



7-9-2017

# Use of Evidence-based Practice to Enhance Decision-Making in Rural Child Welfare Practice

## Use of Evidence-based Practice to Enhance Decision-Making in Rural Child Welfare Practice

Karen Rice  
*Millersville University*

Follow this and additional works at: <https://digitalcommons.murraystate.edu/crsw>



Part of the [Social Work Commons](#)

### Recommended Citation

Rice, Karen (2017) "Use of Evidence-based Practice to Enhance Decision-Making in Rural Child Welfare Practice," *Contemporary Rural Social Work Journal*: Vol. 9 : No. 1 , Article 15.

Available at: <https://digitalcommons.murraystate.edu/crsw/vol9/iss1/15>

This Feature Article is brought to you for free and open access by Murray State's Digital Commons. It has been accepted for inclusion in Contemporary Rural Social Work Journal by an authorized editor of Murray State's Digital Commons. For more information, please contact [msu.digitalcommons@murraystate.edu](mailto:msu.digitalcommons@murraystate.edu).

## Use of Evidence-based Practice to Enhance Decision-Making in Rural Child Welfare Practice

Karen Rice  
Millersville University

**Abstract:** Child welfare practitioners need to ensure they employ effective decision-making when implementing services to families at risk for abuse and/or neglect of their children. Utilizing a structured decision making process, specifically an evidence-based process, may enhance case outcomes (Hagermoser-Sanetti, & Kratochwill, 2009). Evidence-based practice is an attempt to bridge the gap between research and practice (Hagell, & Spencer, 2004). Evidence-based practice (EBP) is defined as a “process that blends current best evidence, community values and preferences, and agency, societal, and political considerations in order to establish programs and policies that are effective and contextualized” (Regehr, Stern, & Shlonsky, 2007, p. 410), which is crucial when working in rural communities (Belanger & Stone, 2008; Landsman, 2012; Saltman, Gumpert, Allen-Kelly, Zubrzycki, 200X). In most developed countries, use of EBP is the goal of public services (Nutley, Walter, & Davies, 2009). In the past two decades, there has been a more conscientious attempt to use EBP in various social work settings including child welfare, employment, health, juvenile justice, mental health, and substance abuse (Fixsen, Blase, Naoom, & Wallace, 2009).

**Keywords:** evidence-based practice, rural child welfare, rural social work

In the United States, approximately 679,000 children were abused and/or neglected in 2013 (United States Department of Health and Human Services, 2013). Public child welfare agencies are charged with ensuring the safety, permanency, and well-being of children referred due to allegations of abuse and/or neglect. The primary purpose of child protective services (CPS) is to protect children from the occurrence and recurrence of child maltreatment (DePanfilis & Zuravin, 1999). The conditions, under which this work occurs, however, are challenging at best. The literature is replete with descriptions of the beleaguered public child welfare system. Alpert and Britner (2005) describe systemic challenges that include time constraints imposed by state and federal policies and other barriers to effective casework including difficulty in engaging parents, poor communication with service providers, and staff turnover, as well as parent-specific issues such as poverty, transportation, mental illness, drug addiction, and non-foster care obligations. The passing of the Adoption and Safe Families Act (ASFA) of 1997 created an increasing need for thorough information about client families' needs. ASFA places an emphasis on establishing permanency within a specified period of time, thus making access to detailed information regarding families' needs and progress in meeting their goals vital in ensuring accurate case decisions.

Child welfare workers are charged with making these critical decisions about substantiating reports of child abuse or neglect, identifying the potential risk for future harm of child abuse and/or neglect, and identifying progress families made on established plans to ensure the ongoing safety of their children. Inaccurate case decisions can be devastating, with the most serious outcomes resulting in the injury or death of a child (Jones, Washington, & Steppe, 2007). Practice wisdom, historically, was the primary method employed by child welfare practitioners

