Decision Tree: A Conceptual Tool for Best Practices

Making Theoretical and Evidence-Based Choices

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The decision tree presented in this article is a conceptual tool that enables practitioners to make practice decisions based on conscientious, explicit, and judicious use of available knowledge. Consistent with evidence-based practice, the decision tree promotes rigor in the teaching and assessment of client needs and in the application of best solutions across diverse disciplines, fields, settings, problems, populations, theories, methods, and practitioner skill levels. As a prescription for practice, the decision tree allows practitioners to make prompt, critically informed decisions from a wealth of information while controlling for confounding factors that affect assessment and treatment outcomes. It serves as a handy quick reference tool for practitioners, agency supervisors, field instructors, practice educators, and learners who wish to engage in best practices. [Brief Treatment and Crisis Intervention 4:37–47 (2004)]

KEY WORDS: conceptual tool, decision tree, best practices, quick reference, managing assessment and treatment choices, theory selection and case application.

This paper introduces a decision tree, a conceptual tool that, consistent with evidence-based practice, enables the practitioner to make conscientious, explicit, and judicious use of available knowledge in making practice decisions. Based on principles derived from decision theory (MindTools, 2003), this decision hierarchy has properties that are capable of building models of practice unique to each client case through the use of the inductive–deductive process of scientific method. Through its model-building properties, the decision hierarchy combines what is best about a single theoretical approach to practice with what is best about a multiple theoretical approach to direct practice. The decision hierarchy provides a framework that is able to quantify the values of outcomes, thus allowing for the creation of a hierarchy based on priorities and the saliency of case data.
Decision Theory as a Conceptual Tool

Decision theory is useful when trying to manage a complex and comprehensive knowledge base. Consistent with this approach is a decision tree, or hierarchy, that can be developed to clearly lay out the problem—in this case, how to apply multiple theories in direct practice—so that all choices can be viewed, discussed, and challenged. It provides a framework that is able to quantify the values of outcomes, thereby allowing for the creation of a hierarchy based on priorities. In the final analysis, it helps the practitioner use critical-thinking skills to make the best decision in a specific case on the basis of existing theories and evidence-based practice.

I developed this hierarchy to help educators teach students and practitioners how to use the inductive-deductive process of scientific theory application to specific cases where more than one theory of intervention is required. The properties of the decision hierarchy help students and practitioners prioritize interventions and avoid errors in theory application.

Combining the Two Conceptual Tools: Decision Tree and Model Building

The decision hierarchy manages practice choice by guiding the clinician through prioritized steps of model building. The practitioner is asked to review each step of the hierarchy to determine its relevance to the case at hand. When a step in the hierarchy is deemed relevant, the hierarchy identifies an appropriate prescriptive theory, which then guides the practitioner in the determination of case-specific treatment goals and objectives. If a step in the hierarchy is not relevant to the case at hand, the practitioner moves on to the next step.

When model building is combined with a decision tree, a practitioner can prioritize multiple theoretical interventions based on the assessment of complex needs. Calibrated on the basis of saliency, the decision tree assigns priority to those facts of the case that have life-threatening and survival relevance—for instance, the first point on the hierarchy corresponds with the worker’s fiduciary responsibilities.

A case illustration follows the presentation of the hierarchy, and an overview of the decision tree is provided in Figure 1 as a preview to the more detailed decision hierarchy to follow.

Decision Hierarchy Steps for Case-Specific Model Building

I. Intake Assessment

Theory-based practice model: structure—functionalism, informs the context of practice—agency mission, policies, and legal mandates.

A. Comply with fiduciary obligations

Inform client of worker duties: duty to protect, warn, and report.

Inform client of client rights and limitations of those rights: right to confidentiality, informed consent, privileged communication, and the refusal of treatment.

Legality: obligation to conform to the law—that is, what (if any) legal mandates must be considered in the case at hand.

