Policymaking Opportunities for Direct Practice Social Workers in Mental Health and Addiction Services

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Abstract: *Direct practice social workers have potentially significant policymaking opportunities as mediators of top-down policy and as creators of policy where none exists. The power they possess stems from their 'on the ground' expertise and the discretion available to them in making practice decisions. By understanding their power as "street-level bureaucrats" they can significantly improve policy. Drawing on policy issues in mental health and addictions services, this article illustrates how social workers can use their power in an ethically sensitive manner to enhance policy outcomes for clients.*

Keywords: *Policymaking, social policy, direct practice, mental health services, addiction services, social work education*

Many direct practice social workers tend to ignore or dismiss their role in policymaking; they think of it as a top-down process for elite governmental and organizational policymakers and not something they should be concerned with (Sherraden, Slosar, & Sherraden, 2002; Weiss-Gal & Levin, 2010). They tend to overlook opportunities to shape policy as they implement it or to provide input into the larger policy development process (Westhues, 2003).

When social workers are not aware of their power to influence policy, they may inadvertently reinforce dysfunctional policies or fail to utilize opportunities to make positive changes. But when they are aware of their power they can use their on-the-ground expertise and discretion in an ethically sensitive manner to positively impact policy. They can a) provide input to policy planners, b) shape existing policy as they provide services, c) create policy in their practice domain where none exists, and d) encourage clients to become involved in policymaking.

To impact policy, social workers must understand the nature of policy, their power to influence policy, and the strategies available to them to make policy. The mental health and addictions field will be used to illustrate the ways in which practitioners can shape policies. Similar opportunities are likely available in other fields of practice.

Policy and the Direct Practitioner

Policy is often misunderstood to be solely the domain of the elite. According to this view, the President, Congress, the Courts, major federal agencies such as the National

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Institutes of Health (NIH) and Substance Abuse and Mental Health Services Administration (SAMHSA), in concert with their counterparts at the state level determine policy (Gerston, 2004). At the local service-providing level, policy is often misunderstood as solely the responsibility of agency staff occupying roles such as organizational leaders, managers, and policy analysts. The source of these misunderstandings is the assumption that policy is what is promulgated. Instead policy should be understood as the typical course of action or what is actually implemented.

The pivotal importance of implementation is reflected in definitions of policy that refer not only to what is promulgated or intended but also to what actually happens. Pressman and Wildavksy (1979) make implementation the key as they assert that so-called policy is only "a collection of words" and "exhortation." Written policy, they argue, "is a point of departure for bargaining among implementers" (p. 180). It is not necessary to fully accept this proposition to appreciate the importance of implementation. Unintended or unforeseen outcomes (some favorable and many not) are a consequence of the implementation of policy. Both the intended and unintended outcomes flow from the numerous decisions social workers and others make as intermediaries shaping policy outcomes (Westhues, 2003).

Whether aware or not, direct practice social workers inevitably mediate the intended policy because the policy rarely comes down the chain of command with instructions detailed enough to implement the policy. Discretion is inevitably involved as decisions must be made to interpret the policy or adapt it to the present circumstance. Even Medicaid rules and regulations, which are numerous and explicit, leave room for discretion as decisions are made about what services the person's need justifies. Most other policies come with fewer directives and constraints. For example, person-centered planning, a broad policy framework endorsed by many agencies relies even more heavily than Medicaid does on social workers' and others' discretion as they mediate the policy. Thus, in mediating top-down policies or taking concrete action to implement a general guide, social workers influence the "what happens" or the on-the-ground course of action.

The Policymaking Power of Direct Practice Social Workers

As policy implementers, social workers have been held up as wielding considerable power to influence policy (Schorr, 1985; Scott & Davis, 2007). Lipsky (1980) suggested this power arises from their role as "street-level bureaucrats," whom he defined as "lower participants in the organization." Earlier Mechanic (1962, p. 352) had observed that these lower participants impact policy outcomes owing to their "commitment, effort, interest, willingness to use power, skills, and attractiveness." The power of street-level bureaucrats has been explored in a large body of research. In their authoritative text Scott and Davis (2007) conclude that:

> while it is widely presumed that policies are determined by political leaders and high-ranking officials, a vast body of research on [policy] implementation suggests that a variety of factors—poorly specified or conflicting objectives, inadequate budgets, weakness of authority, misdirected incentives, existing work routines of operational personnel—transform policies so that the actions of

