

Is Solution-Focused Brief Therapy Evidence-Based?

Johnny S. Kim, Sara Smock, Terry S. Trepper, Eric E. McCollum, & Cynthia Franklin

ABSTRACT

This article describes the process of having solution-focused brief therapy (SFBT) be evaluated by various federal registries as an evidence-based practice (EBP) intervention. The authors submitted SFBT for evaluation for inclusion on three national EBP registry lists in the United States: the Substance Abuse and Mental Health Services Administration (SAMHSA), What Works Clearinghouse (WWC), and Office of Juvenile Justice and Delinquency Prevention (OJJDP). Results of our submission found SFBT was not reviewed by SAMHSA and WWC because it was not prioritized highly enough for review, but it was rated as “promising” by OJJDP. Implications for practitioners and recommendations regarding the status of SFBT as an EBP model are discussed.

Implications for Practice

- A team effort of researchers and social work practitioners is necessary to facilitate SFBT's recognition as an EBP with state and federal agencies.
- As states begin to set their own guidelines and criteria for EBP, social workers will find the need to consult EBP-registered lists before administering treatments to specific populations and disorders.

Solution-focused brief therapy (SFBT) is a strengths-based intervention that was developed in the 1980s by Steve de Shazer (1985, 1988), Insoo Kim Berg (1994), and colleagues (Berg & De Jong, 1996; Berg & Miller, 1992; Cade & O'Hanlon, 1993; Lipchik, 2002; Murphy, 1996) from the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin. Past research studies on SFBT have shown that it has promise as an effective intervention. Research on this model is still growing, with recent studies utilizing more rigorous research designs. Although SFBT has become a popular therapeutic model for social workers and practitioners from all disciplines, current policy demands are pressuring social workers to demonstrate effective services and to choose therapy interventions that have research support (Gorey, 1996; Herie & Martin, 2002). Managed health care organizations have pressed for evidence-based treatment approaches, for example, and it is unlikely the mandate for research-supported practice will disappear any time soon (Herie & Martin, 2002).

More recently state funding agencies have required that therapy interventions show evidence or be recognized and approved by federal agencies as evidenced-based interventions (e.g., the Substance Abuse and Mental Health Services Administration [SAMHSA] and the National Institute on Drug Abuse) or otherwise justify with research studies the effectiveness of the approaches being used in community-based agencies. Some states have also moved to develop their own lists of approved, evidence-based practices (EBP). While this trend is a

fairly new one and varies across states and local jurisdictions, it raises the bar for practice interventions and asks agencies and practitioners to meet certain research standards when applying community-based interventions. Currently, SFBT is widely applied in the community but often omitted from the current federal and state lists of EBP because SFBT has not been recognized by those agencies as having enough empirical support. However, research on emerging practice approaches, like SFBT, is ongoing and promising, and efficacious interventions are being identified. As is common, the practice knowledge and developments often lag behind the research knowledge and developments, hampering updates entering the field in a timely fashion. This also appears to be the case with therapy research and lists of approved evidence-based community practices.

Recently, Kim (2008) conducted a meta-analysis on SFBT and found small but positive results, especially for internalizing behavior problems like depression, anxiety, and self-concept. These results were comparable to other meta-analyses on psychotherapy and social work practices (Gorey, 1996; Weisz, McCarty, & Valeri, 2006). In another meta-analysis, Stams, Dekovic, Buist, and de Vries (2006) found small to moderate effects that SFBT was consistently better than no treatment and as good as other treatments. It also found that the best results were for personal behavior change, and that SFBT required fewer sessions than other therapies that had similar results. In yet another recent systematic review of SFBT studies evaluating outcomes with children and adolescents in schools, Kim and Franklin (2009) found that SFBT had several positive outcomes, as was demonstrated by medium and some large effect sizes calculated for the specific behavioral and academic outcomes that were being measured.

Given the recent increase in the number of outcome studies and these meta-analyses studies on SFBT, the authors wanted to know the following: How do researchers provide updates to community-based practitioners in a timely fashion, and how does a therapy model like SFBT, which is gaining in research studies, get to be considered for

inclusion on the lists of EBP? We also wondered how SFBT would be rated by federal and state agencies that provide registries that judge therapies as evidence-based, given the current research studies that incorporated more rigorous research designs. Thus, the purpose of this article is to describe the process of having SFBT evaluated by federal and state registries and considered for inclusion on the EBP lists. We believe that our experience will be helpful to other researchers and practitioners who are grappling with similar questions in social work practice and are concerned about the community-based interventions in their agencies that may not, as of yet, have been judged by registries and funding agencies as evidence-based. We begin by providing an overview of SFBT and EBP. We then discuss the impact of EBP on SFBT, as well as the process and results of having SFBT evaluated for inclusion on the EBP registry lists in the United States.

Development of SFBT

Diverging from their work at the Mental Research Institute, de Shazer and colleagues at BFTC made a conscious effort to focus on solutions instead of problems when working with clients. In further developing the solution-focused model, specific techniques such as miracle and exception questions were developed to aid in identifying solutions (see De Jong & Berg, 2008; de Shazer & Berg, 1997, for more details). SFBT falls under the social constructionism metatheory because of its philosophy and belief that language is used to construct reality for the client (Franklin, 1998). Recent experimental studies in communication theory suggest that this approach relies on strategic uses of language to change perceptions (Tomori & Bavelas, 2007). In SFBT, the therapist further uses language and Socratic questioning to coconstruct goals with the client and works collaboratively to resolve the problem by utilizing the client's strengths. The goals define what clients want to be different in their lives, and resources are identified to help meet these goals (Berg & De Jong, 1996).