B. Ensure safety


If Yes, exercise social control function and
fiduciary responsibility. (Students: Check with field instructor before taking action.)

Intervention. Take protective action, including possible involuntary commitment, removal of family member, denial of reunification, residential placement, and detention or incarceration. If No, proceed to step II in the hierarchy.

II. Assess Urgency of Client Needs

A. Crisis in progress

Theory-based model of practice: crisis intervention—time-limited (4–8 weeks), action-oriented, and present-focused on the precipitating or hazardous event (Roberts, 2000).

Assessment. Assess the following.

- Type of crisis precipitant: Determine if there is sudden traumatic stress, such as disasters, crime victimization, family violence, sexual assault; or psychiatric emergencies, such as acute onset of major mental illness, exacerbation of preexisting psychopathology, and suicidal attempts or threats.
- Client’s physiological and psychological reactions to crisis: Common symptoms and reactions include intense fear, heightened anxiety, hypervigilence, startle reactions, intrusive thoughts, flashbacks, irritability, terror, sleep disturbances, shock, numbness, extreme distrust of others, shattered assumptive worlds.
- Duration and severity of the crisis: Is it life threatening? Is it violent?
- Type of stress involved: Included among those are single acute stressors, multiple stressors, and traumatic events.
- Client’s state: Determine client’s current emotional status, immediate psychological and social needs, current coping strategies, and past or precrisis level of functioning and coping skills.

Is there case-specific evidence of a crisis in progress?
If Yes, de-escalate the crisis.

Intervention. Perform the following.

- Engage the client immediately: Use active listening skills. Use empathic responding. Allow client to pace the treatment. Use calming techniques.
- Stabilize the crisis and return client to precrisis level of functioning: Become involved in the intervention at a nondirective, collaborative, or directive level according to the assessed needs of the situation and the supports at hand. Define the problem according to the client’s point of view. Mobilize support and resources. Mobilize client’s adaptive coping skills. Examine alternatives. Make plans; ensure safety; maintain contact. Obtain commitment to positive action plan, and secure contract for safety, if warranted.
- Offer counseling: Choose from the following—debriefing, within 24 hours of the event; individual short-term, 4 to 8 weeks; or group therapy, 6 to 12 weeks. Offer counseling for bereavement and loss associated with a crisis event.

If no crisis is in progress, proceed to the following point.

B. Assess need for urgent concrete services (today, within days, this week)

Theory-based model of practice: case management, informed by systems theory and structure-functionalism (i.e., institutional resources).

Assessment: Is there case-specific evidence that there is an urgent need to provide the client...
with food, shelter, clothing, safety, financial support, or health care?

If Yes, intervene using case management.

**Intervention:** Use case management skills to provide needed institutional resources or locate familial or interpersonal resources. Refer client to needed resources.

If there is no urgent need for concrete services, proceed to the following point.

### C. Promptly assess the need for concrete services (weeks, months)

**Theory-based model of practice:** case management, informed by systems theory and structure–functionalism (i.e., institutional resources).

**Assessment:** Is there case-specific evidence that there is a pressing but not immediate need to provide the client with food, shelter, clothing, safety, financial support, or health care?

If Yes, use case management to locate institutional or social network resources.

**Intervention:** Provide agency-based concrete services. Refer client to needed resources beyond those offered by your agency. Locate, monitor, and coordinate fragmented services. Identify and utilize interfamilial and interpersonal networks as resources.

If the client is not in need of concrete services, proceed to step IV of the hierarchy.

If the client is in need of concrete services that have not been delivered or that have been denied, proceed to step III.

### III. Assess the Need for Advocacy

**Theory-based model of practice:** advocacy, informed by conflict theory and empowerment theory.

#### A. Case advocacy

**Assessment.** Is there case-specific evidence that (a) a client has been cut from services, declared ineligible for service, or denied services; or (b) that needed services do not exist?

If Yes, provide case advocacy.

