Appendix A
An Outline for a Biopsychosocial Assessment and Intervention Plan

I. Referral
How and why did the client(s) get to the agency? Is the client self-referred? Is the client voluntary or involuntary?

II. Description of Client
Who is the client? Briefly document relevant identifying information including: Age, gender identity, marital/partner status, race, ethnicity, sexual orientation, religion, social class, income source(s), disabilities, level of education, prominent health issues, medications, substance use, and legal issues.

III. Presenting Issues and Concerns
What are the client's complaints? What are the larger presenting issues? How does the client view these concerns/issues? How do other people (family, friends, agency, work, school, courts, physicians, religious community, you, etc.) view the concerns/issues?

When did these concerns/issues begin? Is there an identifiable precipitant? Why is the client coming in now?

How has the client dealt with these or similar concern/issues in the past? What would the client most want help with?

IV. Assessment of Relevant Contextual, Historical, and Intrapersonal Factors

a. **Current context** What are the family, social community, work, and other issues relevant to an understanding of the client and the problem? (An eco-map and/or a family genogram, identifying family, and environmental resources may help clarify these intertwining issues.)

   - Are the client's basic needs met? (Housing, food, clothing, utilities, emergency, or situational needs such as diaper services or money for medicine or care of pets while inpatient?) What are the clients' strengths in meeting basic needs? Are these needs met in a culturally appropriate/sensitive manner?

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- What are the clients' income sources? Are they stable? Can they be improved? What are the clients' strengths in meeting basic needs? Is this income obtained in a culturally appropriate/sensitive manner?
- Are there language issues for the client in the services and communities to which they relate? In meeting basic needs? In the school or workplace? Are interpreters available? Is language training accessible if sought? What strengths and challenges does language pose for the clients?
- If the client has disability issues, how adapted/accessible are home, neighborhood, workplace, schools, stores, and professionals? How are communication needs met? How are transportation needs met? Does the client have access to needed equipment for safety and for daily living skills? Does the client have training to use such equipment/devices? How is this disability understood in the clients' cultural context? What strengths are evident related to this disability?
- Are the client's medical and dental needs met? (This includes routine checkups, assessment of illnesses, emergency care, immunizations, dental care, rehabilitation services, access to medications or rehabilitation equipment, access to nursing help, and access to long-term care, etc,) Are the services culturally appropriate? Accessible?
- Are the client's safety needs met? (Domestic violence, abuse or neglect of children or elders, violence in housing, neighborhood, and specific threats?) Is the client's physical environment safe? (Free of fire hazards, with accessible fire escapes, no lead paint, etc.?)
- Does the client pose a hazard to the safety of self or others; specifically is there suicide risk or lethality risk? Fire setting risk? (If any of these apply, a specific detailed evaluation and documentation is also required.)
- Is domestic, partner, or marital violence an issue? If so, is a safety plan in place?
- Are there child protective, disability, or elder protective issues for the clients? If so, is there a service plan? What services are involved? What services/needs are ignored?
- Are there legal issues for the clients? Any court involvement, restraints, obligations? Are there obligatory services, costs, or settlements unpaid?
- What is the client's immigration status? Could this be a source of being unsafe or exploited?
- What is the client's religion or spiritual beliefs? What level of involvement do they have with their religion or spiritual organization, its practices, and its community? Does the client have other connections to spirituality? How do these (religion and/or spirituality) shape the meaning of the client's life?
- What are the client's recreational interests? How and where are these met? Are there barriers to recreational activities?
- What are the client's key social supports? Are they accessible?

- Are there important social policy or social structural aspects to the client's situation and problem? Has (or could) the client joined with others to address these issues? How?

b. **Historical influences** Summarize, as relevant, past material about

- Client's childhood, including developmental history.
- Relationships with family of origin.
- School and work history.
- Previous experiences with social, medical or psychological services.
- Intimate relationships.

c. **Coping strengths and weaknesses**

- What are the client's key self-reported strengths? Are there other strengths you observe or can infer?
- How does the client process information? Protect themselves from anxiety and stress? Who do they turn to for support and nurturance?
- How does the client characteristically interact with others? Are these strategies successful in meeting the client's needs? Are they routinely problematic? Can the client show flexibility in style of interaction?
- How do these strengths, challenges, and abilities fit with the client's social and institutional resources? What resources or obstacles facilitate or inhibit the client's mastering current issues/concerns?
- What role do current life cycle tasks play in relation to the concerns and issues that have been identified?