Part of the intervention's appeal to social workers lies in its strengths-based focus. De Jong and Miller (1995) called attention to the fact that social work history has its roots in strengths-perspective principles, yet specific tools and techniques social workers seek when using strengths-based practice are lacking. Building on Saleebey's (1992) summary of strengths-based assumptions and principles, De Jong and Miller made a case for how SFBT can advance social work's tradition of using strengths-based principles by incorporating various solution-focused brief therapy techniques and assumptions.

SFBT has become one of the social work profession's most popular and widely used models of therapy. Because it is based on the resiliency, previous solutions, and exceptions of the client, it has been applied to most problems and populations that are of interest to social workers. These have included family therapy (McCollum & Trepper, 2001), sexual abuse (Dolan, 1991), substance abuse (Berg & Miller, 1992; de Shazer & Isebaert, 2003), and persistent mental illness (Eakes, Walsh, Markowski, Cain, & Swanson, 1997).

There have been self-help books written from a solution-focused perspective (Dolan, 1998), and solution-focused principles are now being applied to areas outside of psychotherapy, including interventions in social service agencies (Pichot & Dolan, 2003), education (Rhodes & Ajmal, 1995), and business (Caufman, 2001). Drawing on a preliminary manual developed by Trepper and McCollum (2003), the Research Committee of the Solution-Focused Brief Therapy Association (SFBTA) has developed and now made available a research treatment manual that meets the criteria for the use of manuals proposed by Carroll and Nuro

(1997). The manual describes the use of the SFBT model with individuals and describes the following aspects of the model:

- (a) overview, description and rationale of SFBT; (b) goals and goal setting in SFBT; (c) how SFBT is contrasted with other treatments; (d) specific active ingredients and therapist behaviors in SFBT; (e) nature of the client-therapist relationship in SFBT; (f) format; (g) session format and content; (h) compatibility with adjunctive therapies; (i) target population; (j) meeting needs of special populations; (k) therapist characteristics and requirements; (l) therapist training; and (m) supervision. (Trepper et al., 2008, p. 1)

This manual was designed to serve as a structure or outline for researchers who want to develop manuals for specific SFBT studies and target problems.

Why It Is Important to Evaluate SFBT as an Evidence-Based Therapy Model

It could be argued that SFBT, as an atheoretical approach, does not need to demonstrate that it is an EBP model, or that as a postmodern approach, it does not lend itself to the rigors of empirical investigation. We strongly disagree with these suggestions for a number of reasons. First, SFBT is so widely used that its effectiveness and efficacy need to be established, along with all other commonly used psychotherapy approaches, so that social workers and consumers of psychotherapy understand its benefits and limitations. Second, while SFBT was developed as a pragmatic and atheoretical approach, it does have standards of practice and possesses an underlying philosophy and framework, a set of both general and specific interventions, and ways to assess whether those interventions are working (de Shazer et al., 2007). In fact, as previously noted, a SFBT treatment manual has been developed based on these standards of practice (<http://www.ebta.nu/EBTA-multicenterresearch.pdf>). Third, SFBT needs to be evaluated and its credibility tested so that it can stand alongside other current psychotherapy approaches. If SFBT does not attempt to demonstrate its evidence basis, it will be marginalized and may not even be allowed to be practiced in settings that require the psychotherapy it offers to be demonstrated to be an EBP therapy model.

Evidence-Based Practice

In discussing EBP development, we first need to clarify terminology. The terms *empirically supported treatment* (EST) and the more recently labeled *empirically based treatment* (EBT), connote specific interventions or techniques that have been proven effective with specifically defined symptoms or syndromes (Kazdin, 2008; Thyer, 2004). For example, the use of cognitive-behavioral therapy to treat generalized anxiety disorder has been found through outcome data to be effective. The term *evidence-based practice* (EBP), often used in the discussion of the link between research and clinical practice, describes a broader process of using research findings, client needs and preferences, and therapist skills and training to plan the treatment of a specific client presenting with a specific set of problems. The criteria for EST (as described later in this section) have been established by the American Psychological Association (APA), but criteria for EBP are not clearly defined. Although conceptually influential, according to Kazdin (2008), EBP has not been the focus of study by researchers. Thus, in this article, we focus on the process of how treatment approaches are determined to be considered EBPs.

EBP is a term very familiar to social workers and widely discussed in the social work practice literature (e.g., Bilson, 2005; Gambrill, 1999; Gibbs & Gambrill, 2002; McNeece & Thyer, 2004; Sheldon, 1998). The

forementioned process definition—using research findings, client needs and preferences, and clinical skills originally transported from medical practice—has also been widely discussed within social work. Most of the articles mentioned earlier, for example, have discussed the steps of the EBP process, and some presented examples of each step in the process. Even with wide understanding of this definition from medical practice, however, Rubin and Parrish (2007) discovered in their research that there is a disagreement within social work about what actually constitutes EBP and no agreement on a singular definition. The results of the Rubin and Parrish survey led the School of Social Work, University of Texas at Austin, to host the International Conference on Teaching Evidence-Based Practice to discuss definitions of EBP and its practices, with an interest in building unified definitions and effective educational practices (Rubin, 2007). Other scholars in social work have also offered persuasive counterarguments to those who have objected to the adoption of EBPs within the social work field (Gibbs & Gambrill, 2002).