> "street-level bureaucrats" differ markedly from the intentions of those who designed the programs but establish the meaning of the policies. (pp. 318-319)

Lipsky (1980) specifically included social workers among street-level professionals, along with lawyers, doctors, and teachers, who he said were expected to use their discretion on behalf of their clients. That discretion is inherent in social work roles has been documented by Evans and Harris (2004). Discretion, however, is not always a 'good thing.' Its misuse has also been observed particularly in under-resourced public agencies settings (Brodkin, 1997; Smith & Donovan, 2003). Counter observations, however, have been made. Evans' (2011) research suggests that a professional culture promotes the positive use of discretion. He found that the professionalism of mental health workers protected clients from managerialist values that would undermine client interests.

An illustration of the positive use of discretion is when direct service practitioners use their discretion to address shortcomings of established policies by creating new ones. For example, social workers have initiated harm reduction policies out of concern for clients unable to commit to abstinence-based programs. Similarly, social workers and other mental health professionals have created programs to re-engage relapsing clients in addiction-related services (White & Kelly, 2011).

Establishing informal policies is another way discretion is positively exercised by social workers. The decisions they make to create referral patterns or procedures for inter-agency coordination have significant consequences for clients. Other informal or unwritten policies may affect clients who, for example, decline to take prescribed psychiatric medications, or show up in a drug treatment program with signs of having used. To the extent that direct practice social workers decide how to handle these situations they are policy makers.

Finally, social workers can also shape policy by participating in online surveys and community meetings, and where available, directly in policy deliberations. However, since the meaningfulness of these options varies, social workers will need to think carefully about when these opportunities represent effective input strategies (Woodford, 2010).

Three Policymaking Strategies for Social Workers

Providing input to "top" policymakers. Since elite policymakers are usually far removed from the situations the policies are meant to address, they need to tap the experience of those immersed in the situation (King, Feltey, & Susel, 1998; SAMHSA, 2011). Elites need to know the answers to several questions: What needs exist? What options would be most effective? When policy already exists, how well is it working? Are the intended outcomes being achieved? What modifications or revisions should be considered? Without input and feedback, including client feedback, from the practice level, these questions cannot be answered. Needs assessments and client satisfaction surveys fulfill some of this function but since they have limited utility in determining service effectiveness or explaining why things happen they need to be supplemented. Social workers with first-hand experience need to share their insights with policymakers being careful to ensure that their clients' interests, and not their own, get the emphasis.

This form of input and feedback is what C. Wright Mills (1959) insists is necessary to solve problems.

> Know that many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues … Know that the human meaning of public issues must be revealed by relating them to personal troubles—and to the problems of individual life. (p. 226)

Providing input to policy elites is something that all social workers should consider. And yet it is something that not all social workers are prepared to do. However, all direct practice social workers are inevitably involved in mediating policy and they must make wise use of their discretion.

Mediating existing policy. Effective use of discretion requires social workers to be aware of the play or degrees of freedom in human service organizations (Dolgoff & Gordon, 1981). Play in the system or places where practitioners make choices are everywhere and often intentional since no policy can cover all contingencies. A number of guides are available to "street-level" social workers who wish to use this freedom to tailor programs to the individual needs of their clients (e.g., Dodson, 2009; Maynard-Moody & Musheno, 2000; Watkins-Hayes, 2009).

Two evidence-based SAMHSA programs—Assertive Community Treatment (ACT) and Family Psychoeducation—illustrate the play in the system (SAMHSA, 2008, 2009). ACT, an intensive, 24/7 outreach program for people with severe mental illness leaves many choices to the discretion of the social worker implementing the program. To be considered a faithful model, a panel of clients (about 100) is served by a multi-professional staff in a low client to staff ratio (about 10:1). The program design favors work at the client's residence or in other community settings. Staff often work side-by-side with clients engaged in tasks such as shopping and getting to doctor's appointments. Despite design features that are more concrete than what is found in most programs, several key program characteristics are not specified. For example, social workers and other mental health professionals are (wisely) left to decide the frequency of client visits. The choice of program theory backing up the service activities is also left to the discretion of the social workers and other professionals. Even the basic requirement of 24/7 coverage is subject to interpretation and mediation as practitioners (along with managers) decide how they will cover the peak and low demand times of the day. And while the model calls for a variety of professionals, there is considerable discretion at the agency level in deciding the final mix of professions and peer support specialists. The basic idea is that every local adaptation, even those adhering to fidelity requirements, results in a unique interpretation of the model.