**Intervention.** Perform the following.

- Initiate case advocacy: Secure requested services on behalf of client.
- Practice approach: Use conflict resolution and negotiation skills derived from conflict theory. Utilize administrative authority and hierarchy. Initiate appeal or grievance procedures to correct the system on behalf of the client. Identify and utilize alternative pathways to secure needed services. Empower client to act on his/her own behalf.
If case advocacy is indicated, consider whether class advocacy is warranted. Proceed to the following point.

B. Class advocacy

Theory-based model of practice: class advocacy, informed by conflict theory and use of macro-skills—policy, planning, organizing, and social action.

Assessment. Is there evidence that the issue affecting your client is an issue that also affects other clients in your agency or a subpopulation served by your agency?

If Yes, engage in class advocacy.

Intervention. Class advocacy: Remove, modify, or implement a new policy to improve service delivery. Develop a program to meet a gap in service. Initiate a project to address the unmet need or gap in service. Utilize techniques and tactics of community-based issue campaign: raise consciousness, form task groups, organize large group social action, use power and lobbying skills to bring about local or national change. Empower client populations to act on their own behalf.

If there is no need for either case or class advocacy, proceed to step IV.

IV. Assess Need for Therapeutic Interventions

Individual therapy for adults, children, and adolescents: theory-based models of practice based on prescriptive theory.

Assessment. Has the client requested counseling? If the client is involuntary or mandated, has a treatment contract been negotiated with the client?

If Yes, provide therapeutic treatment.

If No, do not provide counseling.

Intervention. Consider the following forms of treatment.

A. Pharmacological or medical models of treatment

Choose this model of practice when the facts of the case lead you to conclude that “nature” explains in part or in full “what is the matter” or when such means can ameliorate the situation. Biological change techniques include biofeedback, pharmacological interventions, and medical treatment. You may choose biological intervention only, or you may use it with a selected talk therapy model. Clinicians often collaborate with medical doctors who prescribe and provide necessary pharmacological or medical interventions.

B. Talk therapy models of intervention

Psychodynamic theory, such as ego support or rational problem solving. Choose this model of therapy when your intent is to change the client’s capacity to cope with life events through active support of the client’s conscious problem-solving skills and coping abilities. This change theory’s roots lie in psychodynamic theory. Awareness of past developmental history is helpful in terms of working with the weaknesses and strengths of a client’s ego. This theory is appropriately used with those clients who are oriented to person, time, and place and who possess the capacity for formal operational thought and reflection. While the theory accepts the unconscious, it does not focus on it.

Choose a model of practice based on object-relations theory when your intent is to focus on changing interpersonal interactions through insight. This theory holds that current patterns of interaction are unconsciously influenced by past patterns of interaction. In general, this change theory has roots in psychodynamic theory; however, it is specifically rooted in attachment theory. Past developmental history in terms of interpersonal relationships is
important. The worker–client relationship is a focus of counseling. It is contraindicated for those clients who are unable to distinguish self from other.

**Behavioral theory, such as operant or classical conditioning and social learning.** Choose behavioral theory when your intent is to change behavior regardless of insight. According to behavioral theory, all behavior is learned and can therefore be unlearned, modified, or shaped. Immediate history in the form of antecedent and consequent events is more important than distant history. Assessment is concerned with determining what is maintaining the behavior, in contrast to lengthy exploration of the client’s developmental past. This model works well with those who have cognitive impairments or who live or work in settings where others can control the contingencies. These models are often used in behavioral health care with adults where the focus is on changing risk factors such as smoking, overeating, and managing pain. They are also frequently used in schools, structured day and residential living settings, and in juvenile correctional settings.

**Cognitive-behavioral theory (thinking and insight).** Choose cognitive-behavioral theory when your intent is to change negative behaviors and feelings by changing the cognitions that influence them. The intent is to manage feelings by putting them under the control of rational cognitions. The roots of this change model lie in two theories: symbolic interactionism (core beliefs, worldviews, meaning) and social learning theory (i.e., socialization and conditioning). This model requires the capacity for self-reflection but holds that cognitions are consciously accessible.