In the United States, the APA became involved in adopting EBP in the 1990s. The road to EBP in psychotherapy began when Division 12 of the APA (the Society of Clinical Psychology) formed a task force to address and identify EST. At that time, the APA defined EST as possessing the following criteria: The treatment must (a) possess a no-treatment control group, alternative treatment group, or placebo and (b) include a treatment manual, treatment for a specific population, outcome measures, and data analysis (Chambless & Hollon, 1998). This publication continued by giving three possible types of EST: (a) “Efficacious” is defined as any EST “superior in two or more independent research settings;” (b) “possibly efficacious” is used when one study shows superiority as long as conflicting evidence fails to exist; and (c) “efficacious and specific” means the treatment is “statistically significantly superior to placebo or alternative bona fide treatment in 2 or more independent studies” (Chambless & Hollon, 1998, p. 8). In addition, the APA provides an online guide to empirically supported treatments (<http://www.apa.org/divisions/div12/cppi.html>).

In due time, other divisions of the APA began publishing statements on EBP. Divisions 17 (Society of Counseling Psychology), 32 (Humanistic Psychology), and 29 (Psychotherapy) have created principles and guidelines for their specific areas (Norcross, 2002; Task Force for the Development of Guidelines for the Provision of Humanistic Psychosocial Services, 1997; Wampold, Lichtenberg, & Waehler, 2002). Despite various attempts to define and articulate practice guidelines, the APA has not disseminated treatment procedures for specific disorders (Norcross, Beutler, & Levant, 2005). The APA has published “Criteria for Evaluating Treatment Guidelines” (APA, 2002) and “Criteria for Practice Guideline Development and Evaluation” (Task Force on Psychological Intervention Guidelines, 1995). As one can tell so far, the process of defining and providing practice guidelines has become a messy business. While attempting to be the leader in EBP for psychotherapy, the APA noted that their guidelines “are not intended to be mandatory, exhaustive, or definitive” (Norcross et al., 2005, p. 5). So who makes the definitive statement on EBP for psychotherapy? Where do we turn for direction and advice on EBP?

EBP and Community-Based Practice

Other organizations have set guidelines and criteria for EBP with an attempt to influence practitioners and policymakers. One of the oldest is the Cochrane Collaboration (<http://www.cochrane.org>). This organization provides systematic reviews of health care treatments to inform providers on decision making. The Campbell Collaboration (<http://www.campbellcollaboration.org/>) provides systematic reviews

on education, crime and justice, and social welfare for the purposes of improving policies and services. In the field of education, the What Works Clearinghouse (WWC; <http://ies.ed.gov/ncee/wwc/>) reviews ESTs for the U.S. Department of Education (DOE). By having an external review team, these organizations can reduce the bias often experienced in peer reviews. The Office of Juvenile Justice and Delinquency Prevention (OJJDP; <http://www.ojjdp.ncjrs.org>) is another example of an organization that lists promising and effective treatments for youth prevention and intervention. Some organizations have external reviewers determine treatments that they consider to be evidence-based. Other federal agencies, such as SAMHSA, provide a national registry (<http://www.nrepp.samhsa.gov>) with a list of evaluated interventions and programs based on quality of research design. So, how does a social worker or a researcher wishing to help organizations keep abreast of the changing research data know what to do with all of these lists?

Our team sought the answers to several questions: Who are the “experts” in deciding what practices are evidence-based? What are the universal criteria for EBP? How does a treatment get evaluated for inclusion on the evidence-based lists? These questions sparked an interest within our research group and led to further investigation on the process of understanding and communicating with EBP registries. One of our main questions was “How does a treatment become evidence-based?” Our group soon found that this question was not easily answered. It was clear that SFBT would not magically appear on a list of evidence-based treatments without some work. It is also true that a lot of work has to go into the development of an approach before it can even get to a point of being considered for the EBP list, but once it has advanced to the place SFBT has with wide use, popularity, and research advancement, it would seem that an approach would be ready for consideration.

Next is a description of the three national registries to which we submitted SFBT for evaluation as an evidence-based intervention. These national registries were selected because we were able to meet the submission criteria for evaluation, which are available on the registry websites. We discuss the methods required by these agencies and the results of our submissions in the next section.

Methods for Submission to National EBP Registries

SAMHSA

SAMHSA provides a national database of evidence-based programs focusing on interventions aimed at preventing and treating mental disorders and substance use. Developed in 1997, SAMHSA’s National Registry of Evidence-Based Programs and Policies (NREPP) is a Web-based searchable registry that provides intervention details and ratings based on the evaluations of independent reviewers. The aim of NREPP is to provide local organizations and practitioners with interventions and programs that have been empirically tested and are ready for dissemination. There is no restriction in terms of who can submit a program or intervention to NREPP for review, and the program or intervention is then evaluated by independent, expert reviewers who are recruited, selected, and trained by SAMHSA.

