Common practice elements for child and family services:
A discussion paper

Prepared by: Penny Mitchell MPH, PhD. EIP Consulting
July 2014
# Contents

1. Introduction........................................................................................................................................ 1
   1.1 Purpose of this document........................................................................................................... 1
   1.2 Definition of some core concepts ............................................................................................... 1
   1.3 Scope and rationale..................................................................................................................... 2
   1.4 Principles that would guide the use of practice elements within the organisation ............... 3
   1.5 Potential benefits of a practice elements approach................................................................. 3

2. What are common practice elements and how can they help? ........................................................ 4
   2.1 Practice elements in the context of evidence-based practice .................................................... 4
   2.2 The practice elements approach................................................................................................. 9
   2.3 Rationale for the use of practice elements............................................................................... 14
   2.4 Limitations of practice elements............................................................................................... 20

3. Australian and international application of the common practice elements approach............... 22
   3.1 The Stronger Families Project 2009-2011............................................................................. 22
   3.2 The Benevolent Society Project 2009-2014 ........................................................................ 30
   3.3 The Youth Support and Advocacy Service 2011-2014......................................................... 37
   3.4 International work............................................................................................................. 47

4. Organisational contextual considerations........................................................................................ 50
   4.1 Current use of evidence-informed practice .......................................................................... 50
   4.2 Strength of client-focused decision support processes ....................................................... 51
   4.3 Strength and flexibility of practice development processes ................................................ 53
   4.4 Organisational readiness for change.................................................................................... 54

5. Options for Common Practice Elements at Berry Street............................................................... 55
   5.1 Kernels and practice elements appropriate to Berry Street ................................................. 55
   5.2 Packaging the content to make it more relevant to Berry Street users................................. 60
   5.3 Further exploratory work recommended ............................................................................. 61
   5.4 Essential requirements and options for full scale implementation ..................................... 62

6. References........................................................................................................................................ 65
1. Introduction

1.1 Purpose of this document

This document was commissioned by Berry Street in 2014 to inform the organisation about the potential application of the Common Practice Elements or ‘kernels’ approach to child and family welfare practice.

1.2 Definition of some core concepts

A practice element is a discrete technique or procedure used intentionally to influence a psychological process or behaviour. Almost all larger interventions are comprised of a number of practice elements. Other terms that have been used to refer to the same basic construct include kernels, active ingredients and procedural elements.

The idea of breaking down larger interventions into practice elements has been gaining increased attention in recent years from researchers interested in finding ways to speed up the implementation of evidence-informed practice in health and human services, particularly services for children, adolescents and families.

Kernel is a term that is sometimes used interchangeably with practice element, but a kernel may be better understood as a type of practice element. The term kernel was coined to highlight the idea of an indivisible unit or the smallest possible meaningful procedure. Consistent with this, the literature on kernels tends to describe very small practice elements, comprised of only one technique, whereas some practice elements are comprised of several techniques.

Evidence-based practice (EBP) is practice that is designed primarily on the basis of evidence from research about what is effective for particular target populations. Other influences such as client preferences and practitioner judgement may be considered at various points in decision-making, but these tend to take second place behind evidentiary consideration.

The evidence-based practice (EBP) movement has focused most of its attention on the development and dissemination of whole programs, particularly manualised programs, that have been demonstrated in randomised controlled trials (RCTs) to be effective in achieving particular outcomes, for particular client populations, in particular settings. For the sake of convenience these programs will sometimes be referred to as Empirically Supported Treatments (ESTs). Despite demonstrating the effectiveness of hundreds of such ESTs, they have enjoyed only limited adoption throughout community-based child, youth and family services. Research focused on the implementation process has documented many barriers including the attitudes of practitioners, aspects of organisational culture, and resource limitations. This experience has led some implementation scientists to investigate alternative ways of using evidence from research to inform practice.

Evidence-informed practice (EIP) is practice that is informed by research evidence, alongside other influences including client values and preferences, practitioner experience, and organisational or community context. The idea of EIP has grown in popularity among practitioners and researchers who work closely with them, as an important alternative approach to improving the quality and effectiveness of practice, while being sensitive to the realities of each unique practice setting.

Whether justified or not, EBP has developed a reputation among practitioners in health and human services as a process that is largely controlled by academic researchers, that gives insufficient credit to the creativity and expertise of practitioners in real-world services, and which provides too little room for a creative response to the majority of clients who have highly diverse and complex needs.

In contrast, EIP is increasingly viewed as accommodating, even requiring a process of innovation and experimentation within practice settings. Within EIP academic researchers are positioned as equal partners who are invited to exchange knowledge with practitioners, or as consultants invited to contribute to a process controlled or mediated by community-based organisations.

The practice elements approach is an approach to practice and the design of interventions that emphasises the use of practice elements rather than programs. It sits within the new and rapidly
evolving philosophy of evidence-informed practice, because it draws on evidence from empirical research as well as practitioner knowledge, client values, and organisational context. The empirical research base includes controlled trials of intervention or program effectiveness (the core focus of EBP) as well as studies of the implementation of evidence-based interventions within real organisations (implementation science). This empirical influence is complemented by recognition and valuing of practitioner and client perspectives. This perspective is not homogeneous. It is specific to organisational context and highly variable. Hence the practice elements approach places the tools for intervention design into the hands of practitioners so that they are empowered to build or create interventions that are tailored to the unique needs of each individual client.

One of the core strategies of a practice elements approach involves selecting and bundling a set or package of practice elements appropriate to the needs of a particular client or group of clients with a shared need. This can be done by practitioners in real time as they work with clients or when individualised care plans are being developed and revised. Alternatively, practice elements may be organised into pre-arranged modules designed with particular types of emotional and behavioural issues in mind. Pre-arranged modules may be particularly helpful for less experienced practitioners. Effective real-time arrangement of practice elements will strengthen over time with training, coaching and experience.

1.3 Scope and rationale

The idea of practice elements has emerged from work in the field of clinical or therapeutic practice. Consistent with these origins most applications to date have been in the field of specialist mental health care. Section 2 of this document provides a brief review of the scholarly thinking that is driving the practice elements approach within the world of psychological therapy.

While its origins are highly clinical, other sections of this Discussion Paper explore the proposition that the practice elements approach has application beyond the world of psychological therapy, and that practice elements can be used by a wide variety of practitioners who do not work in clinical settings and do not possess high level training in therapeutic disciplines. Work on the implementation of a practice elements approach is beginning to take place beyond the boundaries of psychological therapy. This work is recent and evaluation is yet to be published.