V. Formulation

Develop a brief, clear, biopsychosocial summary of the above material that integrates relevant developmental, theoretical (i.e., psychodynamic, cognitive-behavioral, *P–I–E*, family systems, or risk and resiliency), family, and sociocultural issues. How would you state the client's dilemma in easily understood words that capture the key concerns and strengths?

VI. Plan for Intervention

Drawing upon the formulation, describe your plan for intervention. Identify your goals, separating immediate from long term. What would be the core elements of a treatment contract with this client? Are there elements that might be uncomfortable or unacceptable to the client?

VII. The Best Research Evidence

Given the proposed plan for intervention, what does the research evidence indicate are the best likely effective treatments or services to discuss with the client? Are the treatments realistically available and can they be funded? Are these treatments likely to be accepted by the client?

VIII. Values and Ethics: The Worker's own Values and Experience

What are the value, ethical, diversity, personal reactions, and other challenging issues that surface in this case? Will these alter what you can offer and provide?

IX. Organizational Issues
How will your agency mission and practices shape further service delivery? What organizational factors aid successful services for this case? What factors are barriers or impede services for this case?

X. Social Change Goals
What social change goals can be part of, or related to, your work with the client? What resources might you mention to the client as ways to promote the changes they wish to help make? What resources might you help connect the client with to promote these changes? How might you work to promote social changes related to this client and case?

Appendix B
A Bullet Point Summary of the Merits and the Limitations of Evidence-Based Practice

In this appendix we offer a very brief overall summary of the merits EBM/EBP and the concerns and issues scholars and practitioners have raised about it. Each of these issues has been examined in greater detail in this book.

The Merits of EBP

The General and Practice Merits of EBP

(1) EBP offers a method for clinical social workers to include the use of research evidence in treatment planning, in diagnostic determination, and in the understanding of etiology and prognosis. It helps clinicians select among treatments in manner that includes knowledge of comparative outcomes for large samples. EBP provides policy planners with important data for determining the cost-benefit of specific treatments and procedures.
(2) The current EBP practice decision-making model makes research evidence one key part of practice decision making while also emphasizing the client's clinical needs, patient values and preferences, and the clinical social worker's expertise. Specific aspects of the clinical picture, the client's values, and preferences may override research evidence in clinical decision making. Clinical expertise is used to deterring the relative emphasis to be placed on each component of the practice decision-making process.
(3) EBP should help keep practice up-to-date. The obligation to search current research will bring new knowledge to bear on practice. It should speed up the application of new knowledge in day-to-day clinical practice. It provides a method for clinicians to manage 'information overload.'

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(4) The EBP can help ensure that nothing is overlooked when the EBP practice decision-making process is fully applied after a thorough clinical assessment.
(5) EBP should help make practice more effective, ideally for individual clients as well as for clients overall.
(6) Evidence-based practice can empower clinicians to develop independent views and positions regarding practice claims and controversies. It supports their ability to make alternative treatment choices with a clear rationale.

Methodological Merits

(7) Well-conceptualized and carefully implemented experimental studies (RCTs) of large samples provide a strong basis for documenting that a specific treatment leads to specific outcomes. Carefully applied, these research designs have strong internal validity. This allows researchers to say that a specific treatment *causes* a specific change (or does not cause such a change).
(8) The use of probabilistic, statistical methods proves a clear and well-developed method for making decisions about differences among treatments. EBP applies a well-developed technology for making claims that a specific treatment leads to a specific change (or does not lead to such a change).
(9) EBP promotes the aggregation of multiple studies on a topic. This emphasis has the practical effect of increasing the combined sample size on which calculations and decisions are made. It benefits clinicians by emphasizing large-scale calculations of outcomes; allowing for better representation of large populations than do individual studies (that often use small samples).
(10) EBM/EBP, and particularly the efforts of Cochrane Collaboration methods groups, have led to the creation of quality standards for systematic reviews of research that are transparent and very demanding. Other groups have created standards for reporting systematic reviews that both promote quality and help readers understand the research processes being reported.
(11) The aggregation of multiple RCTs through carefully conceptualized and implemented systematic reviews provides a clear methodology (statistical meta-analysis) for determining the magnitude of treatment effects (i.e., effect sizes, odds ratios, number needed to treat).
(12) The aggregation of multiple RCTs also provides a clear methodology for identification of treatment risks and harms that might not be identified in small-scale outcome studies (so long as the measured outcomes are wide ranging).

Administrative and Policy Merits

(13) Both for individual clients and in the aggregate, EBP should make practice more efficient, by increasing the use of effective treatments and reducing the number of ineffective, benign, and harmful treatments delivered. This should reduce overall costs.
(14) EBM/EBP provides a methodology to help policy makers and funders make choices about which treatments are effective and which are benign, ineffective, or harmful.
(15) EBM/EBP provides a clear rationale for making funding choices.
(16) EBP may provide a rationale for the determination of comparative provider effectiveness.