At first glance, another of SAMHSA's mature and more fully developed, evidence-based programs, family psychoeducation might seem to provide less room for discretion than ACT. Family psychoeducation specifies that programs must be offered for a period of at least six months. Additional standards and guidelines are set forth in several detailed booklets, each of which runs to more than 20 pages covering the following topics: supporting evidence, getting started, building the program, training, evaluating, and using multimedia (SAMHSA, 2009). But even in the faithful implementation of these detailed

guidelines, many important decisions are left to the discretion of social workers and other professionals. They decide, for example, on the relative priority and sequencing of the educational topics, and they decide who will present on these topics. Thus, they decide in a substantial way the educational content of the program.

Many of the guidelines or recommendations associated with the other four SAMHSA evidence-based practices kits (supported housing, supported employment, illness management and recovery, and integrated treatment for co-occurring substance use and psychiatric disorders) require similar choices on the part of those implementing the policy. Thus, much of what actually happens is determined by social workers and others implementing the program. And in programs more generally, there is the paradox that the more numerous the rules, the more the discretion practitioners have in deciding which ones to follow (Evans & Harris, 2004). On the other side many social workers will find themselves in situations where there are few rules and policies to guide them.

Creating policy where none exists. Since policies cannot cover every eventuality, social workers must develop policies. With online technology, for example, social workers have choices to make about emailing clients, recommending treatment-related Internet sites, and advising about online self-help groups or chat rooms (Edwards & Hoefer, 2010). As another example, they may enact a policy (perhaps wisely left unwritten) to suspend paper work when it interferes with client services. On a smaller scale they may decide when it is appropriate to send notes or cards such as birthday greetings to children or sympathy cards to adults.

Larger scale decisions offer choices about what services to offer, and in what priority, which in turn often force choices between case management, education, therapy, and resource development. Then decisions must be made about whether these services will be offered in individual, family, or group formats and what theories will be used to guide them (e.g., attachment, psychodynamic, cognitive, social learning, etc.). Still more decisions must be made about the location of the services—in the home, agency office, or community site such as a park or coffee shop. In all of these decisions social workers, making wise use of their discretion, can affect positive policy outcomes.

In choosing theories and service models, social workers must not assume that a commitment to evidence-based practices simplifies choice and reduces opportunity to contribute to policy (Cohen, 2011). Even if preference is given to certain theoretical frameworks, social workers need to be aware of variables such as relationship quality that need to be managed (Duncan & Miller, 2006; Wampold, 2006). In their review, Norcross and Lambert (2006) conclude that therapist characteristics and therapist commitment to the particular treatment combined with the quality of the relationship account for the largest part of the variance in treatment outcome. The specific treatment intervention, they conclude, accounts for a smaller part of the variance (Baker, McFall, & Shoham, 2009). Thus, social workers need to understand that commitment to evidence-based practice does not exempt them from decisions to be made about the development and maintenance of an effective relationship (Luborsky & Barrett, 2006). Scaling up and looking ahead, decisions must be made about how to recruit social worker therapists with

the appropriate characteristics and help them acquire a confidence inspiring theoretical system to guide their therapy (Duncan, Miller, Wampold, & Hubble, 2010).

From the standpoint of choosing interventions, hundreds have been designated as empirically supported or evidence based (Chambless & Ollendick, 2001; SAMHSA, 2013. Choosing among them involves considerable judgment given the ambiguous and often-contested nature of the empirical support associated with particular interventions (Shedler, 2010) and the need to adapt them to local circumstances (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004). Inevitably the decisions about which treatments to master among the unmanageably large number must take into account the situations in which they are likely to be used (Staller, 2006). Thoughtful decisions about these matters can have a profound positive effect on client outcomes (Glasner-Edwards & Rawson, 2010).