Some of the innovative applications which Berry Street would like to explore include describing a set of practice elements that:

- Constitute a set of core or foundational practices that every member of the workforce is expected to have the capability to deliver;
- Can be used in early interventions implemented in the context of place-based community development models;
- Can be delivered by residential workers;
- Can be taught to kinship and foster carers.

At Berry Street, one of the key drivers of interest in practice elements is a concern that new employees are not necessarily coming into their roles equipped with all of the core skills needed to work effectively with the children and young people in their care. This is despite most having at least Certificate 4 level training in a relevant subject area. As a result the organisation needs to respond by providing education and skill development on-the-job. The practice elements approach may provide a framework for defining a core set of practices that every member of the workforce is expected to have capability for. Documentation in this form could assist with the design of training and professional development in-house, self-directed learning, and a variety of structured continuous quality improvement strategies.
1.4 Principles that would guide the use of practice elements within the organisation

Several key principles that would guide the use of a practice elements approach within Berry Street include embeddedness, choice, realism, flexibility, and support.

- **Embeddedness** – Documentation and use of practice elements can only provide a meaningful contribution to practice if they are embedded within the Berry Street’s own outcomes framework.

- **Choice** – Both services and individual practitioners can choose which elements or modules to use. Procedures need to be developed to ensure choices are made carefully and systematically.

- **Realism** – Practitioners do not need to be experts in any particular therapeutic models. Workers with varying levels of expertise can engage with new practice elements incrementally according to their existing strengths, interests, and comfort zone.

- **Flexibility** – The practice elements approach is designed to maximise flexibility in responding to the needs of individual clients, individual practitioners, teams and organisations.

- **Support** – Practitioners need to be adequately supported to make appropriate choices about the use of practice elements. A comprehensive set of resources needs to be developed, training and supervision provided, and a wide variety of tools made available.

1.5 Potential benefits of a practice elements approach

Many researchers have observed that progress in the implementation of evidence-based practice in child and family health and social care services has been painfully slow. This assessment has mostly been based on observation of a reluctance to formally adopt manualised programs or ESTs. A turn towards evidence-informed practice characterised by greater emphasis on the use of practice elements has the potential to increase use of empirically and theoretically supported interventions within these services.

There are several reasons why a practice elements approach may be more acceptable to decision-makers and more feasible to implement within real world service settings (Mitchell, 2012a). These include:

- Individual tailoring
- Ready integration into existing practice
- Amenable to varied modalities
- Cost efficiencies in training and support
- Sensitivity to context
- Evaluation and continuous quality improvement
- Interagency collaboration

These points are discussed in detail in Section 2.3.2 and revisited regularly in the following sections.
2. What are common practice elements and how can they help?

This section will provide:

i. A brief literature review on the theory and other scholarly thinking on the common practice elements or kernels approach, including:
   a. Different definitions / breadth or scope
   b. Rationale

ii. A brief review of the evidence-base and other relevant literature on the common practice elements approach, including:
   a. Research studies that have examined effectiveness of the approach compared to traditional approaches to evidence-based practice
   b. Research studies that have examined ‘fit’ for purpose.

iii. A brief outline of the key factors known to facilitate effective implementation of evidence-based practice in child, youth and family health and welfare services.

2.1 Practice elements in the context of evidence-based practice

Many scholars have written about the idea of practice elements in the past, and recently, several different groups have elaborated on these ideas quite extensively. The ways in which practice elements are defined share some similarities but there are also some significant differences.

Psychologists and practitioners in other helping professions have long speculated on the question of what is it they do that is most important for helping the client to change. Of course we do recognise the whole package of care or treatment is important, that it is necessary to provide a multifaceted, holistic response. But at the same time we often have a sense that some things, some elements may be more important than others, that certain techniques were the ones that made the biggest difference for a particular client. When we notice this we may be drawn to investigating what these more important elements may be.

2.1.1 Practice elements and therapeutic models

For the purpose of the present discussion, practice elements originate within therapeutic practice, and more specifically, therapeutic models that have been developed for the purpose of helping people to change their behaviour or manage their emotions.

Traditionally, therapeutic interventions or treatment programs that become documented, and disseminated to others have been developed by one practitioner or a group of practitioners working together who find that a particular new approach is working well with a particular group of clients. These practitioners may work intensively and closely with each other for some time and over this time their emerging practice develops an identity of its own that is distinct from what came before.

For example, Solution Focused Brief Therapy was developed by a group of family therapists working at the Brief Family Therapy Center in Milwaukee who were experimenting with Systemic Family Therapy and Brief Therapy. They discovered that certain practices from both established models seemed to be particularly helpful for the families they were seeing. They practiced combining and adapting these elements, learned from their clients responses, and built a new model inductively over time (Simon & Berg, 2004). [Similar for DBT]

As practitioners when we encounter a new therapeutic model for the first time, it is almost always presented in the form of a complete package, or what might be called ‘an integrated therapeutic model’. All the various parts of it seem to be so tightly interconnected that they cannot be taken apart. We may read a book or attend a training program and the first few chapters or first few sessions are inevitably dedicated to explaining the theoretical grounding of the new model, the foundational principles upon which it is based, and the new insights or ideas that help make the new approach different and better
than what came before. Very often there are indeed relatively new, or perhaps rejuvenated, ways of thinking about the human condition that underpin these new models, and the therapeutic practices described are clearly linked to these ways of thinking. The theories, principles and practices seem inseparable from one another.

Theories and principles about human behaviour and recovery from illness, problems or trauma are almost always comprised of several important ideas that are tightly coupled together. Separated they explain little or nothing at all. Hence the practices that flow from each important theoretical idea also appear inseparable. This is the nature of ‘an integrated therapeutic model’.

However when we study the history of psychological therapy we can see that the process of developing new models almost always involves combining parts, but rarely the whole, of models that have come before. The developer observes that certain bits of a model work well with his or her clients and certain bits do not. He or she also finds that certain models meet part of the needs of a client, but not all the relevant needs, and so she introduces ideas and practices from other models. This is the process by which Systemic Family Therapy and Brief Therapy combined to become Solution Focused Brief Therapy, and the process by which Behaviour Therapy and Cognitive Therapy merged over time to form Cognitive Behaviour Therapy. It is also the eclectic process that most practitioners employ every day in their real life work with clients.

The key point is that all integrated therapeutic models are made up of smaller elements, and most of these originate from models that existed previously. Yes there are some new elements, yes the old elements may look a bit different, or are described in different terminology, but the fact remains that most of the content has come from something else that was here before. Most the newness of the new model is in the innovative combinations or sequencing of old elements, and the conceptualisation of problems and solutions that sits behind these new combinations.

Recognising this helps practitioners to understand that they can participate in more conscious and considered processes of designing interventions that are tailored to the unique needs of their clients.

