innovation! It is a bunch of like-minded funders who already agree with EBP reading each other’s proposals deciding only to fund the handful of evidence-based practices that they agree with" (personal communication, January, 21, 2010). Khun's theory of the structure of scientific revolutions suggests that real innovation comes from the periphery – that is, from those members who do not follow the established paradigm (1962). EBP must then seek to incorporate and evaluate social interventions and ideas from alternative sources in addition to peer-reviewed academic journals. To a certain extent, the growing popularity of the evaluation of existing social programs can help in this area. If a client and/or practitioner implements a new intervention, then the success or failure of that intervention should be documented and absorbed into the evidence base so that others can learn from it. Furthermore, the recent support of the stage model of intervention development (the aforementioned process where researchers design and test inchoate interventions in feasibility, efficacy, and effectiveness study stages) is spawning innovation from within academia. We must be cautious not to focus exclusively on current evidence-based practices and, as a consequence, ignore more ground-breaking interventions from non-conformist social work pioneers.

**Conclusion**

EBP is criticized for a variety of reasons. These critiques are mainly based on misconceptions and the impracticality of EBP. However, EBP is a comprehensive approach incorporating research evidence together with clients and practitioners’ values. It utilizes the best, current, and available evidence relevant to the research question asked. There is a clear hierarchy of evidence with regard to questions of effectiveness. If little or no evidence is available, practitioners should report the state of the evidence and use their best judgment. EBP gives us a mode of comparison for competing interventions and a
Evidence-Based Practice

set of tools to make informed decisions. It is a constantly evolving journey, not a stance. EBP researchers must be careful not to overlook innovative approaches, but rather incorporate them into the process as best identified by clients and practitioners. Better methods of evaluation and interventions will replace previous best practices. EBP is not perfect, but when used correctly, it has tremendous potential to provide clients with information, options, and programs that work.

References


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