Research Merits

As noted in the Methodological Merits section above, EBM and EBP have led to many refinements and elaborations of research methods. EBP represents the application of very large-scale (population scale) epidemiological research methods and results to clinical practice decision making. It is an expanded application of an existing, and well-developed, research methodology, rather than a new form of research endeavor.

(17) EBM and EBP have identified, and actively promoted, the need for many more studies of treatment outcome and effectiveness (as well as the effectiveness of diagnostic procedures, the etiology of illnesses and disorders, and the prognosis of disorders). EBM and EBP provide a strong rationale for increasing research funding.
(18) EBM and EBP have shifted research funding priorities heavily toward studies of the effectiveness of treatments, and of diagnostic procedures.

Ethical Merits

(19) EBP is ethical in that clients are offered treatments that are demonstrated to be effective (though they may decline them based on their own values and beliefs).
(20) EBP may provide a public good by reducing or eliminating ineffective and harmful healthcare services. This may also reduce unnecessary healthcare spending and may reduce healthcare costs.

Questions and Continuing Issues About EBP

General Concerns About EBP

(1) There is no evidence that adapting the EBM/EBP model will make health and mental healthcare services more effective or less costly. Medications with demonstrated effectiveness sometimes prove to have harmful side effects after they have been widely used. EBP could end up increasing mental healthcare costs, especially if empirically supported but labor intensive models of treatment such as DBT begin to be widely used for the treatment of personality disorders.
(2) EBP adopts a particular definition of evidence drawing upon large-scale, quantitative research. This definition has been promoted by many physicians, policy makers and funders, psychologists, social workers, nurses, and educators. On the other hand, many professionals from the same groups question the narrow nature of this definition of 'evidence.' They note that some useful forms of research are devalued by the EBP research hierarchy. They also note that it is an act of economic, political, academic, and social power to set a definition of evidence, setting up relative winners and losers. Clinical practitioners question the completeness of EBP's definition of evidence and its relevance to direct practice. Some academic researchers have started to reframe EBP as "Science-based Research" (SBR) to reclaim the word 'evidence' as much broader and varied than is defined in the EBP evidence hierarchy and methods.
(3) EBP offers what is often called an 'objective' approach to scientific knowledge building, but it fails to address theory in many instances. Science is typically defined as a circular process starting with inductive knowledge building based on observation, leading to the creation of theories, which are then tested based on deductive hypotheses or predictions. Based on the result of these tests, theory is revised and modified. New hypotheses and predictions are generated. EBP applies an empiricist approach, comparing treatments outcomes and effects of large groups of people, but does not attend to theories that explain how treatments works or why groups differ that is fundamental to good science.
(4) While EBM and EBP research methods are well developed and increasingly transparent, they value internal validity over external validity and ecological validity. That is, those characteristics of research that allow claims that a treatment caused a change are valued over considerations of to whom research results are applicable, and in what settings and situations. Some researchers call EBM/EBP research 'lab science' that may not be relevant or applicable to the complexity of real-world clinical practice.
(5) EBP results may be so complex that clinical practitioners from many professions can not interpret them correctly, and may be unable to critically

evaluate their strengths and limitations. This has led to the development of a new area of 'translational research' in which researchers help develop ways to make research results more applicable and more useful to practitioners. Practitioners are not widely involved in the conceptualization or implementation of such translational models.

(6) The medical model orientation of EBP addresses mainly personal characteristics and disorders with little attention to social factors and social context. For social workers this narrow focus omits balanced attention to persons in environments. It also omits attention to factors that point to risks and sources of resiliency and factors that may render even the best treatment ineffective (i.e., lack of trust or motivation, of full participation, of full adherence with a treatment plan).

(7) Social workers and others note EBP research often fails to identify and address the needs of socially diverse communities. The bulk of medical and social science research uses middle class whites as its samples. Many large-scale research reports simply do not address or identify the specific subpopulations they include or omit. As population demographics in many countries show growing racial, ethnic, and other forms of diversity, EBP does not include sufficient attention to their often different needs and values to guide knowledge development and practice. This is evident both in the questions EBP research addresses, and in the failure to identify and study the specific needs of social groups. Systematic review standards do not emphasize social diversity as an important variable in health care.

(8) EBP research values the researcher-defined evaluations of clients and clinical professionals. Yet a multidimensional model of EBP has been offered by Petr (2008) which actively seeks out the perspectives of clients and of other community members in their own words and voices, not just through standardized measures of disorders. Why not actively include the views of clients and other community members in outcome research and in searches for the best available evidence?