2.1.2 Practice elements and evidence-based programs

Evidence-based practice (EBP) is a movement that sits within the larger world of therapeutic practice. Not all therapeutic practice is evidence-based. Much clinical psychology research has focused on testing the efficacy of particular therapeutic models in treating particular conditions experienced by specific groups of clients. Some therapeutic models have received or generated much more research than others. For example Cognitive Behaviour Therapy and Motivational Interviewing have been the subject of very large amounts of research while Narrative Therapy has been the subject of almost none. Hence Narrative Therapy sits outside of the world of evidence-based practice because there is a lack of evidence for the effectiveness of Narrative Therapy. This is not the same as saying, however, that there is evidence that Narrative Therapy is ineffective.

Evidence-based ‘programs’ (EBPs) are defined and documented treatments or interventions that are supported by empirical evidence. More specifically Axford and Morpeth (2013) define a ‘program’ as “a discrete, organized package of practices, spelled out in guidance – sometimes called a manual or protocol – that explains what should be delivered to whom, when, where and how” (p269), and consider a program ‘evidence-based’ “when it has been evaluated robustly, typically by randomized controlled trial (RCT) or quasi-experimental design (QED), and found unequivocally to have a positive effect on one or more relevant child outcomes” (p269). Other terms commonly used in the literature to refer to such

1 There are several reasons for this. One is that Narrative Therapy is theoretically grounded in Social Constructionism while Cognitive Behaviour Therapy is more consistent with logical positivism. The latter theoretical perspective is much more consistent with the idea of defining and measuring outcomes, and empirical research designs. Hence practitioners of CBT are more interested in studying effectiveness. Criteria that determine merit for competitive research funding also tend to ensure that fields of study that have been better researched in the past, will continue to be better researched in the future.

2 It is important to note that is possible to identify components of Narrative Therapy that are very similar in function to components of therapies that are evidence-based.
programs include: evidence-based treatments (EBTs), evidence-based psychological therapies (EBPTs) and empirically supported treatments (ESTs) (Mitchell, 2011). For convenience the term EST will be used here.

Definitions of ESTs and EBPs vary in their specificity. Many writers assume a narrow definition, where ESTs refer to standardised treatment protocols that have been demonstrated to be clinically effective in randomised controlled trials (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008; Hovmand & Gillespie, 2009). Some writers use the term more loosely, referring to “treatments supported by empirical evidence” or “interventions showing beneficial effects in outcome research” (Weisz, Jensen-Doss, & Hawley, 2006).

There is an impressive body of evidence demonstrating the performance of ESTs in the treatment and prevention of psychosocial problems among children and adolescents. In a 2005 review of the literature Weisz et al (2006) observed that there have been over 1500 clinical treatment trials, and that meta-analyses have demonstrated substantial beneficial impacts with effect sizes ranging from medium to large. Furthermore these effects generally hold over time, and they are substantially specific to targeted problems, suggesting that ESTs are not merely producing broad non-specific effects (Weisz, Sandler, Durlak, & Anton, 2005).

Several key points need to be emphasised about empirically supported treatments or evidence-based programs that have been studied in outcomes research.

First, these programs are designed for the purpose of treating or preventing precisely defined behavioural or emotional problems, usually diagnosable psychological disorders. In children and adolescents these types of problems include externalising (e.g. conduct disorders) and internalising (e.g. depression and anxiety) mental disorders, borderline personality disorder, substance use problems, and offending behaviour. There is also an emerging literature around persistent suicidality and broadly defined effects of traumatic exposure.

Second, like ESTs themselves, most EST research focuses on establishing efficacy for treating one or perhaps two ‘disorders’. The efficacy of only a few ESTs is well established across more than one disorder. These include cognitive-behaviour therapy (CBT) for substance abuse, offending behaviour and internalising disorders (Schuetz & Berry, 2009; Sukhodolsky & Ruchin, 2006; Waldron & Turner, 2008) and multidimensional family therapy (MDFT) for substance abuse and offending behaviour (Liddle et al., 2006; Schuetz & Berry, 2009; Sukhodolsky & Ruchin, 2006; Waldron & Turner, 2008). Dialectical behaviour therapy (DBT) has been identified as a ‘promising intervention’ in the treatment of several psychosocial problems that may be etiologically connected to trauma including borderline personality disorder, persistent suicidality, substance abuse, and offending behaviour (Schuetz & Berry, 2009; Sukhodolsky & Ruchin, 2006). Consistent with this McHugh et al (2009) label DBT as a transdiagnostic EST.

An important point to make about this group of ESTs is that they have been developed by combining components drawn from pre-existing distinct therapeutic models (Bruun & Mitchell, 2012). For example:

• **Cognitive Behaviour Therapy** emerged from a combination of cognitive therapy and behaviour therapy.

• **Multidimensional Family Therapy** combines cognitive behaviour therapy with interventions based on family systems theory, particularly Structural Family Therapy, developmental theory and assertive case management.

• **Dialectical Behaviour Therapy** combines elements of cognitive behaviour therapy and new insights grounded in mindfulness and the meditative spiritual traditions, especially Buddhism.

The program developers went through a process of carefully considering the psychological processes and behaviours of the client population of concern, the various therapeutic components comprising the available models, selecting the therapeutic components best matched to client needs based on their
practice experience and theoretical perspectives, and packaging these components together in novel ways. During this process and subsequently, developers of evidence-based programs often extend existing theory or develop new theory that explains the rationale for their therapeutic choices, and the new models are subjected to evaluation of their effectiveness in altering the targeted psychological processes.

In addition, most new therapeutic models are documented in the form of manuals, books, and audio-visual training materials. An increasing number of such programs are branded and copyrighted and become the unique property of the developers who have legal rights to sell branded information and resources. The costs involved in acquiring and using branded program materials are sometimes modest but not always. The extent to which the source material drawn from pre-existing therapeutic models is acknowledged by program developers also varies considerably.

Understanding the process through which new treatment models and programs are developed reminds us that despite the claims of program developers, most programs are reducible to smaller components that pre-existed the development of the new program, and that these components can be combined in a variety of ways.

2.1.3 Practice elements, common factors, and characteristics of effective programs

Several meta-analyses that have compared the effectiveness of different psychological treatments have found little or no differences in effect size between the different types or models of psychotherapy (Wampold et al., 1997)3. These findings have led some commentators to conclude that the therapeutic model may account for no more than 15 per cent of the variance in behaviour change and other outcomes, while several factors common across most treatments are largely responsible for the improvements that most clients make (Clark, 2001a, 2001b; Graybeal, 2007; Hubble, Duncan, & Miller, 1999; Miller & Duncan, 2000). Key among these ‘common factors’ are:

- **Client factors** - Factors inherent to the client (e.g. beliefs, understandings, optimism, support networks, other strengths brought to the treatment setting from outside);
- **Therapist factors** - Factors inherent to the therapist (e.g. genuine warmth and concern, empathy, strength of belief in the approach they are using); and
- **Relationship factors** - The quality of the client-therapist relationship.