The ongoing evolution of managed care is another arena of policymaking opportunities. The current bias favoring psychopharmaceutical drugs stands out as requiring examination. But even when psychotherapy is readily available, it is constrained by a subtle bias favoring designs modeled after dose-response pharmaceutical interventions rather than a mutual client-therapist process (Bohart, 2006; Greenberg & Watson, 2006). Social work values and research mandate that clients cannot be treated as merely passive responders to psychotherapeutic interventions. They must be engaged in morale enhancing, resource generating, self-efficacy building practices (Duncan et al., 2010). Such practices embedded in empowering models are needed to tackle the range of complex person-in-environment problems, such as homelessness, unemployment, interpersonal violence, and relationship disruption. In contrast, models narrowly tied to DSM IV problem definitions limit and distort the way many real-world problems can be understood and addressed (Cohen, 2011). Social workers must use their discretion to move toward policies more attuned to the realities of practice.

Implications for Practice

Practitioners are well positioned to influence policy. They can provide input to elite, top-down policy makers. Because of play in the system they make policy in their own service agencies and the field of organizations within which their agencies are situated. Even in well-developed programs like ACT, they make choices and thus shape the course of action for clients. Lastly, they create policy where none exists or where directives or rules conflict. Social workers need to be aware of how these opportunities manifest themselves in an agency context. The following list of questions is meant to raise awareness about the opportunities to influence policy in mental health and addiction service agencies.

Agency Policy Questions

*Client Demographics***.** From a social justice perspective, who are the clients, and who are not clients? What barriers block access for certain groups of people? Are minorities affirmatively included? Are people from all socioeconomic backgrounds treated equitably? Are criteria about severity of illness or level of functioning appropriate?

Mission/Vision. Are agency mandates firmly focused on recovery rather than limited to the control of symptoms and maintenance of functioning? Do clients with substance use disorders have the option to pursue recovery with and without the assistance of medication? Has the agency drifted from its core mission?

Organizational Climate. Do clients experience the climate as warm and friendly or cold and bureaucratic, proactive or reactive, generous or withholding, orderly or chaotic, and efficient or inefficient?

Services. Is there an appropriate mix of services (e.g., medication, counseling or psychotherapy, ACT, clubhouse, psychoeducation, and transitional housing)? Are there gaps? Are the values guiding programs appropriate (e.g., is the family viewed as a resource in psychoeducation programs and ACT programs)? Is employment a goal in case management? Does staff facilitate client involvement in NAMI, the Depression and Bipolar Support Alliance, and other self-help groups? When substance use disorders need to be addressed are clients linked to the recovering community and 12-step groups?

Quality of Services. Is there appropriate fidelity to evidence-based program models? Is there an appropriate balance between fidelity and adaptation to local circumstances? Is attention paid to client preferences, enhancing motivation, and building healthy relationships? Are appropriate feedback mechanisms in place to monitor and correct problems? Are staff qualifications appropriate? Are workloads appropriate?

Budgetary Priorities. Are the allocations to various service units appropriate? Are they in proportion to service demand and needs?

Governance Issues. Do consumer, self-help and recovery community representatives participate in board, task, and advisory groups? Does NAMI, for example, participate in search activities for key staff? Do consumer and family representatives participate in the awarding and monitoring of contracts? Does the agency coordinate with other key agencies and the recovering community?

Organizational Field Policy Questions

Social workers and their organizations interact in a field of organizations. The field or network of organizations is defined "by rules, conventions and expectations that define appropriate activities and legitimate positions" (Owen-Smith & Powell, 2008, p. 601). Within the field, organizations are linked to some as partners and rivals on the horizontal plane, and to others as subordinates or super ordinates on the vertical plane. Those above on the vertical plane are often involved in funding or standard setting for the organization (Scott & Davis, 2007). The questions below describe opportunities to effect changes in the field of organizations.

Justice System. Are there intercept and diversion programs along the criminal justice continuum—police, prosecutor, court, jail, probation and parole? Does the Probate Court seek alternative solutions to involuntary treatment or criminal trial (Munetz & Griffin, 2006)?

The Network of Disability Agencies. Do the community mental health and addictions agencies participate in programs to integrate people with disabilities in the community? Is there an effective relationship with the local Center for Independent Living?

Education and Rehabilitation Services. Does the agency coordinate with community and four-year colleges to provide supportive educational service? Are clients provided effective vocational rehabilitation services? Are supportive employment services offered in conjunction with rehabilitation agencies?

Income Support Agencies. Are Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI) and Medicaid applications efficiently and equitably processed? Are there open channels of communication to relevant offices to facilitate the application process?

Housing. Are supportive housing services available? Is transitional housing available? Is permanent housing the goal? Are there additional opportunities to create more affordable housing units?