to guide their decision-making regarding the current and future risk of child maltreatment. Child welfare has moved from using clinical judgment as a predictor of child maltreatment (Gambrill & Shlonsky, 2000) to relying on standardized assessments in an attempt to more reliably predict future child maltreatment (Crea, Barth, Chintapalli, & Buchanan, 2009). Specifically, the risk assessment model was the most widely used framework guiding instruments that attempted to structure caseworkers' decisions about the likelihood of future harm (Crea, 2010) by including the risk assessment tool factors related to the recurrence of child maltreatment found in the empirical literature rather than gleaned from clinical judgment and intuition (Baird & Wagner, 2000). These risk assessments, however, have been criticized for not assisting workers in developing case-specific intervention plans, not engaging families in the case planning process (Crea, 2010; Shlonsky & Wagner, 2005), and not identifying protective factors that may buffer the effects of the risks (Gambrill & Shlonsky, 2000). Further, research on the utilization of these actuarial models to assess risk show that practitioners may not implement the model as intended and may choose to not implement the model entirely (DePanfilis & Zuravin, 2001). In doing so, practitioners resort to relying on their knowledge and experience derived from practice and educational training, which have been shown to vary across practitioners and result in faulty decision-making (Cash, 2001). Effective decision-making is essential because research shows that when services provided to families are guided by sound evidence, the result often leads to better case outcomes (Hagermoser-Sanetti & Kratochwill, 2009), which suggests, in child welfare, when services aimed at ensuring child safety are implemented well, the outcome may lead to reduced rates of child abuse recurrence.

Child welfare is accountable to the population it serves. Child welfare agencies follow a bureaucratic organizational structure (Fabricant, 1985). The classical bureaucratic model is characterized by a hierarchical ordering of individuals with well-defined roles and responsibilities and with only the necessary authority to complete their job duties (Gordon, 1970; Wasserman, 1971). Further, the behaviors of the individuals within an organization are maintained through a set of rules and regulations that stipulate the exact manner in which duties are to be executed (Gordon, 1970). These duties become routine, which fosters the bureaucratic structure, leaving little discretion for worker innovation. Rather, federal mandates dictate state public child welfare laws and regulations, which determine the local agency's rules and practice and hence, the caseworker's role and job duties. According to the bureaucratic model, an individual worker's attitudes, values, and behaviors within the organization are determined by the organizational climate (Gordon, 1970). Solomon (1976) has described public bureaucracies as organizations that have the ability to adversely influence the employees, clients, and service delivery. As a result, workers' case decisions may be a product of the organizational culture and climate (Cearley, 2004), which may vary from agency to agency. Lipsky (1980) has described this process of bureaucratization in his infamous book, *Street-Level Bureaucracy*, where he suggests working conditions, such as limited resources, time constraints, and conflicting goals, influence frontline workers' ability to implement policy. This lack of policy implementation will influence the effectiveness of case outcomes.

Given the innate bureaucratic structure of public child welfare agencies, it is essential to consider the phenomenon of innovation implementation when evaluating case outcomes to understand innovation effectiveness. Landsman (2012) asserts that the primary differences in rural vs urban child welfare agencies is a manifestation of their organizational structure and

functioning. Therefore, rural child welfare settings place greater autonomy and decision-making on their direct practitioners due to rural social workers being generalist and having fewer resources with which to accomplish their mandates (Landsman, 2012). This increased autonomy and decision-making may be welcomed by some but may also pose a challenge if clear guidelines are not followed to prevent personal biases and values from influencing case decisions, which could have a direct effect on case outcomes.

To compound the situation, public child welfare agencies located in rural areas have unique, diverse needs that may further influence the social worker's practice approach. In addition to the families in rural areas experiencing higher rates of poverty, increased substance abuse, lower levels of education, and higher rates of unemployment (Children's Bureau, 2012; Ginsberg, 2011), rural child welfare practitioners often lack the resources (e.g., education, services, training) to adequately meet the needs of the children and families (Belanger & Stone, 2008; Ginsberg, 2011; Walsh & Mittingly, 2012). As a result, rural child welfare workers often utilize the natural helping networks within the community (e.g., churches, neighbors, schools) to develop creative solutions to the identified risks within a family in order to prevent occurrence or recurrence of child abuse and neglect (Children's Bureau, 2012; Family and Children's Resource Program, 2007; Walsh & Mittingly, 2012). The use of informal resources and relationships to develop individualized services for clients and families is a strength of rural social work practice (Riebschleger, Norris, Pierce, Pond, & Cummings, 2015).

