My Personal Journey of Generating Evidence in Social Work Practice for Social Change

Cecilia Lai Wan Chan

Abstract
This is a reflection of my personal journal of my engagement in research on social worker practice to being out change in society. Through my 40 years of social work practice, I have used touching stories, case studies, pre–post intervention outcome studies, randomized control trials, and eventually moving into using biomarkers as outcome measures on the efficacy of social work intervention.

Keywords
evidence-based practice, methodological article, practitioner-researcher, integrative body–mind–spirit intervention, advocacy for change

Coeditor’s Introduction
When I learned of the recent retirement of Professor Cecilia Chan from the University of Hong Kong, I approached her about preparing a retrospective summary of her development and contributions as a practitioner-scientist within the profession of social work. To my delight, she agreed and prepared the article that follows. I did this so that other developing scholars could learn from her own history and thus promote the types of intervention research and other forms of scholarly inquiry that form the foundation of evidence-based practice. This is also a way of recognizing and highlighting her wonderful contributions to our discipline over the past few decades. Her life and career epitomize melding the activity of being an experienced practitioner with the scientific rigor and training required of conducting evaluation studies in the human services. Another lesson to be learned is that the types of body–mind–spirit practices which she has favored lend themselves very well to the controlled quantitative investigations needed to determine whether they produce effects above and beyond placebo value. Thus, over time, we will learn which of these nonconventional practices are genuinely effective and which are not. This results in disciplinary progress.

It turns out that Hong Kong, and mainland China in general, has become highly productive incubators of professional education, practice, and research in the field of social work. The quantity and quality of professional publications being authored by Chinese social workers is growing exponentially. There are now several hundred professional BSW and MSW programs to be found in China and a growing number of PhD and DSW programs as well. There is a national credentialing program for social workers in mainland China, with a separate long-standing registration program for social workers in Hong Kong. With leaders such as Dr. Cecilia Chan providing such a positive example, we can see continuing constructive developments for global social work coming from China.

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My Journey From Community Advocacy to Randomized Control Trials (RCTs)

As one of the first social workers who ventured into providing physiological outcome markers for nonpharmaceutical interventions in the world, I think it is most important for us to appreciate why it is relevant for social workers to be generating convincing evidence on the impact of our professional practice. Committed to changing society into a better place for all, I see social workers being social engineers, community doctors, and creative entrepreneurs who can create solutions to remedy social problems, relieve people from their suffering, empower service users into taking charge of their own lives, and be innovative in designing social infrastructures to create a more just and equitable world.

Health is not just a matter of lifestyle choice. The health status and longevity of a person is largely determined by their socioeconomic status through their life span and in the context of the societal infrastructures of shelter, hygiene, education, community self-efficacy, and economic security of their country. The well-being of individuals can be severely impacted by environmental circumstances such as inequity, drugs, violence, loneliness, pollution, and toxins. In fact, most of the problems in society today are caused by structural poverty, racism, injustice, discrimination, and exploitation which Berwick (2020) described as “moral determinants” of health.

The COVID-19 global pandemic is a clear sign of how the poor and least resourceful groups are being hit hardest. Social workers need to be working with individuals, families, work units, neighborhoods, communities, corporations, law makers, government officials, and politicians to ensure that the socioeconomic–political infrastructures are established to build a solid social protection floor (International Labour Organization, 2018). Government should provide access to essential health care, education, food, income protection, and social security for citizens, especially persons with disability and older adults.

This article will share my trial-and-error journey in trying to use research to advocate for and produce societal change in the past 4 decades. The research covers the spectrum qualitative single-case interviews, group sharing, questionnaire surveys using self-constructed questions, then, surveys using standardized questionnaires, then pre–post intervention subjective reporting studies, then, with a comparison group, and RCTs, plus using biomarkers as outcome studies and then, ultimately, cost-effectiveness studies of holistic interventions.

Research and Advocacy as a Social Work Student

There were a number of deaths of homeless people in a very cold winter in Hong Kong in 1976. Social service provision to the poor and disadvantaged populations were minimal in the 1970s. Together with 200 other fellow university students, we counted the number of homeless people taking shelter on the streets during Chinese New Year Eve, collected their personal stories and background data through a simple questionnaire from these homeless people on the second and third day of Chinese New Year. Most of them were singleton migrant laborers who lost their residence previously provided by employers after losing their job in old age. These people are truly homeless because Chinese New Year is a time with families. The report was presented to the government, and new policy measures of access to health care, social security and public housing for singleton older adults were introduced soon after our advocacy meeting with the UK expert who happened to be in Hong Kong to advise the government on the social security system in 1977. University students were social change agents in the colonial period of Hong Kong. We were also involved in advocacy of housing issues for people living in small boats (boat squatters) and slums in apartment building (caged bed spaces). Change is possible.