Instead of rating each intervention or program overall, NREPP provides ratings for the individual outcomes targeted by the intervention based on the quality of the research design, as well as its availability of implementation and training material. Ratings for the two criteria (quality of research and readiness for dissemination) are based on a 4-point scale with an overall rating for each outcome targeted and a summary of the strengths and weaknesses. In addition to the ratings, NREPP pro-

vides a summary of intervention information such as targeted population, costs, developer contact, and an abstract. Programs are accepted during submission periods throughout the year and announced on the website (<http://www.nrepp.samhsa.gov>). In order to meet the minimum requirement for submission, the intervention must have one or more statistically significant ($p \leq .05$) result in mental health or substance use among individuals, communities, and populations. The results must be published in a peer-reviewed journal or documented in a comprehensive evaluation report and have training manuals or materials available for public dissemination. Finally, interventions receiving 2 priority points (1 point for targeted outcome that is a SAMHSA high-priority area and 1 point for experimental or quasi-experimental study design) will be given higher priority for review. NREPP's rating system is designed to provide summary information and ratings for the quality of the research supporting an intervention and availability for implementation. It is not intended to be used to rate the level of intervention effectiveness or as an endorsement of specific interventions.

The authors of this article submitted two studies (Froeschle, Smith, & Ricard, 2007; Smock et al., 2008) for review of SFBT for substance abuse. The first submission was a randomized experimental design study by Froeschle et al., using SFBT group sessions, mentorship, and action learning techniques to reduce substance use and negative behaviors, while increasing drug use symptom knowledge and positive behaviors among middle school girls. Results from Froeschle et al. showed statistically significant differences between groups on drug use, attitudes toward drugs, knowledge of physical symptoms of drug use, and competent behavior scores favoring the SFBT group. No group differences were found on self-esteem, negative behaviors, and grade point averages. The second submission was a study by Smock et al. that used a randomized experimental design to examine the effectiveness of the SFBT group for level 1 substance abusers on depression and interpersonal functioning. Although no group differences were found at posttest on both outcomes, within-group differences showed the SFBT group to have statistically significant differences on both outcomes between pre- and posttest data. The within-group differences showed no statistically significant differences on either outcome.

Department of Education

DOE is a federal organization that, along with the American Institutes for Research and the Campbell Collaboration, provides a national registry that evaluates the strength of evidence of educational interventions and programs. This registry, called the What Works Clearinghouse (WWC), was created in 2002 to:

promote informed education decision making through a set of easily accessible databases and user-friendly reports that provide education consumers with high-quality reviews of the effectiveness of replicable educational interventions (programs, products, practices, and policies) that intend to improve student outcomes. (Department of Education What Works Clearinghouse, n.d.)

In order to accomplish this mission, the WWC registry evaluates the strength of the research evidence regarding the effectiveness of educational interventions. The WWC examines submitted interventions and programs and categorizes them into three evidence standards: meets evidence standards, meets evidence standards with reservations, and does not meet evidence screens.

The ranking of *meets evidence standards* is given to intervention studies that use randomized controlled trials that do not have problems with randomization, attrition, or disruptions. This ranking provides

the most persuasive evidence of an intervention's effectiveness. Studies of *meets evidence standards with reservations* include strong quasi-experimental studies without any severe design or implementation problems or randomized clinical trials with randomization, attrition, or disruption problems. These studies can be viewed as offering weaker evidence for an intervention's effectiveness. The final ranking of *does not meet evidence screens* is given to intervention studies that provide insufficient evidence or studies that are not relevant to topic reviews (see WWC website: <http://ies.ed.gov/ncee/wwc/references/iDocViewer/Doc.aspx?docId=2&toCId=1>)

In January 2007, the authors of this article submitted SFBT for review through the WWC website as a "Character Education" intervention. This topic area focuses on interventions aimed at promoting positive student behaviors and improving academic performance. The WWC accepts both published and unpublished reports for a particular intervention submitted for review. We submitted three published studies on SFBT for review: Newsome (2005); Franklin, Moore, and Hopson (2008); and Springer, Lynch, and Rubin (2000). The study by Newsome looked at the impact of SFBT with 26 at-risk middle-school students on behavioral and social outcomes using a one-group repeated measures design. Students participated in an 8-week SFBT group and reported higher homework completion skills and improved behavioral and social skills. The study by Franklin et al. examined the effectiveness of SFBT on externalizing behavior problems with 59 middle-school students using a quasi-experimental design. Results showed externalizing scores declined from the clinical level by posttest and remained there at follow-up, indicating improvement for the SFBT group. The comparison group scores changed little at posttest and at follow-up. The study by Springer et al. also used a SFBT group to improve self-esteem for 10 elementary-age Hispanic students with incarcerated parents. Results from this quasi-experimental design study showed no group difference at posttest but did find the SFBT group improved from pretest to posttest, whereas the comparison group scores were unchanged, and the study also reported a medium effect size ($d = .57$) for the SFBT group score change.

OJJDP

The OJJDP is a federal organization that provides services to address the needs of juveniles and their families. As part of its services, the OJJDP offers a registry of programs tailored for areas such as delinquency prevention and mental health initiatives. Studies conducted on programs are submitted to the OJJDP and evaluated. Anyone can submit programs to the OJJDP; submitters are not limited to the researchers or developers of the program. The OJJDP looks for four main areas displaying a program's effectiveness: "the conceptual framework of the program, the program fidelity, the evaluation design, and the empirical evidence demonstrating the prevention or reduction of problem behavior, the reduction of risk factors related to problem behavior, or the enhancement of protective factors related to problem behavior" (Office of Juvenile Justice and Delinquency Prevention, 2010). The OJJDP self-examines submitted programs and ranks them in one of the following three categories: promising, effective, or exemplary. Programs that do not meet the minimum requirements are not listed on the OJJDP website.