Although this innovative, creative, entrepreneurial, and adaptable approach to solving challenges is an invaluable strength of rural communities, child welfare practitioners often lack the specialized skill, experience, and decision-making necessary to ensure positive outcomes (Children's Bureau, 2012; Landsman, 2012) and therefore, this increased autonomy may result in risk of future abuse and/or neglect of the child. There is also concern by some that the use of these informal resources to address the needs of families in rural communities may be insufficient to meet the mandates of child welfare protocols (Templeman & Mitchell, 2001).

To reduce this risk, previous research, particularly related to the field of child welfare, has largely focused on assessing the efficacy and effectiveness of services in order to ensure accountability on behalf of the children and families receiving them (Cash & Berry, 2003; Fraser, Pecora, & Haapala, 1991; Schuerman, Rzepnicki, & Littell, 1994). This would require rural child welfare practitioners to possess excellent assessment, implementation, and evaluation skills to ensure competent child welfare services are provided to children and families (Riebschleger, et al., 2015) as educational training as a generalist social work practitioner alone is not sufficient (Fiske, 2003) and further, it is not feasible to be an expert in all areas of social work practice.

As previously stated, child welfare practitioners need to ensure they employ effective decision-making when implementing services to families at risk for abuse and/or neglect of their children. Utilizing a structured decision making process, specifically an evidence-based process, may enhance case outcomes (Hagermoser-Sanetti, & Kratochwill, 2009). Evidence-based practice is an attempt to bridge the gap between research and practice (Hagell, & Spencer, 2004). Evidence-based practice (EBP) is defined as a "process that blends current best evidence, community values and preferences, and agency, societal, and political considerations in order to

establish programs and policies that are effective and contextualized” (Regehr, Stern, & Shlonsky, 2007, p. 410), which is crucial when working in rural communities (Belanger & Stone, 2008; Landsman, 2012; Saltman, Gumpert, Allen-Kelly, Zubrzycki, 200X). In most developed countries, use of EBP is the goal of public services (Nutley, Walter, & Davies, 2009). In the past two decades, there has been a more conscientious attempt to use EBP in various social work settings including child welfare, employment, health, juvenile justice, mental health, and substance abuse (Fixsen, Blase, Naoom, & Wallace, 2009).

Rural child welfare practitioners employing an evidence-based practice approach not only enhance case outcomes for families by using evidence to guide their decision-making throughout each stage of the case but also benefit all key stakeholders, including the child welfare organization, community, and social work profession. Most professions are mandated by a code of ethics or other licensing body that require practitioners to utilize evidence to guide their practice and/or to evaluate the effectiveness of their practice and use that knowledge to guide practice decisions. For social workers, this mandate is outlined in the National Association of Social Workers (NASW) Code of Ethics (1999), which states social workers will not only utilize research to guide their practice decisions but will engage in research to advance the field of social work. This expectation ensures accountability to the individuals receiving the service, grantors, and/or tax payers financially supporting the program, and stakeholders with a vested interest in the program. For rural child welfare practitioners, with scarce resources, demonstrating effectiveness in services may help effect change, including funding to ensure more support for families and children in rural areas (Landsman, 2012).

Rural child welfare practitioners have been identified as lacking advanced knowledge, skills, and education (Mackie, 2007), which may hinder the level of service rendered to our most vulnerable citizens; however, using evidence to guide child welfare practice takes the guesswork out of case decisions and grounds the profession empirically, which the social work profession as a whole has historically been criticized for not doing. Therefore, understanding and using research and statistics allows rural child welfare practitioners to make informed decisions about the needs and progress of their clients (Quinn, 2006), as well as allows them to share this evidence and engage the families in the decision-making process, which is a strength in rural social work practice (Belanger, 2004).

Rural social work practice has a reputation of relying on practice wisdom and intuition to guide practice decisions; however, if that practice wisdom is based on past successes from evidence-based services, then sharing these outcomes with colleagues advances rural social work practice by broadening the knowledge base, which aligns with the mandates outlined in the profession’s Code of Ethics (NASW, 1999). Grounding case decisions in knowledge gleaned from evidence and through collaboration with clients, reduces the likelihood of rural child welfare practitioners being influenced by personal values and biases. Some researchers have expressed a need for child welfare administrators and schools of social work to incorporate cultural humility in training and curriculum for rural practitioners to ensure a professional use of self (Ortega & Faller, 2011; Riebschleger, et al., 2015), as well as to analyze rural practice successes and challenges (Riebschleger, et al., 2015). Vandivere and DeVooght (2014) stated that rural child welfare practitioners need knowledge in applied research, including how to locate

evidence-based services, collect data, and apply findings in order to further enhance their strong advocacy skills.