(9) Some social workers argue that the restrictive medical model emphasis of EBM and EBP fails to address social work's core value on social justice.

Practice Concerns

(10) Client populations in real-world practice settings are often very different from the samples used in outcome research. The complex social circumstances and multiple problems and multiple diagnoses of social work clients make it difficult to apply results of studies that exclude comorbid diagnoses and ignore social circumstances.

(11) Access to research results is a mix of free and paid print and online resources. Both individual clinical social workers and many agencies do not have access to the most current paid research results.

(12) Training in EBP, and in empirical supported treatments, is not adequately funded. Supervision on such therapies is also inadequately funded. Agencies do not provide time and support to fully implement the EBP practice decision-making process. This appears to be, in large part, due to reimbursement policies which do not fund the time such efforts require. Learning and doing EBP is a cost shifted onto individual providers rather than supported as a valuable part of the healthcare system.
(13) Even when the EBP practice decision-making process points to empirically supported treatments that are acceptable to the client, such services may not be available in all areas. (The Jennifer case examined in Chapter 16 is an example of this dilemma.) Ironically, some such services may not be reimbursed by state or insurance companies as they do not appear on their lists of empirically supported treatments (ESTs).
(14) It is unclear if treatments and services that are based upon empirically supported treatments (ESTs) can claim demonstrated effectiveness when they are modified to meet local circumstances and needs. It is unclear if ESTs that are not delivered fully according to treatment programs or manuals, and by appropriately trained and certified providers, can claim any empirical support for their altered treatments.

Methodological Concerns

(15) It is often unclear how relevant and applicable large-scale research results are to any individual client. EBP uses medical model definitions of individual disorders. These often include many components in a 'menu' of options. Clients may fit a diagnosis based on presenting with 5 of 7 to 12 characteristics. This may create subtypes of people within a diagnostic category that are not differentiated in EBP conceptualization or in EBP research. This may make EBP findings more or less relevant to individual clients within the same large diagnostic category.
(16) EBP uses measures of disorders that vary widely in content, comprehensiveness, and psychometric properties. Many standardized measures used in research have highly variable scores on concurrent validity. The measures on which EBP outcomes are based may themselves be suspect. The psychometric properties of measures are often omitted from, or minimally reported, in research reports. These measures may also not have been tested for validity and reliability for diverse social groups.
(17) Research on clinical processes are not a major part of EBP research but are of great interest to clinical practitioners. What factors within a treatment model make the treatment effective? How are individual differences and preferences best accommodated in clinical practice? There is research that demonstrates that even "demonstrated effective" therapies may not lead to good outcomes unless a good working alliance between client and clinician is in place (see, for example, Castonguay, Goldfried, Wiser, Raue and

Hayes 1996). How does the relationship and the alliance differentially impact outcomes?

(18) The active roles of both client and clinical are not widely addressed in EBP research. Common factor research suggests that the client is the largest source of variation in clinical outcome. Why are not client differences more studied? Clinical practitioners also vary in strengths, styles and skills. Why are not differences among clinicians studied in detail?

(19) Investigator bias and/or allegiance bias is underexamined in EBP research. Studies may be conceptualized and designed in ways which overtly or covertly favor one theory over another. This bias may also extend to favoring one type of outcome, or type of treatment, over others. In turn, researchers fail to question adequately whether their own biases may influence the design, implementation, results, and interpretations of their studies.

Administrative and Policy Issues

(20) While rising healthcare costs are a concern to everyone, who does it benefit to portray clinical practitioners as lacking in knowledge or skill, or even as incompetent? Is not there a way to address financial concerns that is less accusatory and inflammatory? Why are the financial concerns of professionals suspect while the motives of for-profit healthcare corporations are assumed to be righteous and are not examined as equally suspect?

(21) Managed care policies and practices may actively discourage acceptance of EBP by practitioners. It is even possible that managed care administrative practices may directly conflict with the emphasis on clinical expertise as the integrating factor in the EBP practice decision-making model. That is, if treatments with empirically demonstrated effectiveness are not authorized by managed care companies, or if their lists of reimbursable treatment differ from those of major research organizations, managed care practices may directly conflict with the use of the best available evidence in clinical practice.

Glossary

Absolute Risk Reduction (ARR) also known as Absolute Risk Difference: In epidemiology a measure of the effectiveness of a treatment. ARR is the risk of an outcome for the control group minus risk of the same outcome for the treated group. An ARR of 0 means there is no difference due to a treatment. Negative values indicate that treatment reduces the risk of unwanted outcomes, i.e., an ARR of −12% means the treatment leads to 12% fewer rehospitalizations. This is a positive treatment effect.