The ranking of *promising* is given to programs that possess a single pretest-posttest design. Promising is described as "in general, when implemented with minimal fidelity these programs demonstrate promising (perhaps inconsistent) empirical findings using a reasonable conceptual framework and a limited evaluation design (single group pretest-posttest) that requires causal confirmation using more appropriate experimental techniques" (Office of Juvenile Justice and Delinquency

Prevention, 2010). A rating of *effective* is given to programs that use a quasi-experimental design. Effective is described as “in general, when implemented with sufficient fidelity these programs demonstrate adequate empirical findings using a sound conceptual framework and an evaluation design of the high quality (quasi-experimental)” (Office of Juvenile Justice and Delinquency Prevention, 2010). The highest ranking, *exemplary*, is given to programs that have been tested using an experimental design. Exemplary is listed as “in general, when implemented with a high degree of fidelity these programs demonstrate robust empirical findings using a reputable conceptual framework and an evaluation design of the highest quality (experimental)” (Office of Juvenile Justice and Delinquency Prevention, 2010).

Our journey began by submitting the Newsome (2004) study using SFBT with at-risk middle-school students to the OJJDP. Newsome used a quasi-experimental design to see if SFBT aided in raising grades and attendance in at-risk youth. The experimental group consisted of 26 students who received SFBT one class period for 8 weeks, and the control group consisted of 26 students who did not receive any intervention. There was a small but statistically significant difference in grades between the groups but no differences in attendance.

Results

SAMHSA

Our submission to SAMHSA's NREPP occurred in February 2007 and entailed a cover letter, an SFBT treatment manual, and the two studies described in the previous section. During the submission review process, the NREPP program review manager contacted us seeking clarification on the two submitted studies. Of concern was whether either of the articles used substance abuse outcome measures and whether the combination of using mentorship and action learning along with SFBT in the Froeschle et al. (2007) article qualified it to be considered SFBT. Our response to NREPP stated that neither study submitted used substance abuse as an outcome measure. The Smock et al. (2008) article used the Substance Abuse Subtle Screening Inventory (SASSI) for screening but not as an outcome measure. Our reply also stated that the SFBTA believes that SFBT can be used in addition to or as a component of a comprehensive treatment program, like the one described in the Froeschle et al. study, and still be considered solution-focused. One month after our follow-up responses, NREPP replied back by e-mail with a decision that it was unable to review our submission for this fiscal year. This decision not to review our submission does not mean SFBT “lacks merit,” but rather that our submission was not prioritized highly enough for review in this fiscal year. Our submission did receive 1 priority point for study design but did not receive another point for priority area related to outcomes.

Department of Education

In February 2008, we followed up with the WWC registry to check the status of our SFBT submission. We received an e-mail response indicating that our submission had not been reviewed, and WWC was unable to provide any timeline of when it might be reviewed. Currently, the DOE does not consider the Character Education topic area as an active review topic and hence is not reviewing any of those submissions. According to the WWC website, current active topic areas include: Beginning Reading, Early Childhood Education, Early Language Learners, Middle School Math, Elementary School Math, and Student with Disability. The following topics do not have reports in progress: Dropout Prevention and Character Education (Department of Education

What Works Clearinghouse, n.d.). As a result, our submission is still on hold and may be reviewed in the future.

OJJDP

Our submission to OJJDP's national registry occurred in February 2007. We submitted a cover letter along with the Newsome (2004) study and four unpublished dissertations. (After we contacted the OJJDP, it recommended submitting the four dissertations even though they preferred published work.) Along with the article and dissertations, we submitted the SFBT treatment manual (treatment manuals are required for submission) found on the SFBTA website (<http://www.sfbta.org>). By February 2008 we received news that our submission received a *promising* rating and would be added to the OJJDP website (http://www2.dsgonline.com/mpg/mpg_program_detail.aspx?ID=712&title=Solution-Focused%20Brief%20Therapy). To date, the OJJDP is the first federal registry that lists SFBT as a *promising* evidence-based treatment. Although the rating was given in February 2008, the OJJDP officer stated that we can resubmit additional studies as they become available to strengthen our rating.

Discussion

As has been shown, the answer to this article's title question—Is SFBT evidence-based?—is complex. However, we believe that SFBT has a solid beginning evidence base and is an emerging EBP model for a number of reasons. First, SFBT has a basis of empirical support. The research so far has shown that SFBT has at least a small to moderate effect, is better than no treatment, and is as good as other treatments, but often in a shorter amount of time (Corcoran & Pillai, 2007; Gingerich & Eisengart, 2000; Kim, 2008; Stams et al., 2006). Second, while the number of empirical studies on the effectiveness of SFBT is small, there has been an increase in such work in the last few years, and the most recent studies with better methodologies have shown the strongest support (Stams et al.). Third, based on these early empirical findings, SFBT has had its first external agency registering it as an EBP through the OJJDP model programs guide.