To offer guidance to rural child welfare practitioners on how to embrace an evidence-based practice approach to guide decision-making, the rest of this article will focus on how to integrate research concepts into practice as well as how to evaluate the effectiveness of one's practice to ensure optimal case outcomes for children and families.

Research and practice rely on the problem-solving method to achieve its goals (Grinnell & Unrau, 2011). In practice, the client's needs are identified, goals are established, a plan is developed and implemented, progress on the plan is assessed, and a decision about ongoing services is made. In research, a problem is identified, a hypothesis is formulated to understand the problem, a research design is developed and implemented, the data collected are analyzed, and findings are presented. Therefore, research allows us to create new knowledge about a phenomenon and use that knowledge to make case decisions.

Practitioners need to be critical appraisers of research evidence rather than accept the knowledge at face value as all research studies contain limitations as no research study is designed perfectly. Therefore, being skeptical and considering multiple perspectives are essential. However, this should not be a new skill as practitioners do this all the time when assessing clients' needs, challenges, and issues.

So how do you obtain multiple perspectives? For example, if you are working with someone experiencing anxiety, how do you know what is the best course of treatment for that individual? Do you refer him or her to a provider you worked with in the past because you heard "good things" from former clients on how well it worked? Do you ask the individual where he or she would prefer going for treatment? Do you turn to the literature to find out what is the latest best practice for treating individuals with anxiety? Hopefully, you answered with a "yes" to all three.

Usually, the first place to begin is with the literature. Practitioners need to explore the evidence in the literature on what is the best treatment for specific issues and how effective those treatments are across various demographic characteristics (e.g., age, sex, race, ethnicity, geographic location, class). An exhaustive review is not essential but exploring the issue from more than one source is the bare minimum as evidence may identify the treatment as effective with one population such as young, single adults, but ineffective with older, married adults. You want to have as much knowledge as possible as this information will be shared with your client.

After you review the literature and identify one or more treatment options that have proven effectiveness, you can use your own practice knowledge to assess how effective they will be, as designed, with your specific client. Based on your experience, you may believe one treatment to be better suited than another or may believe one treatment would work if able to be modified based on your understanding of the needs of your individual client and/or organization's resources. Therefore, you take the evidence from the literature and integrate that with what is specific to your organization and community to develop the best course of treatment for the individual with whom you are working. This practice approach is ideal for rural child

welfare practitioners as they often lack sufficient resources and/or require individualized services to meet the unique needs of those living in rural areas.

Equipped with this knowledge, rural child welfare practitioners share this with their clients to engage them in the decision-making process and empower them at the same time. Obtaining the client's perspective is essential in empowering the individual to take an active role in his or her well-being. Therefore, the client is now a part of the evidence-based decision-making in determining which best practice treatment model would work for him or her based on his or her perspective. Engaging the client in the decision-making is also consistent with social work's values of empowerment and self-determination (NASW, 1999).

Once a decision is made, it is important to monitor the implementation of the agreed upon service to determine if the decision was the right decision. It is important to remember that when implementing evidence-based practices into the "real world," the client outcomes may not be the same as outlined in the literature for a number of reasons, including the uniqueness of the individuals receiving the service.

Unfortunately, there is not always agreement on what evidence is considered "best." However, given that the central goal in child welfare is promoting and ensuring the safety, permanency, and well-being of children, it is essential that the practices and programs implemented are not doing any harm. To assess the effectiveness of the practices implemented, it is essential to develop a method for evaluating them. There are a number of research methodologies, but the one preferred for evaluating one's practice is single-subject research designs (SSRD).

Single subject research (SSR), also referred to as single-subject, single case, or  $N = 1$  (Bloom, Fischer, & Orme, 2010; Nugent, 2010) has been around since the 1970s (Miller, Warner, 1975). The use of single-subject research designs is promoted in practice (Bradshaw & Roseborough, 2004) because it provides a model that demonstrates accountability to practitioners, clients, community, and funding sources (Bloom, et al., 2010). As Lambert (2007) noted following a meta-analysis of large-scale experimental research, formally monitoring of client progress and providing practitioner feedback as in single-system designs not only may reduce program drift, but may also positively affect overall outcomes (Bloom, et al., 2010). SSRDs have been successfully applied in research clinics, hospitals, and schools (Wong, 2010).