AMSTAR: Stands for the Assessment of Multiple Systematic Reviews is an 11 item measurement tool for the assessment of quality in systematic reviews.

Analysis of Variance or ANOVA or *F* test: In statistics a test used to determine differences across two or more groups on an interval level dependent outcome variable. ANOVA only determines difference across all the groups, so it is often used in combination with *post hoc* or *a posteriori* tests that identify if specific groups differ one from another. Common *post hoc* tests include the Tukey-B, Bonferroni, and LSD [Least Significant Difference].

Attribution Bias: Refers to the possibility that creators of a treatment might consciously or unconsciously favor their own theories treatments or methods leading to a falsely positive implementation of services or falsely positive interpretation of research results.

Bias: In general bias is any unknown or unidentified influence that alters the results of a study or its interpretation. Biases may be systematic or random, intentional, or unintentional. In experiments or RCTs, bias is any influence that affects the results of a trial or its interpretation other than the specified intervention under study.

Blinding: A research technique involving the concealment of an intervention or any other influence that might consciously or unconsciously influence study

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results from patients clinicians, and/or researchers. Single blinding involves concealment from participants but not from the researchers doing the study. Double blinding involves concealment from both researchers and participants. Blinding in psychosocial interventions can be very difficult.

Boolean Operators: Commands used to specify the logical connections among search terms. The most common Boolean operators are "Or" (which yields all content on both terms), "And" (which yields only content including both terms), and "Not" (which excludes all content with the specified term). They are widely used in electronic database searches.

Campbell Collaboration: An international volunteer, organization promoting high quality outcome research in education, social welfare, and crime and justice. Works in close cooperatively with the Cochrane Collaboration. Named in honor of psychologist Dr. Donald T. Campbell who was a pioneering research methodologist.

Case Control Study: In research design a naturalistic design in which participants with an outcome of interest (known as "cases") and control patients with different outcomes are compared for exposure to specific risk or resiliency factors.

Case-Series: In research design a naturalistic design in which participants who show a specific target outcome are studied without using controls.

Case Study: In research design a naturalistic design which focuses on just one, or very few, cases. Cases may be individuals, groups, families, organizations, or communities. Case studies often provide in-depth information about the focal case and the intervention process.

Chi-square Statistic: In statistics a test used to show if a relationship exists among nominal or categorical variables, such as gender or ethnicity.

Cochrane Collaboration: An international volunteer, organization begun in 1993 to promote standards for medical and psychiatric outcome research and to increase the use of high quality research results in practice and policy. Established and publishes the *Cochrane Handbook for Systematic Reviews of Interventions*, widely acknowledge as the most clear and rigorous set of procedures for summarizing quantitative outcome research. Named in honor of physician Dr. Archibald Cochrane who argued for including large scale research results in treatment planning.

Cohen's *d*: A statistical measure of effect size summarizing the magnitude of change. Small effects are in the 0.00–0.20 range moderate effects are in the 0.21–0.79 range, and large effects are 0.80 or higher. Effects sizes of 0.20 may also be interpreted as a 55% success rate, 0.50 as a 62% success rate, and 0.80 as a 69% success rate.

Cohort Study: In research design a naturalistic design comparing two distinct groups (or cohorts) of clients, one which has a received a specific exposure or intervention and another which has not, to determine how the groups differ over time on a specific outcome.

Conceptual Definition also called a Theoretical Definition: Are definitions stated in terms of concepts or theories not specific measures. To define theoretically is to create a hypothetical construct acknowledged as useful within a profession. For example, that depression is generated by dysfunctional cognitions in cognitive theory, or that repetitive patterns of early childhood cognition and interaction may be unconsciously continued as transference in psychodynamic theory. Contrasts with operational definition.

Confidence Interval (CI): In statistics the range around a study's main statistical result within which the unknown true or population value is determined to be located. Defined as a range of values between specific lower and higher limits, if a statistical result falls within the CI, it is statistically significant. If it does not, the result is not statistically significant. In research reports, study outcomes that fall within the CI are statically significant, while those that fall outside the CI are not. In Forest plots used in meta-analyses, if the null result falls within the CI, the result is not statistically significant. CIs allows for sampling error in estimating how well a study's sample reflects the larger but unknown, population the study seeks to represent. Smaller CIs are preferable to large CIs as the point estimate is likely more representative of the larger population.

Confounding Variable also Known as Confounds: An extraneous variable that is not under explicit study but which may impact both the independent and dependent variables. Confounding variables undermine the internal validity of studies most often by increasing false positives or Type I errors.