Together the three types of common factors are thought to account for at least 70 per cent of the variance in behaviour change or other outcomes.

There is argument in the literature about the validity and strength of the claim that there is minimal difference in effectiveness between different therapeutic models, and disagreement about the extent to which common factors are responsible for therapeutic gains made by clients who receive therapy. Despite this there is widespread agreement that client factors, therapist factors and relationship factors do exert very considerable influence.

On the other hand, even the strongest advocates for the importance of common factors, do not claim that all therapies are equally effective for all psychological problems or that every treatment is equally effective with every patient (Wampold et al., 1997; p210 & p211).

The common factors are quite different from the ‘common practice elements’ that are the focus of this Discussion Paper. While the common factors are active and influential within the therapeutic encounter,

---

3 Note for future discussion - Almost all of this work has been done with adult clients and has compared models such as ‘CBT’, ‘Functional Family Therapy’, ‘Adlerian Therapy’, ‘Interpersonal Therapy’ etc, NOT manualised EST ‘programs’ (however some of the studies in Wampold et al 1999 used manuals, see page 207). This is important because within any ‘model’ there is likely to be a lot of variance due to practitioner and therapeutic relationship variables. The research on manualised ESTs has tried to minimise this ‘intra-model’ variance.
they sit outside of any particular therapeutic model or treatment program that is being employed. The common factors are contextual and exist independently. In contrast, therapeutic practice elements have generally been conceptualised as components comprising or sitting within therapeutic models or treatment programs.

A substantial body of literature identifies and describes the most important client factors, therapist factors, and the characteristics of the client-therapist relationship. This work has expanded over time to include consideration of other aspects of the therapeutic and service context that may enhance the potency of client factors and therapeutic relationship characteristics. Much of this literature is practice wisdom-based rather than research or evidence-based. This does not mean that there is no evidence to support these characteristics, rather the nature of the evidence is rarely to the ‘gold-standard’ of multiple independent randomised controlled trials demanded by strict advocates of the EST approach. There is increasing recognition of the value of alternative research methods such as naturalistic evaluation and qualitative methods, which are contributing to a merging of insights originating in practice-wisdom with key threads of the integrative approach to EBP.

A good example is provided by Henderson and colleagues, who describe a consensus-based method for integrating research evidence with clinical expertise (Henderson, Taxman, & Young, 2008). Scientists worked with practitioners in a deliberative process of compiling, reviewing and evaluating findings from research studies plus clinical experience to develop recommendations for practices with the best empirical and clinical support. This process, which distilled conclusions from reviews and meta-analyses of ‘evidence-based treatment practices’ used in the criminal justice system, yielded 10 ‘key features’. The use of specific treatment orientations, such as cognitive behaviour therapy and family-based treatments, was included as one of these 10 features. The other features referred to meta-level characteristics of practice, such as interventions to engage and motivate offenders and the use of incentives to improve program retention.

Other work that fits into this approach includes practice-wisdom and health services research literature arguing that to be effective, services and programs for children and youth with complex needs must be:

- Client-centred or individualised (Bell, 2006; Bruun, 2008; Clark, 2001a, 2001b; Miller & Duncan, 2000; Pichot, 2001; Schuetz & Berry, 2009; Ungar, 2005);
- Nurture a healthy client-therapist working relationship (Bruun & Hynan, 2006; Garland, Hurlburt, & Hawley, 2006; Karabanow & Clement, 2004; McLeod & Weisz, 2005; Moos, 2007; Rodd & Stewart, 2009; Schuetz & Berry, 2009);
- Be developmentally appropriate (Brannigan, Schackman, Falco, & Millman, 2004; Bruun, 2008; Henderson et al., 2007);
- Address the practical needs that youth and families present with (Karabanow & Clement, 2004; Statham, 2004) and
- Be comprehensive according to varied needs or integrated with services in other sectors (Bruun, 2008; Cameron & Karabanow, 2003; Chan, Godley, Godley, & Dennis, 2009; Crome, Christian, & Green, 2000; Muck et al., 2001; Schuetz & Berry, 2009).

While these types of wisdom- or consensus-based features have been named ‘evidence-based treatment practices’ (Henderson et al., 2008; Henderson et al., 2007) and ‘elements of effective treatment programs’ (Brannigan et al., 2004) they clearly refer to aspects of practice or service provision that operate at a different level from therapeutic practices. They are best understood as meta-level

---

4 Having said this, the Common Factors have recently begun to be subject to detailed analysis in order to better describe them, and this is leading to identification of the components or elements that they are comprised of and the factors that facilitate and inhibit them. There are signs that these elements are becoming incorporated into the corpus of ‘common practice elements’ (e.g. see Li and Julian, 2012 on developmental relationships). Note also in relevant section that the YSAS Practice Elements include a significant proportion that target the Common Factors.
characteristics of service contexts that enable and moderate the delivery of treatments. Thus, for the purposes of this Discussion Paper, these types of features will be called ‘characteristics of effective programs’.

Having said this however, therapeutic practice elements exist and can be created that specifically target the common factors and the characteristics of effective programs. For example, therapeutic practice elements have been employed for the purpose of enhancing the therapeutic relationship. Commonly known practices employed for this include demonstrating empathy through reflective listening and affirmations, and ensuring that the client’s understandings and preferences are incorporated into the approach through participatory goal-setting, checking-in, and seeking regular feedback.

Some writers might argue that if therapeutic models account for only 15 per cent of the variance in outcomes, while common factors account for up to 70 per cent, is it really worth investing in further refinement of therapeutic practices?

A key point to remember here is that meta-analytic studies provide highly generalised conclusions that apply to the average treatment, the average client population and the average treatment context. All contextual influence is stripped out of meta-analytic data. Hence while therapeutic models may account for an average of 15 per cent of variance in outcomes, the variance may be higher or lower for particular client populations. Many experimental treatment outcome studies are conducted on university student populations, or clients voluntarily attending private clinics for treatment of depression or anxiety disorders. For these populations the nature of the therapeutic model, or the therapeutic elements, may be less (or more) important than for client populations with more complex psychosocial problems to contend with such as adolescents who have experienced neglect and abuse. Within this latter population there may also be variations. For some young people in out-of-home care, formation of a strong therapeutic relationship with a social worker, psychologist or foster carer may be all that is needed to achieve healing of disrupted attachment processes. For others, perhaps those with severe post-traumatic stress and persistently disruptive challenging behaviours, additional therapeutic practices may be necessary to assist the young person onto a healing developmental pathway. At present we do not know the answers to these questions. Further research is needed.