SSRDs can be simple or complex; however, the most common design used in practice is the AB design. This design allows the practitioner to collect data on the client's behavior intending on changing prior to implementing the practice model or intervention. This is referred to as the baseline (A) phase and can vary in length but the goal is to collect the data as long as necessary to show a stable pattern in the behavior. During the B (intervention) phase, data continue to be collected while the practice model or intervention is implemented. After the client completes the intervention, data collected during both phases are compared to assess how effective the treatment was and whether the client's outcomes improved.

The following steps can guide the evaluation process:

1. With the client, identify the behavior to be changed and define it. In research, we refer to this as operationalization, meaning to clearly define the behavior so that it can be measured. It is essential that both the practitioner and client are clear on what the behavior “looks like” so that they are tracking the same thing. Therefore, if you are working to improve a parent’s parenting skills, what does “good” parenting “look like?”
  
2. Next, identify how you will measure the behavior. Answer the following questions: Who will collect the data? What data will be collected? Where will the data be collected? When will the data be collected? How will the data be collected? For example, using the above example, when measuring parenting skills, will you as the practitioner collect the data or will the parent be asked to keep track of his or her behavior, or will there be a combination of individuals collecting the data? Again, what data are collected is dependent on how you operationalized the behavior. Will the data be collected in a natural setting such as the home or an artificial setting such as the office? Are data collected daily during a certain timeframe or once a week during parent/child visitation? How you collect the data may comprise more than one method. For example, you may decide to use a checklist comprising all the parenting skills you would like the parent to exhibit and every time you witness the parent exhibiting that behavior during the specified observation period, you place a checkmark by that skill. Additionally, you may have the parent complete a standardized survey found online that measures the parent’s perception of his or her parenting skills.
  
3. Identify the SSRD you will employ. There are a number of designs from which to choose and the purpose is not to do research on your clients, but the design will provide you with a framework on when to collect the data (e.g., before and after the intervention).
  
4. Implement services and collect data on the client’s behavior as outlined.
  
5. Assess the data collected throughout the entire process and make decisions as outlined below based on what the data reveal about the client’s progress.

As previously stated, utilizing evidence to guide child welfare practice has many benefits, including ensuring accountability to the client and ensuring protection of the practitioner by providing effective practice models and interventions and allowing for timely case decisions.

The practice decisions that are made based on the findings from evaluating one’s practice include:

1. Intervene or not intervene. By collecting data prior to implementing an intervention, you can determine whether a problem really exists, and if so, how extensive or pervasive the problem is. Even when working with someone who is referred to you for specific services, assessing how extensive and/or pervasive the symptoms and/or behaviors are prior to intervening ensures the right level and intensity of treatment is provided.
  
2. Continue an intervention. Ongoing monitoring of the individual through collection of data throughout the intervention phase, allows you to assess whether the individual is

making progress. If the intervention stops, and the data show a decline in behavior and/or symptoms, then you may want to continue with the intervention. The data can be used with the client to articulate the need for ongoing treatment and can also be used during supervision or when speaking with insurance companies to justify the need for ongoing services.

3. Modify an intervention. Again, if the ongoing monitoring of the client's behavior and/or symptoms during the intervention phase shows a plateau, then you may suggest a need to increase the intensity of the intervention. During a time of managed health care, ensuring the right level and intensity of treatment are provided is more crucial now than ever before and monitoring of the client's progress through data collection affords practitioners the opportunity to do just that.

4. Change to a new intervention. At any point in time when the individual displays a lack of progress, you will be equipped with this knowledge immediately and may decide to change the intervention employed. This is crucial because providing ineffective services may actually do harm to the client.

5. Discontinue services. When the data reveal the individual has made and continues to maintain progress at the agreed upon level, it may be time to discontinue services.