General Medical Services. Do clients have appropriate access to primary care? Do they have a health care home? Are outreach programs effective? Do services meet quality standards? Are there special programs for people at risk for, or struggling with, diabetes, coronary disease, hepatitis, HIV, or other chronic diseases?

State Mental Health and Addiction Agencies. Are relationships in place to take advantage of special incentive programs and training resources?

SAMHSA. Do agencies regularly access electronic resources and take advantage of opportunities for in-person consultation?

Insurance Organizations. Are communication channels available to address issues such as benefit eligibility, definition of service, and reimbursement procedures?

Safeguards Against the Misuse of Discretion

Notwithstanding the potential for positive uses of discretion, it should be understood that discretion intrinsically is neither good nor bad and can be misused. Its use must be monitored and conditions must be established to ensure its effective and ethical use. Research can be used to identify a number of conditions associated with the risk of misuse. Workers in situations with limited resources and poor work conditions may be at risk to use their discretionary power to disentitle clients and privilege their own interests (Brodkin, 1997; Smith & Donovan, 2003). High caseloads may incline workers to ration services or triage clients based on informal categories of “deserving” and “undeserving” (Lipsky, 1980). Workers may also be at risk for sharing among themselves practice ideologies that rationalize their discriminatory practices (Hasenfeld, 1987). The result may be, for example, racial or gender bias that systematically disadvantages entire categories of people (Fording, Soss, & Schram, 2007).

To safeguard against these risks, a culture of professional accountability and support needs to be cultivated within agencies. This culture is more likely to be found in an agency that employs professionally educated social workers who are personally

committed to the agency's mission and their profession's code of ethics (Evans, 2011). The culture is also more likely to flourish in adequately resourced agencies that incentivize quality services. This culture is often associated with agencies that have a relatively flat power structure, reasonable caseloads, and a culture that values the voice of direct practitioners and their clients (Shera & Paige, 1995).

Conclusions

Direct practice social workers, whether they are cognizant of their policymaking role or not, influence what actually happens to clients as they inevitably make decisions that mediate or implement top-down policies. Social workers are also policymakers insofar as they make decisions in areas where there is play in the system and policy is absent. The effective and ethical use of discretion in implementing and creating policy is a topic that deserves more attention in social work policy courses. Part of this training should help social workers to provide policy relevant input up the chain to elite policymakers. Another part would be to make social workers more aware of their discretion and mediation opportunities such that they enhance their positive impact on policy or what actually happens to clients.

References

Baker, T. B., McFall, R. M., & Shoham, V. (2009). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest, 9,* 67-103.

Bohart, A. C. (2006). The active client. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 218-226). Washington, DC: American Psychological Association.

Brodkin, E. Z. (1997). Inside the welfare contract: Discretion and accountability in state welfare administration. *Social Service Review, 71,* 1-33.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52,* 685-716.

Cohen, B. J. (2011). Design-based practice: A new perspective for social work. *Social Work, 56*(4), 337-346.

Dodson, L. (2009). *The moral underground: How ordinary Americans subvert an unfair economy*. New York, NY: The New Press.

Dolgoff, R., & Gordon, M. (1981). Education for policy making at the direct service and local levels. *Journal of Education for Social Work, 17*(2), 98-105.

Duncan, B. L., & Miller, S. D. (2006). Dialogue: Convergence and contention. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 151-153). Washington, DC: American Psychological Association.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2010). *The heart & soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Edwards, H. R., & Hoefer, R. (2010). Are social work advocacy groups using web 2.0 effectively? *Journal of Policy Practice, 9*(3), 220-239.

Evans, T. (2011). Professionals, managers and discretion: Critiquing street-level bureaucracy. *British Journal of Social Work, 41*(2), 368-386. doi: 10.1093/bjsw/bcq074

Evans, T., & Harris, J. (2004). Street-level bureaucracy, social work and the (exaggerated) death of discretion. *British Journal of Social Work, 34*(6), 871-895. doi: 10.1093/bjsw/bch106

Fording, R. C., Soss, J., & Schram, S. F. (2007). Devolution, discretion, and the effect of local political values on TANF sanctioning. *Social Service Review, 81*, 285-316.

Gerston, L. N. (2004). *Public policy making: Process and principles*. Armonk, NY: M. E. Sharpe.