Generating Stories for Community Development

Community Surveys

I worked as a community social worker in an urban slum and a low-income community for 7 years (1978–1985). We developed a community and resources profile through visits to households and relationship building with residents and local officials. Youth delinquency, truancy, violence, crime, incest, and gang bullying were common events. Theories of the cycle of poverty in sociology were actually real as there were low aspirations with a strong sense of helplessness among the population. Through mobilizing mutual help and collective problem-solving, a local residents’ association and a youth volunteer group were formed to improve access roads, fire prevention, and community spirit. In collaboration with other community workers and resident leaders in other urban slums, we formed the Alliance of Squatters in 1981. We collected evidence on the needs of the squatters and low-income populations to advocate for infrastructural improvement and access to clean water and electricity as a basic human right. For example, we found the E. coli count in well water in various slum areas was 100 times above acceptable WHO hygiene standards. With the wide publicity of the laboratory results and advocacy, the government provided piped water for the population living in squatter huts throughout Hong Kong. We also conducted community surveys and collected stories of how individuals and families changed as they participated in neighborhood mutual help. Models on intervention were established and shared as textbook in community development in Hong Kong.

Community Advocacy

Besides advocating for rights for the squatter population in the Mount Davis area, our team also organized community concern groups on public transport, community green space, effective refuse collection, and urban renewal in the bigger community of Kennedy Town. Youth leaders advocated for the extension
of the massive transit railway to Hong Kong Island West and mobilized neighborhood surveys and petitions on the insufficient public transportation support for this low-income community. The District Boards started to have local elections of board members who could speak on behalf of the residents in 1982. With their experience of community organization, these youth leaders participate in local election, and their voices were being heard. I joined the University of Hong Kong as a social work fieldwork supervisor in 1985. I continued to mobilize my students in community action-research and advocacy (Henderson & Thomas, 2013). Environmental pollution for low-income communities was severe, and community development teams organized community advocacy on pollution control, environmental planning standards, and urban design (C. L. W. Chan & Hills, 1997). My doctoral thesis was on community management in Guangzhou in south China during the rapid economic reform (C. L. W. Chan, 1993).

### From Geographic to Functional Communities

#### Hard-to-Reach Underprivileged Groups

With locally elected District Council members taking care of needs in geographical communities, I shifted my attention to serve functional communities of underprivileged groups who were dispersed and hidden, while suffering in silence and in pain. I mobilized my social work students and colleagues to set up new service platforms for persons with chronic illness and single parent families living in poverty in the 1990s. In order to convince policy makers of the importance of psychosocial care for patients, we try to collect evidence on how quality of life of patients was transformed as a result of social workers’ intervention. Stories and surveys on quality of life of chronic patients, bereaved wives, women of divorce were conducted to share the hardship and needs of these populations who fall outside of existing service provision (S. M. Y. Ho et al., 2004).

#### From Victim to Survivor

While chronic patients and mothers on welfare shared their personal stories and their pain, they were retraumatized by exposing their hidden wounds in public. I felt guilty and committed to find ways to heal their sorrow so that would be proud to have become a survivor instead of staying a victim (C. L. W. Chan et al., 1999). When they advocated again, they could share how they have grown out of their suffering. I designed intervention by learning from survivors of cancer, stroke, divorce, domestic violence, and bereavement. Through in-depth interviews of survivors, we learnt how they overcome their trauma and be able to help others unconditionally. By synthesizing the wisdom from these survivors who were transformed by their experiences of loss, I developed an holistic empowerment intervention for these underprivileged populations, so that they could learn coping strategies and techniques in transcending their suffering into becoming a self-compassionate person who could love, forgive, and be kind to oneself and others (Hung et al., 2003).

### Impact Assessment of New Service Models

In the early 1990s, the government put forth a Green Paper on Rehabilitation to inform the public on holistic service provision for persons with disabilities. Persons living with a chronic illness were not on the list with no service provision. I worked with the Hong Kong Society for Rehabilitation, the Hong Kong Medical Association, and the Alliance of Patients’ Organizations to persuade policy maker in creating a new service structure of Community Rehabilitation Network (CRN) in two regions of Hong Kong in serving patients living with chronic diseases (Wong & Chan, 1994). Our team conducted studies to provide evidence that patients, after receiving community support services of CRN, utilized less hospital bed days, took less sick leave from work, enhanced communication and trust of medical professionals, reported higher confidence in self-care and improvement in quality of life (C. L. W. Chan et al., 1996). With the research evidence on the impact of CRN, the government provided regular funding support to the organization and expanded services to six centers in different parts of Hong Kong 3 years later.