**Solution-focused theory (goal directed and strengths based).** Choose solution-focused theory when your intent is to promote coping by building on client strengths. This model does not assess developmental history, nor is it problem-focused. Assessment consists of the client’s presentation of current needs and wants, with a focus on identifying past coping capacities and current strengths. The goal of the model is for the worker to help the client identify internal strengths and external familial and social resources. Techniques include identification of past coping skills, exceptions, and desired goals (miracle question).

If the client cannot benefit from a talk therapy model of practice, or if the client is in need of treatment alternatives in addition to pharmacological or talk therapy intervention, explore the following point.

**C. Social milieu therapy: Structured day programs and residential services**

*Theory-based model of practice:* informed by structure-functional theory, a provision of therapeutic structural alternatives to maximize client functioning in the environment.

**Assessment.** Is the client in need of a day program?

If Yes, choose a program appropriate to the facts of the case.

**Intervention.** Select the appropriate structured day program: substance abuse day treatment program; structured day program for the chronically mentally ill, the elderly, or the cognitively challenged; sheltered workshop program or vocational training; daycare programs, Headstart, Child Find, special education, or GED; after-school programs or recreational programs; respite care or hospice care.

If No, consider whether the client is in need of a residential living program.

**Residential Living Assessment.** Is the client in need of a residential living program?
If Yes, choose a program appropriate to the facts of the case.

**Intervention.** Choose a residential living program appropriate for the case: kinship care; family foster care; group home foster care; independent living; shelter; public housing; maternal and infant home; halfway house; a living program for the chronically mentally ill or cognitively challenged; assisted living or nursing home for the elderly; hospitalization or partial hospitalization for the acutely mentally ill; in-house substance abuse treatment programs; institutionalization for the seriously and dangerously mentally ill; juvenile detention or rehabilitation; adult correction facility or jails.

If additional or alternative methods of counseling are needed, proceed to step V.

**V. Methods**

When individual counseling appears to be contraindicated or insufficient, explore other methods of treatment, such as family models of treatment or models of group treatment.

**Assessment.** Is there case-specific evidence that individual counseling is contraindicated or insufficient?

If Yes, consider whether a family model of practice is more appropriate to the case situation.

**Intervention.** Consider the following forms of treatment.

**A. Family method of practice: Family and child welfare**

**Theory-based model of family practice:** informed by systems theory and structure–functional theory—that is, provision of institutional alternatives to fulfill the tasks and roles of families with compromised functioning.

**Assessment.** Is this family at risk of disintegration due to a lack of a viable structure? Is this family able to function adequately to provide for the basic survival needs of its members? Is this family in need of multiple resources due to an array of complex needs?

If Yes, choose one of the following interventions.

**Intervention.** Select one of the following to keep families intact and to protect children: family preservation/wrap-around principles; or permanency planning.

If the family is not in need of family and child welfare services, consider whether other models of family practice are indicated. See the following step.

**B. Family method of practice: Methods for unhealthy or maladaptive interfamilial relationships**

**Theory-based model of family practice:** informed by family systems theory to modify unhealthy or maladaptive intrafamilial relationships (marital, parent/child, sibling).

**Assessment.** Is the family requesting counseling for unhealthy or maladaptive interfamilial relationships?

If Yes, consider one the following counseling models of family therapy.

**Intervention.** Choose a model of family practice: family life cycle (Carter and McGoldrick, 1989); structural–strategic (Haley, 1971; Minuchin, 1974); individuation-differentiation (Bowen, 1978); strengths (Saleeb, 1996).

If individual or family methods of counseling are inappropriate or insufficient, proceed to the next step.