2.2 The practice elements approach

The practice elements approach is grounded on explicit acknowledgement of the fact that effective therapeutic models are comprised of numerous elements that can be identified, specified and employed in different ways. It rejects the assumption that these elements can only be organised and delivered in fixed arrangements specified in EST models (Mitchell, 2011).

While the new model development process has always made use of this fact, it has rarely been explicitly acknowledged, and the implications of this recognition have not been fully realised. The practice elements approach makes a qualitative break with the model development tradition. It does not seek to create new models of therapeutic practice, rather it seeks to place tools for therapeutic practice development into the hands of reflective practitioners so that they can consciously build bodies of therapeutic practice that are tailored to their unique circumstances.

Academic writing describing the practice elements approach began to emerge less than 10 years ago in the mid-2000s. There are two main groups of authors whose work has been influential in sparking adoption of the approach in child, youth and family services.

The first influential papers were published by Bruce Chorpita, Eric Daleiden and John Weisz in 2005. The first of these, published in *Mental Health Services Research* described a method of identifying and selecting practice elements from evidence-based interventions. A second paper published in *Applied and Preventive Psychology* described how selected practice elements can be combined into modules targeting particular psychological processes.

Shortly after this in 2008, Dennis Embrey and Anthony Biglan published a paper in *Clinical Child and Family Psychology Review* coining the term ‘kernels’ to refer to practice elements, defining the concept in depth, and describing a taxonomy of potential kernels (Embry & Biglan, 2008).
The work of Embrey and Biglan is presented here first (Section 2.2.1) because they concentrate more on the key definitional features of the construct of practice elements. This information provides useful background before examining the work of Chorpita, Daleiden and Weisz (Section 2.2.2), which moves more into application. Section 2.2.3 briefly describes the work of several other writers who provide additional nuance to the construct of practice elements. Finally, Section 2.2.4 introduces the idea of modularity in intervention design and explains how this can be applied to common practice elements.

### 2.2.1 Evidence-based kernels

Embrey and Biglan (2008) define a ‘kernel’ as a “behaviour-influence procedure shown through experimental analysis to affect a specific behaviour and that is indivisible in the sense that removing any of its components would render it inert” (p75).

This definition has two features that distinguish Embrey and Biglan’s conceptualisation of ‘kernels’ from Chorpita, Daleiden and Weisz’s conceptualisation of ‘common practice elements’ (see Section 2.2.2 below).

- First the idea of kernels is of a unit that is indivisible. It is the smallest possible meaningful procedure for influencing behaviour.
- Second, there is evidence from experimental research demonstrating the effectiveness of the procedure in influencing a specific behaviour.

The types of evidence included as demonstrating effectiveness are restricted to experimental designs including randomised controlled trials and interrupted time series designs. Most studies have involved the latter because they are easy to implement using a single subject design and can be conducted regularly in routine practice.

Use of the term ‘kernel’ to refer to evidence-based or evidence-informed practice elements was chosen because:

- It has the metaphorical resonance of something organic that influences life or behaviour, like a seed that contains information for growth or change; and
- It is about something very compact and indivisible, because a broken seed will not grow (p77).

Embrey and Biglan (2008) also differentiate kernels from other constructs with which they might be confused. Specifically they note that kernels are distinct from “earlier nebulous” concepts such as “principles of effectiveness”, and “programs”, which are rarely irreducible. “Programs contain many components or kernels, and the loss of a single one enables the program still to have some effect” (p78).

In addition to defining and explaining the roots of the idea of kernels Embrey and Biglan (2008) concretise their account by providing a list of 52 kernels including names, a brief description, accounts of the behaviours affected, and references to studies that have provided evidence of their effectiveness.
The kernels they select are organised into a theoretical taxonomy. This framework specifies four processes (mainly operant conditioning processes) through which kernels exert their influence on behaviour:

- **Kernels that alter consequences for behaviour** – This includes consequences that increase the frequency of a behaviour (e.g. verbal praise) and consequences that decrease the frequency of a behaviour (e.g. time out).

- **Kernels that affect behaviour mainly via antecedents** – Antecedents are conditions or cues that signal that a particular behaviour is required. Commonly understood examples include traffic lights and school bells.

- **Kernels that affect behaviour mainly via relational frames** – Behaviours can be increased by stimuli that begin as intrinsically neutral but which become associated with positive consequences or with something that a person values. For example a child may be told they can stay up for half an hour longer (intrinsically valued consequence) if they collect five stickers. The stickers are awarded for particular desired behaviours. The stickers come to be valued because they are associated with the intrinsically valued consequence. Conversely some behaviours can be decreased by training the person to relate the behaviour to aversive stimuli. For example, messages suggesting that an adolescent’s peers will reject them for smoking may reduce their motivation to use tobacco.

- **Kernels that alter behaviour through physiological interventions** – Examples include deep breathing which has been shown to reduce anxiety, arousal and aggression, and Omega-3 fatty acid which has been shown to reduce violent aggression amongst men.

The 52 kernels presented in Embry and Biglan (2008) are not intended to be exhaustive, they are simply examples that meet their criteria and illustrate their definition of kernels from the four types. They anticipate that a database of kernels will emerge over time.

---

**Some potential limitations of Embrey and Biglan’s kernels**

The kernels are primarily about behaviour management in the here-and-now and their relevance to long term therapeutic care or healing from trauma appear limited. The majority of these behaviour management techniques are most relevant to children and they have less relevance for adolescents and young adults. This is because they are designed to be done to the child and are not very amenable to working with a client in a partnership-based relationship. These behaviour management techniques are widely taught in universal parenting skills programs but are not tailored for use in trauma-informed therapeutic settings.
2.2.2 Common practice elements

The term ‘practice element’ was coined by Chorpita and colleagues who defined it as “a discrete clinical technique or strategy (e.g. ‘time-out’ or ‘relaxation’) used as part of a larger intervention plan” (Chorpita, Daleiden, & Weisz, 2005a; p11).

In this seminal article these researchers describe a Distillation and Matching Model which demonstrates the feasibility of coding and identifying the specific techniques and procedures that make up evidence-based protocols for specific problem areas, thereby producing aggregate profiles that they also refer to as ‘common elements’ (Chorpita, Becker, & Daleiden, 2007; Chorpita & Daleiden, 2009; Chorpita et al., 2005a).