Glasner-Edwards, S., & Rawson, R. (2010). Evidence-based practices in addiction treatment: Review and recommendations for public policy. *Health Policy, 97*(2-3), 93-104.

Greenberg, L. S., & Watson, J. C. (2006). Dialogue: Convergence and contention. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 112-114). Washington, DC: American Psychological Association.

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly, 82*(4), 581-629.

Hasenfeld, Y. (1987). Power in social work practice. *Social Service Review, 61*(3), 469-483.

King, C. S., Feltey, K. M., & Susel, B. O. N. (1998). The question of participation: Toward authentic public participation in public administration. *Public Administration Review, 58*(4), 317-326.

Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. New York, NY: Russell Sage Foundation.

Luborsky, L. B., & Barrett, M. S. (2006). Theoretical allegiance. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 257-267). Washington, DC: American Psychological Association.

Maynard-Moody, S., & Musheno, M.C. (2000). State agent or citizen agent: Two narratives of discretion. *Journal of Public Administration Research and Theory, 10*(2), 329-358.

Mechanic, D. (1962). Sources of power of lower participants in complex organizations. *Administrative Science Quarterly, 7*(3), 349-364.

Mills, C. W. (1959). *The sociological imagination*. New York, NY: Oxford University Press.

Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*(4), 544.

Norcross, J. C., & Lambert, M. J. (2006). The therapy relationship. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 208-218). Washington, DC: American Psychological Association.

Owen-Smith, J., & Powell, W. W. (2008). Networks and institutions. In R. Greenwood, C. Oliver, R. Suddaby, & K. Sahlin (Eds.), *The Sage handbook of organizational institutionalism* (pp. 596-623). Los Angeles: Sage.

Pressman, J. L., & Wildavsky, A. B. (1979). *Implementation* (2nd ed.). Berkeley: University of California Press.

Schorr, A. L. (1985). Professional practice as policy. *Social Service Review, 59,* 178-196.

Scott, W. R., & Davis, G. F. (2007). *Organizations and organizing: Rational, natural, and open system perspectives*. Upper Saddle River, NJ: Pearson Prentice Hall.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65*(2), 98-109.

Shera, W., & Paige, J. (1995). Creating more effective human service organizations through strategies of empowerment. *Administration in Social Work, 19*(4), 1-15.

Sherraden, M. S., Slosar, B., & Sherraden, M. (2002). Innovation in social policy: Collaborative policy advocacy. *Social Work, 47*(3), 209-221.

Smith, B. D., & Donovan, S. E. F. (2003). Child welfare practice in organizational and institutional context. *Social Service Review, 77,* 541-563.

Staller, K. M. (2006). Railroads, runaways, & researchers: Returning evidence rhetoric to its practice base. *Qualitative Inquiry, 12*(3), 503-522.

Substance Abuse and Mental Health Services Administration. (2008). *Assertive Community Treatment: Getting started with EBPs.* DHHS Pub. No. SMA-08-4344. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (2009). *Family psychoeducation: Getting started with evidence-based practices.* HHS Pub. No. SMA-09-4422. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions 2011-2014.* HHS Pub. No. SMA-11-4629. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2013). *SAMHSA's registry of evidence-based programs and practices.* Retrieved from http://www.nrepp.samhsa.gov/ViewAll.aspx

Wampold, B. E. (2006). Not a scintilla of evidence to support empirically supported treatments as more effective than other treatments. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 299-308). Washington, DC: American Psychological Association.

Watkins-Hayes, C. (2009). *The new welfare bureaucrats: Entanglements of race, class, and policy reform*. Chicago, IL: The University of Chicago Press.

Weiss-Gal, I., & Levin, L. (2010). Social workers and policy practice: An analysis of job descriptions in Israel. *Journal of Policy Practice, 9*(3-4), 183-200.

Westhues, A. (Ed.). (2003). *Canadian social policy: Issues and perspectives* (3rd Ed.). Waterloo, ON: Wilfrid Laurier University Press.

White, W. L., & Kelly, J. F. (2011). Recovery management: What if we *really* believed that addiction was a chronic disorder? In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management theory, research and practice* (pp. 67-84). Totowa, NJ: Springer Science+Business Media, LLC.

Woodford, M. R. (2010). Successful community-government collaborative policymaking: A case study of a workgroup to improve income support services to victims of intimate violence. *Journal of Policy Practice, 9*(2), 96-113.

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