All 41 public hospitals were moved from the previous Medical and Health Department to a new structure of the hospital authority in 1992. I worked closely with the hospital chief executives of two major hospitals, Queen Mary Hospital and Queen Elizabeth Hospital, in setting up pilot projects of patients resource centers in 1995. Social workers were hired to organize patients in self-help activities, coordinate doctors and nurses in offering health and self-care education to patients, and to train volunteers in providing support services to patients. There were impressive stories of personal change and growth through self-help programs. Witnessing very positive impact of these two patients resource centers, the hospital authority establish similar service units in all of its hospitals in the subsequent 10 years.

Through CRN and alliance of mutual help organizations, around 50 patients’ groups were formed. Many of these organizations such as the Hong Kong Cancer Fund, the Down Syndrome Association, and Care for Your Heart hired social workers in running holistic psychosocial, empowerment, and educational activities for patients with different types of illness or disabilities. The Society for the Promotion of Hospice Care also set up a community bereavement support center for bereaved persons after our intervention research program (C. L. W. Chan & Chow, 2006). Our students also participated in the in-depth interviewing of patients, wrote their stories for advocacy purposes, provided support for patients’ self-help groups, and developed disease-specific intervention programs to build a health social work system that cares (C. L. W. Chan & Rhind, 1997).
Experiential Synthesis and the Science of Muddling Through: The Establishment of the Integrative Body–Mind–Spirit (IBMS) Approach

When a person experiences loss in their life, it is easy to feel anxious, unsafe, low energy, want to hide or escape, or being hyper-vigilant, take an aggressive stance to attack, and may become violent. Clinical social workers often focus on feelings and emotions under the influence of psychiatry and psychopathology. The cognitive-behavioral approach is among the best proven research-supported treatments in clinical social work. However, the bodily and spiritual well-being are being neglected in conventional clinical social work practice. Survivors taught me the exercises they use to train themselves and personal reflections on developing a holistic mind–body and soul.

Mind–Body Connection

Not everyone in the Chinese community is strong in verbalizing their emotional hurts and pains. Cancer survivors taught me a lot of self-help techniques that they practice daily which improved their physical conditions and some even experienced remission from an end-stage diagnosis. There are ample research publications on exercise being helpful in disease prevention and in improvement of mental conditions. Being a person who is not strong in sharing my emotions, I found sharing of simple exercises and acupressure techniques with my group members being very helpful, especially in recruitment and engagement of patients. Besides physical movement and exercises, patients are also keen to learn more on what to eat that can improve their health. The body intervention can also alter the mind and soul of individuals (Li et al., 2015).

Connection of the Mind and Soul

Although most people I served did not have a religion, they liked to have a clearer sense of meaning in life. I defined spiritual well-being as having (i) meaning in their life and (ii) being able to live with a peace of mind despite social and environmental adversities. Most suffering is caused by (i) the unfulfilled attachment to or (ii) expectations on people, relationships, achievements, and material possession. Individuals are bound by the often conflicting and competing role expectations and filial obligations of being a parent–child, a couple, a sibling, an in-law, a friend, an employer–employee, a teacher–student. Eastern religions promote mindfulness, emptiness, and letting-go of attachments as holding-on or attachments are the roots of suffering (Ng et al., 2006). I believe it is actually important to incorporate spirituality into our social work intervention.

Cultural Wisdom

By synthesizing wisdom from survivors and social workers, we felt that the spiritual peace and gratitude are core elements in wellness. Some of the key lessons learnt from the survivors’ interviews include growing through pain, exercise qigong in healing, Chinese culture and philosophies of resilience and perseverance, acceptance of pain, and “regaining control by letting-go of control” (C. L. W. Chan et al., 2006). These Eastern concepts of post-traumatic growth and transformation through pain were less popular in the emotion-focused Western social work counseling traditions but deeply imprinted in the Chinese culture (C. L. W. Chan et al., 2001). Thus, the body–mind–spirituality are connected as an integrated whole. It would be essential that we adopt a multimodal intervention model in promoting sustained wellness of the individuals through time (R. T. H. Ho, Chan, et al., 2016).