Research and practice should not be considered as separate concepts but rather interrelated concepts that work together to bring about optimal outcomes. As can be seen, utilizing research to guide and evaluate one's practice ensures optimal and timely decision-making throughout the treatment process. Therefore, how to evaluate the practice implemented should become a natural component of the treatment planning process. We owe it to our clients to be the best practitioners we can be; research is the tool to be just that. In rural child welfare settings, where resources are scant and/or based on the use of informal services, utilization of an evidence-based process to guide decision-making ensures families and children receive adequate services necessary to minimize the risk of occurrence and/or recurrence of child abuse and/or neglect.

### References

- Adoption and Safe Families Act (ASFA) of 1997, Public Law No. 105-89, 111 Stat. 2115 (November 19, 1997). Retrieved from <http://www.nicwa.org/law/asfa/ASFAII.pdf>
- Alpert, L. T., & Britner, P. A. (2005). Social workers' attitudes toward parents of children in child protective services: Evaluation of a family-focused casework training program. *Journal of Family Social Work, 9*(1), 33-64. doi:10.1300/J039v09n01\_03
- Baird, S., & Wagner, D. (2000). The relative validity of actuarial-and consensus-based risk assessment systems. *Children and Youth Services Review, 22*, 839-871.

- Belanger, K. (2004). In search of a theory to guide rural practice: The case for social capital. In L. Ginsberg (Ed.), *Social work in rural communities* (4<sup>th</sup> ed., pp. 75-93). Alexandria, VA: Council on Social Work Education.
- Belanger, K., & Stone, W. (2008). The social service divide: Service availability and accessibility in rural versus urban counties and impact on child welfare outcomes. *Child Welfare, 87*, 101-124.
- Bloom, M., Fischer, J., & Orme, J. (2010). *Evaluating practice: Guidelines for the accountable professional* (7th ed.). Needham Heights, MA: Allyn & Bacon.
- Bradshaw, W., & Roseborough, D. (2004). Evaluating the effectiveness of cognitive-behavioral treatment of residual symptoms and impairment in schizophrenia. *Research on Social Work Practice, 14*, 112-120. doi: 10.1177/1049731503257872
- Cash, S. (2001). Risk assessment in child welfare: The art and science. *Child Welfare, 80*, 811-827.
- Cash, S. J., & Berry, M. (2003). Measuring service delivery in a placement prevention program: An application to an ecological model. *Administration in Social Work, 27*(3), 65-85. doi: 10.1300/J147v27no3\_5
- Children's Bureau. (2012). *Rural child welfare practice*. Retrieved from [http://www.childwelfare.gov/pubs/issue\\_briefs/rural](http://www.childwelfare.gov/pubs/issue_briefs/rural)
- Crea, T. M. (2010). Balanced decision making in child welfare: Structured processes informed by multiple perspectives. *Administration in Social Work, 34*, 196-212.
- Crea, T. M., Barth, R. P., Chintapalli, L., & Buchanan, R. L. (2009). Structured home study evaluations: Perceived benefits of SAFE versus conventional home studies. *Adoption Quarterly, 12*, 78-99. doi: 10.1080/10926750902978824
- DePanfilis, D., & Zuravin, S. (2001). Assessing risk to determine the need for services. *Children and Youth Services Review, 23*, 3-20.
- DePanfilis, D., & Zuravin, S. J. (1999). Predicting child maltreatment recurrences during treatment. *Child Abuse & Neglect, 23*(8), 729-743.
- Fabricant, M. (1985). The industrialization of social work practice. *Social Work, 30*(5), 389-395.
- Family and Children's Resource Program. (2007). *Child welfare practice in rural North Carolina*. Retrieved from [www.practicenotes.org](http://www.practicenotes.org)
- Fiske, H. (2003). Reflections on rural social work. *Social Work Today, 3*, 13-15.
- Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