Using the Distillation and Matching model they were able to ‘distil’ a set of 615 different treatment protocols for child and adolescent mental health problems down to a set of 41 different common practice elements (Chorpita & Daleiden, 2009). Further, they were able to demonstrate different frequencies in the use of these elements across protocols targeting different problem areas and youth of different age groups and ethnic backgrounds. This observation supports the ‘matching’ feature of the Distillation and Matching Model to the extent that practice elements can be selected from the pool to match particular client characteristics.

Along very similar lines, Garland and colleagues have also used the term ‘common elements’ (Garland et al., 2008) to refer to the same basic concept. Importantly, they identify four different types:

- Therapeutic content (e.g. problem-solving skills);
- Treatment techniques or clinician strategies (e.g. role-playing);
- Aspects of the working alliance (e.g. affective bond); and
- Treatment parameters (e.g. number of sessions).

They reviewed eight evidence-based programs targeting disruptive behaviour problems in children aged 4-13 years to identify a set of common elements (elements included in at least three different efficacious treatment models), and then refined and confirmed these using an expert consensus process (Garland et al., 2008; Garland et al., 2006). Most of the 21 core common elements identified in this process were consistent with the practice elements identified by Chorpita et al. (2005), lending consensual validity to the overall construct and the specific elements identified for disruptive behaviour problems (Garland et al., 2008).

2.2.3 Theory-based approaches to practice elements

An alternative approach to conceptualising the basic idea of practice elements has evolved from thinking about how and why effective interventions actually work, and in doing so makes use of theory (Moos, 2007, 2008; Murphy, Cooper, Hollon, & Fairburn, 2009; Weersing, Rozenman, & Gonzalez, 2009).

Moos has elaborated the concept of ‘active ingredients’ or ‘common social processes’ that appear to underlie effective psychosocial treatments for, and continuing remission from, substance use disorders...
(Moos, 2007, 2008). Drawing from four different theories commonly used in the substance abuse literature, Moos (2008) defines two or three key social processes that are specified by each of these theories and analyses how these processes may operate as the active ingredients in substance use self-help programs of demonstrated effectiveness, such as 12-step groups.

Examples of such active ingredients include structure and monitoring (from Social Control Theory), observation and imitation of prosocial norms and models (Social Learning Theory), involvement in protective activities (Behavioural Choice Theory), and developing effective coping skills (Stress and Coping Theory).

Murphy et al. (2009), also using a theory-based approach, describe several ‘procedural elements’ comprising Cognitive Behaviour Therapy for eating disorders (i.e. a weekly weighing procedure, a regular eating procedure, dietary rules, and a body shape checking procedure). Using CBT, they explain how these procedural elements can be predicted to affect specific psychopathological processes (cognitive distortions and maladaptive behaviours) thought to be central to eating disorders.

Murphy et al. also observe that in usual practice most psychological treatments are tailored to the individual client’s psychosocial issues, circumstances, and progress at making change. They demonstrate how procedural elements can be selected based on an assessment of the relative importance of each process for a client at different points in time.

### 2.2.4 Practice elements and modularity

Chorpita, Daleiden and Weisz (2005b) make a clear distinction between practice elements and modules. Practice elements are defined purely in terms of the content and techniques of therapeutic interventions; the concept implies nothing about the overall design or structure of an intervention in terms of how practice elements are combined. They can be combined equally well within integral or modular designs.

However, modularity in treatment design is greatly assisted by the definition and use of practice elements. “[A] module is best thought of as a structured ‘container’ that can contain one or more practice elements” (Chorpita et al., 2005; p145). Because modules are distinguished by functionality, a module would contain practice elements that theory or practice wisdom suggests will add value to one another in achieving specific functions or therapeutic purposes.

Scholarly analysis of the variety of ways in which practice elements could be configured within modules is only just beginning to emerge. Two examples of how this might be done are described by Mitchell (2012) in her discussion of how a modular practice elements approach could help design more client-centred interventions for young people with multiple and complex needs.

One type of module can comprise elements that are drawn from the same therapeutic model and are already well established as sequential steps. An example of this is ‘Problem solving skills training’ (from Cognitive Behaviour Therapy), which includes the following elements: ‘Define the problem’, ‘Generate several alternative solutions’, ‘Decide on one solution’, ‘Try out the chosen solution’, and ‘Evaluate the outcome’. This and similar modules are described in the manual of the Adolescent Community Reinforcement Approach (Godley, Meyers, et al., 2001).

A second type of module could comprise elements drawn from a wide variety of different therapeutic models. For example, elements such as ‘Active and reflective listening’, ‘Collaborating with the client’, ‘Rolling with resistance’, ‘Affirmative statements and positive reinforcement’, ‘Joining or establishing a common language’ and ‘Reciprocal communication style’ could be combined into a module with a name such as ‘Engagement’, ‘Joining forces’, or ‘Building a working relationship’. These elements are drawn from Motivational Interviewing, Solution Focused Therapy, and Dialectical Behaviour Therapy.

They all contribute to the same therapeutic intention, but they do so in subtly different ways. Different elements within such a module could be used with different clients depending on their preferred communication style, and at different times depending on the specific engagement and relationship challenges that emerge over time.
2.2.5 Summary

Each group of scholars that has worked on the idea of practice elements has highlighted different features of the construct that all have value in a practice setting. There are also some unifying similarities.

Common or shared points are that complex interventions are comprised of smaller parts that can be identified and precisely described, and which are meaningfully related to equally describable behavioural and psychological processes.

Both the ‘kernels’ elaborated by Embry and Biglan, and the ‘common practice elements’ elaborated by Chorpita, Garland and their colleagues have been identified using a highly empirical approach. Moos and Murphy have explored the same idea from a theoretical perspective.

Chorpita and colleagues demonstrate the practical utility of describing precise, objectively observable clinical techniques and strategies. Using operant conditioning theory Embry and Biglan elaborate a typology of mutually exclusive behavioural elements. Garland and colleagues draw attention to the distinction between elements defined by content (e.g. problem-solving skills) and elements defined by techniques (e.g. role-playing) that can be applied to a wide variety of content-based elements. The content-based elements refer to underlying psychological processes. Moos’ work underscores the importance of understanding these processes and demonstrates how they can be robustly and precisely described using theory. Murphy et al. demonstrate how understanding the connection between underlying psychological processes and practitioner strategies can help practitioners to select the practice elements that are needed by particular clients at particular times. Finally, Chorpita, Daleiden and Weisz (2005b) introduce the idea of how practice elements can be combined into groups or modules to build a logically coherent series of interventions. Taking this idea further, Mitchell (2012) illustrates two different ways in which modules could be constructed and explains how a modular practice elements approach could help practitioners design interventions that are tailored to the unique characteristics of individual clients with highly complex needs.