Eclectic Approaches in Research and Practice

We adopted an eclectic approach by adopting a variety of creative means such as expressive arts, songs, poetry, games, and narratives to facilitate individuals to articulate their losses, hurts, and gains (R. T. H. Ho et al., 2009; G. L. Lee et al., 2012). These sharing can lead to deep reflections and healing by cultivating humble, humane, flexible, and accommodating personal qualities committed to unconditional loving-kindness to all creatures and the environment. In fact, most people who survived their bio–psycho–social–environmental challenges can learn, grow, and reach new heights in their life. The traditional concepts of being “older and wiser” is probably relating to how personal struggles can become a purification process by creating a more virtuous person who is considerate, compassionate, caring, and forgiving. These concepts are generated through a continuous process of clinical data mining and critical reflection from the clinical research team (Epstein, 2009). Qualitative studies on deeper understanding of the dynamics of holistic needs of various user populations are also essential for social workers to be able to design most efficacious interventions (Ji et al., 2015). Systematic reviews and meta-analysis of what works and does not work are essential steps in developing a firm grasp on what have already been done (Xie et al., 2019).

Through continuous intervention, testing, revision of this model in the subsequent 10–15 years, an IBMS intervention model was established (M. Y. Lee et al., 2018). The individuals who participated in our intervention groups reported improvements in sleep, physical energy levels, happier, more willing to let-go, finding meaning of their suffering, and their life identity was transformed from victims to survivors (T. H. Y. Chan et al., 2007). They were willing to appear on press conferences, to share their stories, to advocate for community acceptance and de-stigmatization of persons with chronic illness, disabilities, broken marriages, or other mishaps in life. Books, articles, and practice manuals were produced to share these important insights from practice wisdom (C. L. W. Chan, 2001; Fielding & Chan, 2000). Training programs and public
education projects were organized to empower the community in this holistic approach to wellness.

Practitioner–Researcher and Evidence-Based Research

Ten-Point Scales as an Outcome Measure

Despite large numbers of case reports, personal sharing on television, and newspapers, it was hard to bring about significant policy change in the support of psychosocial care for users of the health and social care system. Thus, my team had to move from wide publicity of touching stories to pre–post intervention questionnaires on how the IBMS intervention can enhance the bio–psycho–social–spiritual well-being of participants. Initially, we use subjective self-report questionnaires on a 10-point scale for participants to share their bodily, mental, and spiritual wellness. Results were very encouraging (C. L. W. Chan & Chow, 1998). Ten-point scales are easy to understand and effective in demonstrating impact among participants pre and post intervention, especially among Chinese people who adopted a metric mindset.

Scale Validation in Chinese

However, evidence measured by self-composed measurement scales without going through a vigorous validating and standardization process were often read with caution, especially among health care professionals who had adopt a more empirical and research-based perspective. In order to convince medical doctors, policy makers, and to show the academic community that our service impact are credible, we have to adopt standardized measurement tools. Yet some of the tools were not validated in Chinese, and we have to go through the tedious process of validating international assessment tools into Chinese (Ho et al., 2003). Validating research instrument is an impossible task for social work practitioners in the field. The lack of culturally relevant outcome measures for social work practice had deter social workers from participating in systematic outcome or impact measurement.

Practitioner–Researcher–Educator

Our commitment is to generate knowledge, so that we can empower practitioners to use research to collect evidence of efficacy of social work intervention. We adopted a practitioner–researcher–educator stance in the process of knowledge building (C. L. W. Chan & Ng, 2004). Learning from practitioners on their practice wisdom of what works, and to consolidate practice wisdom systematically into practice principals and guidelines as well as process procedures (Yin et al., 2020). Unlike measuring a single concept of depression and anxiety, the IBMS attempts to foster holistic wellness on the physical, emotional, and spiritual dimension of a person. Adopting the Chinese medicine concepts of dynamic balance of the yin and yang, IBMS interventions aim at promoting harmony and synchronicity of a total well-being which is more complex and subtle than Western measures of happiness and sadness especially in a relational context (Ng et al., 2008). The dynamic process of sense making and meaning making in turning a victim to a survivor was carefully studied (Tang et al., 2007).

The team generated several generations of measurements of holistic wellness and ultimately translated spiritual well-being in terms of affliction and equanimity (C. H. Y. Chan et al., 2014). With our measurement scales, our team members continue to test the application of IBMS through clinical trials into serving population groups of women on in vitro fertilization (IVF), youth, persons with depression, schizophrenia, advanced end-stage illness, and so on (Rentala et al., 2020).