There are two key points that must be highlighted for social work practitioners regarding the use of these national registries to determine EBP models. First, most registries are only evaluating the quality of the research studies of submitted programs or interventions. The methods of analysis and results of the studies are examined to determine if there is statistical support to conclude that an intervention is effective or not. The most common research method is to compare a treatment group to a control group that did not receive the treatment and then examine the results on an outcome measure to see if any statistically significant differences are present at the end of the treatment (Kazdin, 2008). So it is important for social work practitioners to remember that these registries are looking at the quality of the research study design as well as the results, which both form the basis for the ratings given to a particular program or intervention.

This leads us to the second point, which is that most registries do not endorse the interventions or programs that are submitted. A good understanding of research tells us that nothing is completely certain when it comes to answering a research question, and this applies to EBP as well (Soydan, 2008). Because these registries are evaluating the research design used to determine whether an intervention is effective, they too are constrained by the limitations of research and therefore cannot know with absolute certainty whether it works or not. However, this does not mean that using EST or EBP registries is a futile effort. In fact, it is quite the contrary as advances in systematic reviews and

meta-analyses further confirm the claim that interventions based on scientific knowledge lead to better outcomes than authority- or commonsense-based practices (Mullen, Bledsoe, & Bellamy, 2008). The two points highlight that caution is warranted when generalizing results from studies on registries to clinical practice, and one should keep in mind that interventions like SFBT that are viewed as promising may prove more or even less effective than initially thought as the empirical evidence continues to grow with more rigorous research designs.

As more national registries make an effort to provide social workers with guidelines and ratings of empirically supported and evidence-based interventions, more needs to be done at the local level. It is important for state or local agencies to get involved in this discussion and establish guidelines. Since our initial contact with the state psychological associations in early 2007, several states have formed task forces to develop criteria for evaluating evidence-based services. For instance, Hawaii's Child and Adolescent Mental Health Division has begun grading programs to see if they qualify as evidence-based services. Its *2007 Biennial Report* lists five levels of evidence ranging from "best support" to "no support" (Hawaii Department of Health, Child and Adolescent Mental Health Division, 2007, p. 5). In addition, other states have made progress toward the evidence-based movement. Michigan's mental health EBP initiative encourages physicians to adopt EBP for specific mental health ailments such as depression and schizophrenia. Not only does Michigan support EBP, but it is also involved in establishing research programs to test promising treatments (Flinn Foundation, n.d.). Currently, one of the most progressive states in the EBP movement is Oregon with its Department of Human Services. This state uses independent reviewers to score interventions, including the use of fidelity measures. Oregon officials stated that by their 2009–2011 budget cycle, they will spend 75% of public dollars only on evidence-based services (Oregon Youth Authority, 2010). These are just a few states paving the way to an evidence-based services trend.

As states begin to set their own guidelines and criteria for EBP, social workers will find the need to consult EBP lists before administering treatments to specific populations and for specific disorders. While federal agencies provide independent ratings of interventions and services, the role of the states seems to be to enforce the use of EBP at the local level. States may look to federal registries for guidelines, or may develop their own criteria for ranking programs, but will probably be the ultimate enforcers of EBP for social work practitioners.

Conclusion

As EBP continues to be discussed and advocated, concerns still remain regarding practitioners' use of empirical evidence in their practice (Proctor & Rosen, 2008) and the applicability of research findings to clinical practice (Kazdin, 2008). One of the strengths of SFBT research is that most studies are conducted under real-world conditions and settings. Given the model transfer problems common in interventions tested in optimal efficacy trials (Hawley & Weisz, 2002; Weisz, Chu, & Polo, 2004), the current status of SFBT research should be viewed as promising. In order to continue the work of getting SFBT recognized by the various national registries, more rigorous research is needed within the priority areas.

With the SAMHSA registry, studies using substance abuse as an outcome measure are needed because currently there are no SFBT efficacy studies using this outcome. For DOE's WWC registry, it is clear that the priorities are aimed at improving academic performance with dropout prevention programs and character education interventions not being reviewed. Studies in schools need to continue to examine

academic measures along with behavioral and mental outcomes while improving research designs and exploring new applications of SFBT in school-based settings. SFBT has a good start on school-based studies and could continue to build on its promising outcomes in that area (Kim & Franklin, 2009). Despite SFBT's rating of promising by the OJJDP registry, more rigorous studies are needed to further strengthen the evidence for youth problems. SFBT can be resubmitted to the OJJDP registry in the future as more research studies are done that utilize more high-quality evaluation designs and with outcomes that support the model.

So what does all of this mean for solution-focused practitioners? By going through the process of submitting SFBT to these national registries and obtaining a rating of promising by OJJDP, social workers using SFBT in their clinical work can emphasize their use of an intervention that has some promising empirical support. Also, more rigorous research is needed to further strengthen the evidence for SFBT, but research alone will not facilitate SFBT's recognition as an EBP. As this article illustrates, it will also take the work of interested researchers and social work practitioners who will submit that research to state and federal agencies for evaluation and inclusion on EBP lists. That requires a team effort, and from our experience, it will also take that same type of effort for other social work practices to be recognized as EBP.