Continuous Variable: In measurement a variable that may take on any value, including fractions or decimal values between whole numbers. Opposite of a discrete variable.

CONSORT: Stands for Consolidated Standards of Reporting Trials begun in 1993, is an international medical working group seeking to improve standards for the reporting of randomized controlled trials (RCTs). The CONSORT statement offers a standard, detailed, format for reporting the results of RCTs.

Criterion Level: In statistics the probability that, in comparison to a defined null hypothesis, a statistical test will generate a false-positive error. In research, the criterion level is used by researchers to make a determination that an observed result is unlikely to have occurred by chance alone. The common criterion levels are $p < .05$ (or less than 1 chance in 20) or the more conservative $p < 0.01$ (or less than 1 chance in 100).

Degrees of Freedom: In statistics the number of values in a distribution that are free to vary. Degrees of freedom are used to help determine if the value of a

statistic is statistically significant compared to a previously selected criterion level or probability.

Discrete Variable: In measurement a variable that may only take on whole number values, such as number of children in a family. Opposite of a continuous variable.

Effect Size: In statistics a measure of the magnitude of experimental effects. Effect sizes go beyond simple statistical significance to measure the size of the observed effect. Effect sizes are typically reported using the Cohen's *d* statistic for large samples and the Hedge's *g* statistic for small samples. *d* and *g* values are interpreted as 0.00–0.19 indicates no effect, from 0.20 to 0.49 as a small effect, from 0.50 to 0.79 as a moderate effect and over 0.80 as a large effect. Odds ratios and relative risk are also measures of effect size used with binary data.

Effectiveness Studies: Research studies done on real-world clinical populations rather than as fully controlled experiments. Effectiveness studies reflect everyday practice conditions well but often allow for threats to the interval validity of study results.

Efficacy Studies: Research studies done as very carefully controlled experiments. In clinical trials efficacy studies often involve diagnostic procedures and other efforts to insure treatment fidelity that are not typical of everyday practice. They seek to demonstrate treatment effects under ideal controlled conditions with very few threats to internal validity.

Epidemiology: The study of the relationships of the various factors determining the frequency and distribution of diseases.

Event Rate: In epidemiology the proportion of clients in a group or population for whom a specific result or event is observed.

False Negative: In everyday usage deciding there is no problem based on a test or procedure where a problem actually exists. In statistics, a false negative, or Type II error, occurs when statistical test results lead to acceptance of a null hypothesis that is actually incorrect.

False Positive: In everyday usage deciding a problem based on a test or procedure where no problem exists. In statistics, a false positive, or Type I error, occurs when statistical test results lead to rejection of a null hypothesis that is actually correct.

Fidelity: The degree to which an intervention treatment, or service adheres to the manual, principles, or rules that define the original intervention, treatment, or service. An intervention that omits aspects of the defined treatment, or is not fully implemented, or is delivered by poorly trained personnel may be said to lack fidelity to the defined model.

Forrest Plot: A chart or diagram representing the results of individual studies included in a meta-analysis. Forrest plots clearly portray how individual study

results compare to the mean outcome of the meta-analysis as a whole. This makes individual study results that were better or worse than the mean for all studies quickly apparent.

Funnel Plot: A flow chart documenting how the results of trials in a meta-analysis are affected by publication bias.

Generalization: The ability to apply the results of any single study based on a specific sample to the larger population from which the sample was drawn.

GRADE: Begun in 2000 the GRADE working group is a collaboration of health professionals working to develop a common approach to grading the quality of quantitative research results.

Heterogeneity: In statistics a property of a dataset, indicating how similar or varied are the cases that constitute it. In meta-analysis and in systematic reviews, a measure of variation or difference among trials included in the review. Forest plots graphically display heterogeneity of results. The χ^2 (Chi-square) statistic is often used as a test of significant differences among combined study results. The I^2 statistic is also used to measure the parentage of variation not due to chance alone. I^2 values of less than 25% are considered low by convention.

Incidence: In epidemiology the number of new cases of illness arising during a specified time period for a defined population.

Intention-to-Treat: In research design a design in which client data are analyzed in the groups to which they were originally assigned, despite the possibility that they may have switched treatment types (or arms) during the study. Such changes often occur for clinical reasons to maximize positive outcomes for the client. For example, a client with serious side effects to a medication might be switched to a group not receiving medications but would still be analyzed at the end of the study in the original group that received medication. In sampling, specifying how non-compliant cases and drop outs are handled in the study analysis.