- Fraser, M. W., Pecora, P. J., & Haapala, D. A. (1991). *Families in crisis: The impact of intensive family preservation services*. Hawthorne, NY: Aldine de Gruyter.
- Gambrill, E., & Shlonsky, A. (2000). Risk assessment in context. *Children and Youth Services Review, 22*, 813-837.
- Ginsberg, L. (2011). Introduction to basic concepts of rural social work. In L. H. Ginsberg (Ed.), *Social work in rural communities* (4<sup>th</sup> ed., pp. 4-7). Alexandria, VA: Council on Social Work Education.
- Gordon, L. V. (1970). Measurement of bureaucratic orientation. *Personnel Psychology, 23*, 1-11.
- Grinnell, R. M., & Unrau, Y. A. (2011). *Social work research and evaluation: Foundations of evidence-based practice* (9th ed.). New York, NY: Oxford University Press.
- Hagell, A., & Spencer L. (2004). An evaluation of an innovative audiotape method for keeping social care staff up to date with the latest research findings. *Child and Family Social Work, 9*, 187-196.
- Hagermoser-Sanetti, L. M., & Kratochwill, T. R. (2009). Toward developing a science of treatment integrity: Introduction to the special series. *School Psychology Review, 38*, 445-459.
- Jones, J. L., Washington, G., & Steppe, S. (2007). The role of supervisors in developing clinical decision-making skills in child protective services (CPS). *Journal of Evidence-Based Social Work, 4*, 103-116. doi: 10.1300/J394v04n03\_07
- Lambert, M. J. (2007). Presidential address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research, 17*, 1-14.
- Landsman, M. J. (2012). Rural child welfare practice from an organization-in-environment perspective. *Child Welfare, 81*, 791-819.
- Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. New York, NY: Russell Sage.
- Mackie, P. F. E. (2007). Understanding the educational and demographic differences between rural and urban social workers. *Journal of Baccalaureate Social Work, 12*, 114-128.
- Miller, E., & Warner, R. W. (1975). Single subject research and evaluation. *Personnel and Guidance Journal, 11*, 130-133.
- National Association of Social Workers. (1999). *Code of Ethics*. Washington, DC: Author.

- Nugent, W. R. (2010). *Analyzing single system design data*. New York, NY: Oxford University Press.
- Nutley, S., Walter, I., & Davies, H. T. O. (2009). Promoting evidence-based practice: Models and mechanisms from cross-sector review. *Research on Social Work Practice, 19*, 552-559.
- Ortega, R., & Faller, K. C. (2011). Training child welfare workers from an intersectional cultural humility perspective: A paradigm shift. *Child Welfare, 90*, 27-49.
- Quinn, A. (2006). Reducing social work students' statistics anxiety. *Academic Exchange, 3*, 167-171.
- Regehr, C., Stern, S., & Shlonsky, A. (2007). Operationalizing evidence-based practice: The development of an institute for evidence-based social work. *Research on Social Work Practice, 17*, 408-416.
- Riebschleger, J., Norris, D., Pierce, B., Pond, D. L., & Cummings, C. (2015). Preparing social work students for rural child welfare practice: Emerging curriculum competencies. *Journal of Social Work Education, 51*, 209-224.
- Saltman, J., Gumpert, J., Allen-Kelly, K., & Zubrzycki, J. (20XX). Rural social work practice in the United States and Australia: A comparison. *International Social Work, 47*, 515-531.
- Schuerman, J. R., Rzepnicki, T. L., & Littell, J. H. (1994). *Putting families first: An experiment in family preservation*. New York, NY: Aldine de Gruyter.
- Shlonsky, A., & Wagner, D. (2005). The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management. *Children and Youth Services Review, 27*, 579-598.
- Solomon, B. (1976). *Black empowerment: Social work in oppressed communities*. New York, NY: Columbia University Press.
- Templeman, S. B., & Mitchell, I. (2001). Challenging the one-size-fits-all myth: Findings and solutions from a statewide focus group of rural social workers. *Child Welfare, 81*, 757-772.
- United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2009*. Retrieved from [http://www.acf.hhs.gov/programs/cb/stats\\_research/index.htm#can](http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can)
- Vandivere, S., & DeVooght, K. (2014). *Knowing the numbers: Accessing and using child welfare data*. Retrieved from <http://childwelfaresparc.org/wp-content/uploads/2014/Knowing-the-Numbers.pdf>

Walsh, W. A., & Mattingly, M. J. (2012). *Understanding child abuse in rural and urban America: Risk factors and maltreatment substantiation*. Carsey Institute: University of New Hampshire. Retrieved from [www.carseyinstitute.umh.edu](http://www.carseyinstitute.umh.edu)

Wasserman, H. (1971). The professional social worker in a bureaucracy. *Social Work, 16*, 89-95.

Wong, S. E. (2010). Single-case evaluation designs for practitioners. *Journal of Social Service Research, 36*, 248-259. doi: 10.1080/01488371003707654