2.3 Rationale for the use of practice elements

The key factors driving the uptake of the practice elements approach within child and family services is a concern to increase the use of evidence-informed therapeutic practices combined with recognition that traditional approaches to disseminating evidence-based practice have yielded very slow progress in these settings (Mitchell, 2011).

Over the past 10-15 years a growing body of research in the field of implementation science has identified and described a range of powerful barriers to the implementation of EBP, particularly EBP in the form of manualised programs or Empirically Supported Treatments (ESTs). Much of the relevant research has been conducted within behavioural health services for children and young people. Authors who have explored the utility of practice elements in scholarly work and in practice have noted that the practice elements approach may help overcome some of the most potent barriers.

Understanding these barriers is important to understanding the potential benefits of the practice elements approach. In her review of this literature Mitchell (2011) described barriers within five categories:

- Attitudes of practitioners
- Characteristics of client populations
- Characteristics of usual practice
- Organisational factors
- Resource availability
2.3.1 Barriers to the implementation of evidence-based practice

Attitudes of practitioners

Implementation researchers have found the attitudes of service providers to be crucial to successful EBP implementation (Aarons & Palinkas, 2007; Garland et al., 2008; Garland et al., 2006; Garner, 2009; Godley, White, Diamond, Pasetti, & Titus, 2001; Stirman, Crits-Christoph, & DeRubeis, 2004). Treatments found to be efficacious in controlled research settings are often perceived as impractical in real-world settings (Aarons & Palinkas, 2007) and there is pervasive scepticism about the clinical value of much of the literature, particularly for ESTs (Garland et al., 2006). One of the most commonly cited criticisms of ESTs is that they have been developed for and tested with client populations that are relatively simple and homogeneous (e.g. adolescents aged 12-18 with depression or children aged 4-8 with conduct disorder) (Larner, 2004; Weisz et al., 2006). Practitioner attitudes are particularly negative towards highly structured ESTs, such as session-by-session-based manuals, because they are perceived as less flexible and more difficult to tailor to individual needs (Aarons & Palinkas, 2007; Garland et al., 2006; Godley, White, et al., 2001). Manual-based ESTs have been criticised as lacking spontaneity and flexibility, thereby interfering with building rapport and development of a good therapeutic relationship (Ahn & Wampold, 2001; Weisz et al., 2006).

Characteristics of client populations

Practitioner perceptions about client characteristics exert strong influence on their attitudes towards and use of particular ESTs. One of the strongest themes emerging across several studies is that evidence-based treatment programs have limited appropriateness for children and families with multiple and complex needs. Practitioners report needing to deal with other issues before they can attend to the EST (Aarons & Palinkas, 2007) and that a lot of flexibility is needed in the use of treatment manuals when families are in a lot of chaos and experience psychopathology and conflict not covered in the manual (Godley et al, 2001). These same authors also found that therapists reported deviating from the manual due to adolescents’ cognitive abilities being insufficient to follow the manual, and a lack of cooperation.

Characteristics of usual practice

Successful implementation of EBP may be helped or hindered by characteristics of practice approaches regularly used in service settings. There has been little research directly examining this question, but several hypotheses can be discerned.

It is possible that practice cultures that place high value on clinical freedom, autonomy and eclecticism will be less receptive to EBP, particularly the EST model. Surveys have found that the majority of clinicians identify their theoretical orientation as eclectic and that clinical freedom is highly valued (Garland et al., 2006).

A related hypothesis is that practice frameworks with a client-centred approach may be less receptive to EBP, at least the EST approach that emphasises fidelity to treatment models. Critics of ESTs, Miller and Duncan (2000) argue for a client-directed as opposed to a model-driven approach to clinical work, based on their claim that factors common to all therapeutic modalities account for 85 per cent of the variance in outcome and that the additional benefit of any particular approach depends on client acceptance. A recent observational study of clinician behaviour found that although child therapists treating anxiety and depressive disorders use a wide variety of modalities, they generally favour client-centred approaches (McLeod & Weisz, 2010).

Compatibility of an innovation with existing practice is one of five core factors that Rogers’ Diffusion of Innovation Model posits as predicting the rate or success of diffusion at an organizational level (Stirman et al., 2004). Aarons and Palinkas (2007) report that, for practitioners in child welfare services, an initial reluctance to implement a new evidence-based treatment was overcome when they realised it helped to provide structure to existing practice.
Organisational factors

Organisational cultures characterised by openness, learning, flexibility, risk tolerance and external orientation are more receptive to change and innovation and achieve higher performance (Cooke & Szumal, 2000; Gordon & DiTomaso, 1992; Mannion, Davies, & Marshall, 2005; Ogbonna & Harris, 2000). Research in mental health services has found that open, ‘constructive’ cultures are associated with more positive provider attitudes towards EBP (Aarons & Sawitzky, 2006; Chaffin, 2006).

Organisational climate refers to workers’ perceptions of, and emotional responses to, their work environment. Studies of organisational climate in services for children and youth have found a positive climate to be associated with better outcomes (Glisson & Hemmelgarn, 1998) and a negative climate to be associated with perceptions of greater divergence between EBP and usual care (Aarons & Sawitzky, 2006). ‘Climate’ can also refer to perceptions of the extent to which a practice, innovation or change is supported by management or the organisation. A ‘climate’ of management support for quality has been found to be associated with more use of EBPs in youth justice services (Henderson et al., 2008).

Transformational and transactional leadership have both been associated with more positive provider attitudes towards EBP (Aarons, 2006). Rosenberg (2009) argues that leadership is essential to effective implementation of EBP in behavioural health services, but that absolute consensus is not. She explains the role of leadership as demonstrating preparedness to stay the course through setbacks and despite uncertainty and negative attitudes.

Resource availability

Implementation of manualised programs (ESTs) generally demands extensive training of practitioners and ongoing support such as clinical supervision, secondary consultation and case reviews (Aarons, Sommerfeld, & Walrath-Greene, 2009a; Fixsen, Blase, Naoom, & Wallace, 2009; Henderson et al., 2008; Maierhofer, Kabanoff, & Griffin, 2002; McHugh & Barlow, 2010). Attending a workshop or completing an online course does not yield sufficient expertise to deliver an evidence-based program (Toth & Manly, 2011). To achieve sustained implementation, workforce development strategies need to be supplemented by adequate incentives, material resources, administrative support, and changes in organisational procedures and structures (Fixsen et al., 2009). These forms of capacity building demand long term investment of funds and other resources (Kazak et al., 2010; Liddle et al., 2006; McHugh & Barlow, 2010; Stirman et al., 2004).