Interval Level Variable: In measures and statistics a measure with mutually exclusive categories, a clear hierarchy of values, and equal intervals between each value. An example is I.Q. scores which are normed on a value of 100 with a standard deviation of 15 points (and a value of zero has no clear meaning).

Likelihood Ratio: In epidemiology the likelihood that a given result is expected in a person with the disorder of interest compared to the likelihood of the same result in persons without the disorder.

MeSH: An abbreviation for the Medical Subject Headings created by the United States National Library of Medicine. MeSH provides a thesaurus of medical terms (including psychiatry and psychology) used by many databases and libraries. Very useful to target precise literature searches.

Mean: In statistics the numerical average of observed scores. Only appropriate to use with interval or ratio level measures.

Median: In statistics the category that divides a distribution of scores into two equal parts. Only appropriate to use with ordinal, interval or ratio level measures.

Meta-analysis: In statistics are methods for combining the results of several quantitative studies exploring related content using weighted effect sizes. Statistically, meta-analytic results overcome the limited statistical power inherent in studies using small sample sizes by combining studies and increasing overall sample size. Results of meta-analysis are often reported as effect sizes, in Forrest plots, or in Funnel plots. Meta-analysis originally refereed to combined literature search efforts and statistical methods, but the design of systematic reviews have largely replaced meta-analytic search methods. Meta-analysis statistics are a key part of systematic reviews.

Mode: In statistics the most frequent score. Appropriate to use with all levels of measure.

Nominal Level Variable: In measures and statistics a categorical measure with mutually exclusive values but without a clear hierarchy of values or equal intervals between values. For example, gender defined by the categories female, male, and other.

Number Needed to Harm (NNH): In the epidemiological literature a measure summarizing the number of clients who must to be treated in order for one negative outcome to occur compared to untreated controls. Lower values (i.e., two or three) represent greater risk of harmful effects due to the treatment compared to controls.

Number Needed to Treat (NNT): In the epidemiological literature a measure summarizing the number of clients who must be treated in order to prevent one negative outcome over the course of the treatment. Lower values (i.e., two or three) represent greater positive effects over the course of treatment.

Odds: In probability theory a summary measure calculated as the ratio of an event occurring to not occurring. If hospitalization occurs for 25% of clients with a disorder, its odds are calculated as the probability of occurrence/1–probability of occurrence, or 25/75%, or one in three.

Operational Definition: An operational definition defines a concept in terms of a specific measurement process. Contrasts with theoretical or conceptual definitions.

Ordinal Level Variable: In measures and statistics a measure with mutually exclusive categories and a clear hierarchy of values, but lacking equal intervals between values. An example is highest level of school completed, scored in the hierarchy, 'none,' 'some elementary,' 'completed elementary,' 'some middle

school,' 'completed middle school', etc. The categories include unequal numbers of years but do represent a hierarchy of schooling.

Outlier: In statistics a term for a case or element of a distribution that is much higher or much lower than are the great majority of values.

***p* value:** In statistics the probability that a particular result would have happened by chance alone. Compared to a defined criterion level, or alpha level, the *p* value is used to decide if observed results are unlikely to have occurred by chance alone.

P.I.C.O. (or P.I.C.O.T.): An acronym used to guide the formulation of practice questions. *P* stands for patient *I* for intervention, *C* for comparison (to contrast with the intervention), and *O* for outcome of interest. *T* stands for type of question which may address treatment, diagnosis, etiology, prognosis or cost effectiveness.

Point Estimate: In statistics an estimate based on a sample of treated clients used to represent the unknown population value. Since the population value for all possible persons whom might receive a treatment is often unknown, point estimates based on large probability samples are used as the best estimates of these unknown values. Point estimates are best reported with confidence intervals for the estimate.

Prevalence: In epidemiology the baseline risk of a specific disorder occurring in a population, usually reported as a proportion or a percentage.

Prevalence Rate: The proportion or percentage of a population that has a target characteristic such as a major depressive episode, often over a specific period of time.

PRISMA: An abbreviation for Preferred Reporting Items for Systematic Reviews and Meta-Analyses. PRISMA is a working group of researchers who seek to improve the reporting of systematic reviews. PRISMA offers a 27 item checklist for reviewing the quality of systematic reviews and meta-analyses updating QUORUM reporting standards.

Probability Sample: A sample in which every case has equal chance of selection.

PubMed: A database of the United States National Library of Medicine that compiles over 20 million citations from the electronic biomedical literature including online books (but not print books). Also a valuable gateway to many free full text articles.

Publication Bias: In systematic reviews and meta-analysis a bias due to omission of important but unavailable research reports. Publication bias can be due to an inadequate search strategy, exclusion of reports in different languages, but is most often due to omission of unpublished reports, including those with negative findings (that are less likely to be published in journals).