References

- American Psychological Association. (2002). Criteria for evaluating treatment guidelines. *American Psychologist*, 57, 1052–1059.
- Berg, I. K. (1994). *Family-based services: A solution-focused approach*. New York: W.W. Norton.
- Berg, I. K., & De Jong, P. (1996). Solution-building conversation: Co-constructing a sense of competence with clients. *Families in Society: The Journal of Contemporary Human Services*, 77, 376–391.
- Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution-focused approach*. New York: W.W. Norton.
- Bilson, A. (Ed.). (2005). *Evidence-based practice in social work*. London: Whiting & Birch.
- Cade, B., & O'Hanlon, W. H. (1993). *A brief guide to brief therapy*. New York: W.W. Norton.
- Carroll, K. M., & Nuro, K. F. (1997). The use and development of treatment manuals. In K. M. Carroll (Ed.), *Improving compliance with alcoholism treatment* (pp. 53–72). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.
- Caufman, L. (2001). Challenging the family business: The relational dimension. *Scandinavian Journal of Organizational Psychology*, 2, 1–12.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7–18.
- Corcoran, J., & Pillai, V. (2007). A review of the research on solution-focused therapy. *British Journal of Social Work*, 10, 1–9.
- De Jong, P., & Berg, I. K. (2008). *Interviewing for solutions* (3rd ed.). Belmont, CA: Thomson Brooks/Cole.
- De Jong, P., & Miller, S. D. (1995). How to interview for client strengths. *Social Work*, 40, 729–736.
- Department of Education What Works Clearinghouse. (n.d.). *List of all current topic areas*. Retrieved April 19, 2010 from <http://ies.ed.gov/ncee/wwc/reports>
- de Shazer, S. (1985). *Keys to solution in brief therapy*. New York: W.W. Norton.
- de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: W.W. Norton.
- de Shazer, S., & Berg, I. K. (1997). What works? Remarks on research aspects of solution-focused brief therapy. *Journal of Family Therapy*, 19, 121–124.
- de Shazer, S., Dolan, Y. M., Korman, H., Trepper, T. S., McCollum, E. E., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. New York: Haworth Press.
- de Shazer, S., & Isebaert, L. (2003). The Bruges model: A solution-focused approach to problem drinking. *Journal of Family Psychotherapy*, 14, 43–52.
- Dolan, Y. (1991). *Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for survivors*. New York: Norton Professional Books.
- Dolan, Y. (1998). *One small step: Moving beyond trauma and therapy to a life of joy*. Wastonsville, CA: Papier-Machier Press.
- Eakes, G., Walsh, S., Markowski, M., Cain, H., & Swanson, M. (1997). Family-centered brief solution-focused therapy with chronic schizophrenia: A pilot study. *Journal of Family Therapy*, 19, 145–158.