**C. Group methods of counseling**

**Theory-based model of practice:** group method, informed by theories of small-group dynamics and the curative factors associated with groups.
Assessment. Is there case-specific evidence that group methods of counseling will better serve the client or augment existing counseling? If yes, determine if your client’s culture is compatible with group methods of treatment. Determine whether your client’s history and current functioning are appropriate for group treatment.

If Yes, consider one of the following interventions.

Intervention. Select from the following treatment groups: self-help, socialization, social skills training, psychoeducational support, or therapy. Or, choose from the theory-based group therapy models: psychodynamic, cognitive-behavioral, object relations, narrative therapy, transpersonal (list not comprehensive).

VI. Culturally Responsive Models of Practice

Theory-based model: culturally responsive practice, informed by symbolic interaction theory.

If there are racial, language, class, gender, religious, or other cultural differences between the worker and the client, use step VI of the hierarchy to assess whether your model of practice is culturally responsive.

Assessment. Is your model of practice culturally responsive to race, language, class, gender, religion, sexual orientation, or physical capability (i.e., a handicap)?

If Yes, proceed to step VII in the hierarchy. If No, consider the following modifications.

Intervention. If you are not fluent in the language of your client, refer the client to a professional who is fluent. If you are not fluent in the client’s language and a referral to another professional is not feasible, use the services of a trained interpreter. Avoid using a child or other family member as an interpreter. Address worker–client cultural differences openly. Engage in ethnographic interviewing to discover how problems and their solutions are defined in the client’s culture. Through ethnographic interviewing, contract for an acceptable “helping” relationship consistent with the client’s culture. Use a method that is compatible with the culture of the client. Some methods are culturally contraindicated.

Proceed to the last step of the hierarchy.

VII. Ethics

Ask yourself, is there any case-specific evidence that the situation at hand poses an ethical dilemma?

If Yes, engage in ethical decision making.

Assessment. Identify the ethical dilemma. Use deontological and teleological philosophical theories to analyze the dilemma. Examine relevant sections of the NASW code of ethics. Use hierarchies to weigh the value dimension of the dilemma. Apply relevant theories of social justice in analyzing the dilemma.

Intervention. Follow an ethical decision-making hierarchy (see Kirst-Ashman and Hull, 2000, 2001). Take action in accordance with your analysis of the dilemma. If there is no indication of an ethical dilemma, stop.

Latitia’s Case Data

See Table 1 to see how the decision hierarchy is combined with model building to help practitioners make critically informed practice decisions based on theory and best evidence.

Latitia is a young, single, African American woman with three children, ages 5 and under. Latitia is seeking help because she is faced with
eviction due to rent increases (gentrification) coupled with a recent job loss (layoffs and economic downturn). During the course of the intake interview, Latitia reports insomnia, weight loss, and a feeling of impending doom. She states that the stress caused by her job loss and pending eviction is affecting her ability to care for her children, who are becoming more and more unruly every day.

**Summary and Implications for Practice**

As a prescription for practice, the decision tree is a conceptual tool that makes a contribution to the literature on best practices. It also makes a practical contribution by addressing the realities of time constraints in current practice, by allowing practitioners to make prompt, critically informed decisions from a wealth of information. Because the scope of direct practice is broad, it is difficult to conceptualize precise tools for standardized use across diverse disciplines, fields, settings, problems, populations, theories, methods, and levels of practice. The decision tree presented in this paper concisely summarizes substantive areas of practice in terms of progressive decision points, thereby promoting rigor in the teaching of assessment of client needs and in the application of best solutions. Its use provides the learner with skills, and the seasoned practitioner with procedures, that direct the continued development of effective treatment and intervention approaches consistent with evidence-based practice. As a tool,
it can be used to monitor the delivery of quality services to clients as well as the performance of students in field and class. However, as a conceptual tool not yet subjected to rigorous empirical testing, the decision tree is waiting the appropriate research to provide evidence of its utility.

References*


* For a more extensive source reference list related to the steps in the hierarchy, contact the author.