Not only is well-being multidimensional and multicausalional, there is also interactions among family members on wellness of one another. The team adopted analysis such as dimensionality of measurement scales, actor–partner relationships in understanding patient and family caregiver interactions. To transcend from using single approaches to measuring depression, anxiety, and other symptoms, our team ventured into the dynamic interaction constructs of ambiguity, gratitude, ambivalence, mixed emotions that are entangled in complex self-identify with conflicting role expectations (Joubert et al., 2015; Lau et al., 2019).

Having witnessed remarkable improvements of participants from our intervention, our team’s assessment methods expanded into measuring salivary cortisol almost 20 years ago. Our first study on salivary cortisol was in collaboration with the psychiatry team in Stanford University under Dr. David Spiegel, the first person who found that group therapy may prolong survival of advanced stage breast cancer patients in the United States (R. T. H. Ho, Fong, Lo, et al., 2016). As the laboratory was set up, we subsequently started to use salivary cortisol in the understanding of stress and as outcome indicator of our IBMS and qigong interventions with patients with cancer, chronic fatigue, depression, and so on, in Hong Kong and Taiwan (R. T. H. Ho, Fong, Lo, et al., 2016; R. T. H. Ho, Fong, Wan, et al. 2016; Hsiao et al., 2014). Our psychosocial intervention can improve on cortisol responses of our participants.

With support from colleagues in the laboratory sciences, we were able to collect blood from participants and use more biomarkers as outcome measures of our intervention in the late 2000. With plasma data, our team was able to develop understanding on how IBMS and exercise intervention, experience of childhood abuse, and marital trust can affect immunity performance on adults such as telomerase and interleukin 6 (IL-6) levels (C. H. Y. Chan et al., 2017; R. T. H. Ho et al., 2012; Ng et al., 2020). More research is being conducted on the immune markers and childhood eczema in Hong Kong in the past 2 years, and more laboratory analysis is underway (Xie et al., 2020). The difficulty of using immune markers as outcome of psychosocial intervention is that the range of these markers can be very wide and may range from single digit to a few hundreds. There are also complex interaction effects among different pro-inflammatory markers and inflammatory suppression markers in response to the IBMS intervention.
Future Directions

There are countless practice innovations and research going on in clinical social work. Social workers are using more physical activities of yoga, dance, exercise, mindfulness, meditation, electronic games, online chat rooms, and retreats in fostering holistic wellness among clients with different special needs. In the eclectic approach of integrating gratitude, self-compassion, forgiveness (Chi et al., 2019), hope, social support (Lai et al., 2019), meaning reconstruction by using physical exercises, narratives, online groups, internet games and may be artificial intelligence (AI) to promote holistic wellness, it will be a continuous process for practitioner–researcher–educators to learn–consolidate–disseminate knowledge concurrently. The capacity of social workers in the wise use of research evidence into our intervention needs to be supported and enhanced. It is unrealistic to expect social workers to be drawing blood to test the efficacy of our work on a day-to-day basis. Yet, the effective dissemination of evidence-based interventions and how the mind, body, and spirituality affect total wellness will be crucial (Yao et al., 2019).

The Medical Research Council (2008) developed a guideline on the development–piloting–evaluation–implementation process for building complex interventions. The IBMS model development process has adopted a whole range of mixed practice and research methods in the generation of knowledge by identifying existing evidence and wisdom to disentangle hard-core complexes of the body, mind, and soul. The conceptual review of cognitive, emotional, behavioral, and physiological pathologies will be necessary in the construction of clear building blocks on how the self and others, the process and mechanism of change, the strategic pivotal intervention focus in the building of a healthy, happy, and fulfilling person. Social workers can learn to read protocol papers of clinical trials, so that they can pick up what medical doctors and nurses are doing in their everyday research. We should also aim at publishing research protocols to join the requirements of clinical research (Fung et al., 2019).

The rapid technological innovations and high-power computers will create demands on social workers to be using big data in the search of people with suicidal thoughts, internet counseling for hidden youth with gaming or social network addiction, online support groups for vulnerable groups especially in the social isolation situations of pandemic, and the use of AI in early identification and prevention of disasters. Trans-professional competence in software design, big data analysis, online game design, and clinical social work will be needed when large populations are in mental health risks.

We shall also need more implementation science research in which the impact on how social work services can reduce cost and improve quality can be effectively documented for effective measurement of policy efficacy. For example, how introduction of community palliative social work service can reduce hospital stay of patients in their end-of-life (I. K. N. Chan et al., 2019). With the increasing demands for health and mental health support in the mid of COVID-19, online support for clients, supervision, and training of professional social workers may be the new reality. We shall have to move really quickly into practice–research–education on online social work.

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