- Flinn Foundation (n.d.). *Michigan mental health evidence-based practice initiative* [Fact sheet]. Retrieved April 30, 2010, from <http://www.flinnfoundation.org/pdf/MiMHEBPI%20Fact%20Sheet.pdf>
- Franklin, C. (1998). Distinction between social constructionism and cognitive constructivism: Practice applications. In C. Franklin & P. Nurius (Eds.), *Constructivism in practice: Methods and challenges* (pp. 57–94). Milwaukee, WI: Families International.
- Franklin, C., Moore, K., & Hopson, L. (2008). Effectiveness of solution-focused brief therapy in a school setting. *Children & Schools*, 30, 15–26.
- Froeschle, J. G., Smith, R. L., & Ricard, R. (2007). The efficacy of a systematic substance abuse program for adolescent females. *Professional School Counseling*, 10, 498–505.
- Gambrill, E. (1999). Evidence-based practice: An alternative to authority-based practice. *Families in Society: The Journal of Contemporary Human Services*, 80, 341.
- Gibbs, L., & Gambrill, E. (2002). Evidence-based practice: Counterarguments to objections. *Research on Social Work Practice*, 12, 452–476.
- Gingerich, W. J., & Eisengart, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process*, 39, 477–498.
- Gorey, K. M. (1996). Effectiveness of social work intervention research: Internal versus external evaluations. *Social Work*, 7, 63–80.
- Hawaii Department of Health, Child and Adolescent Mental Health Division. (2007). *2007 Biennial Report*. Retrieved April 12, 2010, from <http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs012.pdf>
- Hawley, K. M., & Weisz, J. R. (2002). Increasing the relevance of evidence-based treatment review to practitioners and consumers. *Clinical Psychology: Science and Practice*, 9, 225–230.
- Herie, M., & Martin, G. W. (2002). Knowledge diffusion in social work: A new approach to bridging the gap. *Social Work*, 47, 85–95.
- Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist*, 63, 146–159.
- Kim, J. S., & Franklin, C. (2009). Solution-focused brief therapy in schools: A review of the outcome literature. *Children and Youth Services Review*, 31, 464–470.
- Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice*, 18, 107–116.
- Lipchik, E. (2002). *Beyond technique in solution focused therapy*. New York: Guilford Press.
- McCollum, E. E., & Trepper, T. S. (2001). *Creating family solutions for substance abuse*. New York: Haworth Press.
- McNeece, C. A., & Thyer, B. A. (2004). Evidence-based practice and social work. *Journal of Evidence-Based Social Work*, 1, 7–25.
- Mullen, E. J., Bledsoe, S. E., & Bellamy, J. L. (2008). Implementing evidence-based social work practice. *Research on Social Work Practice*, 18, 325–338.
- Murphy, J. J. (1996). *Solution-focused brief therapy in the school*. In S. D. Miller, M. A. Hubble, & B. S. Duncan (Eds.), *Handbook of solution-focused brief therapy* (pp. 184–204). San Francisco: Jossey-Bass.
- Newsome, S. (2004). Solution-focused brief therapy (SFBT) groupwork with at-risk junior high school students: Enhancing the bottom-line. *Research on Social Work Practice*, 14, 336–343.
- Newsome, W. S. (2005). The impact of solution-focused brief therapy with at-risk junior high school students. *Children & Schools*, 27, 83–90.
- Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs*. New York: Oxford University Press.
- Norcross, J. C., Beutler, L. E., & Levant, R. F. (2005). *Evidence-based practice in mental health*. Washington, DC: American Psychological Association.
- Office of Juvenile Justice and Delinquency Prevention. (2010). *OJJDP model programs guide: Ratings*. Retrieved April 19, 2010, from <http://www2.dsgonline.com/mpg/ratings.aspx>
- Oregon Youth Authority. (2010). Reports and publications. Retrieved April 29, 2010, from http://www.oregon.gov/OYA/rpts_pubs
- Pichot, T., & Dolan, Y. (2003). *Solution-focused brief therapy: Its effective use in agency settings*. New York: Haworth Press.
- Proctor, E. K., & Rosen, A. (2008). From knowledge production to implementation: Research challenges and imperatives. *Research on Social Work Practice*, 18, 285–291.
- Rhodes, J., & Ajmal, Y. (1995). *Solution focused thinking in schools*. London: BT Press.
- Rubin, A. (2007). Improving the teaching of evidence-based practice: Introduction to the special issue. *Research on Social Work Practice*, 17, 541–547.
- Rubin, A., & Parrish, D. (2007). Challenges to the future of evidence-based practice in social work education. *Journal of Social Work Education*, 43, 405–428.
- Saleebey, D. (1992). *The strengths perspective in social work practice*. New York: Longman.
- Sheldon, B. (1998). Social work practice in the 21st century. *Research on Social Work Practice*, 8, 577–588.
- Soydan, H. (2008). Applying randomized controlled trials and systematic reviews in social work research. *Research on Social Work Practice*, 18, 311–318.
- Smock, S. A., Trepper, T. S., Wetchler, J. L., Ray, R., Pierce, K., & McCollum, E. E. (2008). Solution-focused group therapy for level 1 substance abusers. *Journal of Marital and Family Therapy*, 34, 107–120.
- Springer, D. W., Lynch, C., & Rubin, A. (2000). Effects of a solution-focused mutual aid group for Hispanic children of incarcerated parents. *Child and Adolescent Social Work Journal*, 17, 431–432.
- Stams, G. J., Dekovic, M., Buist, K., & de Vries, L. (2006). Effectiviteit van oplossingsgerichte korte therapie: Een meta-analyse [Efficacy of solution-focused brief therapy: A meta-analysis]. *Gedragstherapie [Behavior Therapy]*, 39, 81–94.
- Task Force for the Development of Guidelines for the Provision of Humanistic Psychosocial Services. (1997). Guidelines for the provision of humanistic psychosocial services. *Humanistic Psychologist*, 25, 65–107.
- Task Force on Psychological Intervention Guidelines. (1995). *Template for developing guidelines: Interventions for mental disorder and psychosocial aspects of physical disorders*. Washington, DC: American Psychological Association.
- Thyer, B. A. (2004). What is evidence-based practice? *Brief Treatment and Crisis Intervention*, 4, 167–176.
- Tomori, C., & Bavelas, J. B. (2007). Using microanalysis of communication to compare solution-focused and client-centered therapies. *Journal of Family Psychotherapy*, 18, 25–43.
- Trepper, T. S., & McCollum, E. E. (2003). *Solution-focused group therapy for substance abuse: Preliminary treatment manual*. Unpublished manuscript.
- Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W., & Franklin, C. (2008). *Solution focused therapy treatment manual for working with individuals*. Solution Focused Brief Therapy Association Research Committee. Retrieved May 20, 2008, from <http://www.sfbta.org/Research.pdf>
- Wampold, B. E., Lichtenberg, J. W., & Waehler, C. A. (2002). Principles of empirically supported interventions in counseling psychology. *Counseling Psychologist*, 30, 197–217.
- Weisz, J. R., Chu, B. C., & Polo, A. J. (2004). Treatment dissemination and evidence-based practice: Strengthening intervention through clinician-researcher collaboration. *Clinical Psychology: Science and Practice*, 11, 300–307.
- Weisz, J. R., McCarty, C. A., & Valeri, S. M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin*, 132, 132–149.

Johnny S. Kim, PhD, LICSW, is assistant professor, School of Social Welfare at the University of Kansas. **Sara Smock**, PhD, is assistant professor, Applied and Professional Studies, Texas Tech University. **Terry S. Trepper**, PhD, is professor, Psychology Department, Purdue University at Calumet. **Eric E. McCollum**, PhD, is professor, Marriage and Family Therapy Program, Virginia Tech at Northern Virginia Center. **Cynthia Franklin**, PhD, LCSW, is Stiernberg/Spencer Family Professor in Mental Health, School of Social Work, University of Texas at Austin. Correspondence regarding this article can be sent to the first author at jkim@ku.edu or School of Social Welfare, University of Kansas, 1545 Lilac Lane, Lawrence, KS 66044.

Manuscript received: October 28, 2008

Revised: February 2, 2009

Accepted: February 3, 2009