QUORUM: An abbreviation for Quality of Reporting of Meta-analyses. QUORUM was a working group of researchers who sought to improve the reporting of meta-analyses and systematic reviews. QUORUM produced a checklist for reviewing the quality of systematic reviews and meta-analyses and a chart format for summarizing literature searches.

QUORUM Chart: A flow-chart style diagram used to display visually the literature search and review process in a meta-analysis or systematic review. Makes plain why research reports were included or excluded from a given analysis and the numbers of reports included at each stage of the analysis.

***r* or Pearson's *r*:** A statistic used to assess association or correlation between two interval or ratio level variables.

r_s or Spearman's rho: A statistic used to assess association or correlation between two ordinal level variables or one interval level and one ordinal level variable.

Random: In statistics refers to an equal chance of selection for all members of a population of sampling frame. Randomization limits biased assignment of cases to treated and control conditions in experiments or RCTs.

Randomized Controlled Trial (RCT) also Known as a Randomized Controlled Clinical Trial: In research design, an experimental research design used in clinical research. Clients are randomly assigned into treatment and control groups, assessed at baseline and again after treatment concludes. Both groups are compared on the same outcome variable(s). RCTs allows determination of changes caused by the treatment, and for attribution of cause and effect relationships: that the treatment caused any changes observed. May also be referred to as a *parallel-group design*, since randomization is used to generate equivalent—or parallel—treated and control groups.

Ratio Level Variable: In measures and statistics a measure with mutually exclusive categories, a clear hierarchy of values, equal intervals between each value, and a non-arbitrary zero point such as age in years.

Relative Risk (RR) also Known as the Risk Ratio: RR is the ratio of the probability of an event occurring in a treated group divided by the probability of its occurring in an untreated group (or a known prevalence rate). It is a measure of improvement due to treatment. An RR of 1 shows no difference in outcomes between the groups. Values greater than 1 means that the treatment increases the risk of the outcome which is good for positive outcomes but bad for unwanted outcomes. (The treated group fared better) Values less than 1 mean that the treatment reduces risk of the outcome, which is good for unwanted outcomes but bad for positive outcomes. (The untreated group fared better).

Relative Risk Reduction (RRR): A widely used measure of medical treatment effect calculated as 1 − RR. RRR summaries the reduction in an unwanted outcome in the treated group compared to the control group. An RRR of 50%

would indicate that 50% fewer treated clients were rehospitalized after treatment compared to controls.

Reliability: In tests and measures refers to how consistently a measure produces similar scores over time, setting and administrator, not based on any changes in the content under study.

Sensitivity: In standardized tests a measure of how well a test can capture very small changes.

Specificity: In epidemiology refers to the proportion of people without a disorder who have (correctly) a negative test.

Sampling Error: In statistics the uncertainty generated by collecting data from a sample rather than from every member of a population.

Systematic Review: A peer-reviewed research summary on a specified topic involving systematic and transparent searching, evaluation, selection, and meta-analytic summarizing of all high quality relevant results found in the literature. The standards for a systematic review are set by the *Cochrane Handbook for Systematic Reviews of Interventions*, but many published reports use different, and often much lower, quality standards. Cochrane reviews heavily emphasize quantitative, experimental research.

***t* test:** In statistics a test used to determine differences between two groups of a nominal level independent variable on an interval level outcome variable. t Tests are useful for determining if differences exist with small sample sizes.

Treatment as Usual: Used as a comparison intervention in some experiments or RCTs refers to the treatment or services routinely available in a community. A limitation of treatment as usual as a comparison group is that it may be composed of many different treatments, with varying fidelity of delivery. The choice of such services may also be subject to several forms of bias. In favor of this approach is that, done well, it represents routine care and can be a reasonable, naturalistic, basis for comparison of treatment effects.

Validity: The extent to which a variable measures what it is intended to measure. There are several types of validity. In research design *internal validity* refers to the ability of an experiment research design to make cause and effect attributions when fully and carefully implemented. The *external validity* of a study refers to how well results based on the study sample can be generalized to other people and settings. *Statistical conclusion validity* refers to how fully and carefully the statistical analysis was completed. In tests and measures, validity refers to how well the measure represents the concepts and content they are intended to capture.

***z* Scores:** In statistics and in meta-analysis individual scores may be converted mathematically from their original scales into *z* scores which have a mean value of 0 and a standard deviation of 1. The relative distribution among scores in a

distribution is not altered in this process, but the label for each value is changed to a new, common, metric. This allows different interval or ratio level measures, with different ranges, to be meaningfully compared in meta-analysis.

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