Henderson et al (2008) found that greater availability of resources was associated with more use of EBPs in adult and youth justice programs. A recent study of the views of stakeholders in public mental health services found that perceptions of resource availability (including the costs of EBP, funding availability, staffing resources, and staff development and support) were rated among the most important factors affecting EBP implementation (Aarons, Sommerfeld, & Walrath-Greene, 2009b).

A key resource limitation for child and family health and social care services is workload. Caseloads as high as 100 children, all with complex family situations, have been reported in the literature on evidence-based interventions targeting prevention of child maltreatment (Toth & Manly, 2011). The demands accompanying such caseloads limit the ability of even the most dedicated practitioners to learn new models.

2.3.2 Potential benefits of a practice elements approach

The barriers to the uptake of empirically supported treatments and manualised programs outlined above are powerful and pervasive. Many researchers have observed that progress in the implementation of evidence-based practice in child and family health and social care services has been painfully slow. A turn towards evidence-informed practice characterised by greater emphasis on the use of therapeutic practice elements has the potential to increase use of empirically and theoretically supported interventions within these services.
The evidence-base for the use of a practice elements approach is only just beginning to be built. Currently this approach may be most accurately aligned with the notion of evidence-informed practice. For the purpose of the current analysis evidence-informed practice is defined as practice informed by the integration of five sets of considerations:

- Evidence from empirical research;
- Theory;
- Practitioner experience and perceptions;
- Client characteristics and values, and
- Organisational context.

The following series of points explain how the practice elements approach might be expected to overcome the documented barriers to EBP identified in the implementation science literature. As described in Section 2.3.1 above, these barriers largely derive from the latter three sets of considerations for evidence-informed practice (practitioner experience and perceptions; client characteristics and values; and organisational context). Practice elements address these three sets of considerations directly. This material is adapted from (Mitchell, 2012a).

**Individual tailoring**

By breaking interventions into small elements, practitioners and clients are better able to choose therapeutic content that addresses individual needs and therapeutic techniques best suited to the skills and style of the worker and the nature of the relationship. Content and techniques can be more readily selected and organised according to the personal goals of a young person and their developmental stage (Barth et al., 2012; Garland et al., 2008; Moos, 2007; Murphy et al., 2009).

If a practitioner is using a manualised program in their work with a young person, discrete practice elements can be added at relevant points whenever challenging issues arise that are extraneous to the program. Alternatively, a number of pre-packaged modules (comprising several elements) could be selected, or new bespoke modules formulated especially for the client. Particular modules or elements within them can be used for as long as, or on as many occasions as necessary.

**Ready integration with existing practice**

Implementing a whole new evidence-based program across a service setting generally involves displacing a substantial amount of the practice that was in place previously. A large amount of practice change is needed. This puts substantial burden of change management upon the practitioners as well as supervisors and other managers. This process can also risk stimulating resentment from practitioners who value practices that are being displaced or deemphasised.

Rather than attempting to replace existing practice, the modular practice elements approach provides a way of building on the strengths of existing practice through incremental enhancement (Chorpita et al., 2007; Garland et al., 2008).

Because they each involve only a small number of techniques and a discrete selection of content, practice elements (on their own or combined into modules) can be readily added to existing practice approaches or adjusted as the need arises (Southam-Gerow, Hourigan, & Allin, 2009). Of course the intention is that more effective evidence-based practice elements will eventually replace practices that are less effective. However, because practitioners have a high degree of control and choice in which practices they adopt and when they use them, they can pace this transition according to their capacity. Ensuring worker control over the change process helps to minimise stress and overload.

Following Rogers (1995), Embry and Biglan (2008) point out that people are more likely to adopt and use a new practice if it is simple, easily tested, and offers advantages over existing practice with effects
that are easily observable. Consistent with this they observe that most of the kernels they describe consist of simple, low-cost activities that are easily tested because it is usually possible to observe their immediate impact on a person’s behaviour.

**Amenable to varied modalities**

Most ESTs are designed for use in highly structured modalities, such as a series of one-on-one, family, or group-work sessions. In contrast, many of the agencies serving children and young people with complex needs rely on varied modalities. Out-of-Home Care services in Australia offer services through residential units, home-based care, and office-based meetings. Youth AOD services are offered through outreach, day programs, acute residential and long-term residential rehabilitation.

Within these service modalities, opportunities for psychotherapeutic work are built into and interspersed with other activities and interaction; the shape of these opportunities is highly variable. Furthermore, each child, adolescent or family connects with services for variable amounts of time; few are offered structured counselling sessions by practitioners within the sector. This diversity of modality presents significant barriers to the implementation of structured, session-by-session manualised programs.

In contrast, the modular practice elements approach is amenable to diverse modalities. Because of their small size and interchangeability, one or several practice elements can be selected and used whenever opportunities arise. For example, elements comprising social skills training, problem-solving and emotion regulation skills training can be built into everyday domestic activities in a residential setting, or modelled and practiced with foster carers during visits from support workers.

**Cost efficiencies in training and support**

If an agency was to adopt evidence-based practice for managing several different problems in the form of manualised programs, they may need to adopt several different such programs. For example three different programs may be needed targeting issues such as parenting skills for foster parents; managing anger in children aged 8-12; and preventing and managing depression and anxiety in teenagers.

Implementation of such programs to a high level of fidelity would require training and supervising a critical mass of staff, and in many agencies a substantial proportion of practitioners (e.g. those who carry diverse caseloads) might require training in all three.

Even though it is helpful to revise and update our skills regularly, this approach to professional development is costly and not optimally efficient. Training in evidence-based manualised programs frequently requires staff to take significant blocks of time away from regular duties. There can also be substantial duplication as participants are re-taught skills they already have.

In contrast, a modular practice elements approach may offer significant efficiencies because, like the therapeutic content itself, the professional development can be more readily tailored to the characteristics of the learners. Rather than training and supervising staff in multiple elaborate ESTs, training can focus on practice elements that are missing from, or underdeveloped within, the skillset of workers within particular service settings (Chorpita et al., 2007).

Modularity also allows much more flexibility in the allocation of resources to training and support. Effective introduction of a new integral EST demands large sums upfront. In contrast, after practitioners have been introduced to the overall modular system and trained in a core set of modules, introduction of new modules is not a major undertaking (Southam-Gerow et al., 2009). By working with smaller chunks of training material, workforce development investment can be spread out more easily, or scaled and timed more readily according to funding, readiness and need. Smaller chunks of content are also likely to be learned more easily and comprehensively because they can be readily digested and more quickly integrated into practice.

Embry and Biglan (2008) argue that kernels can also help reduce costs because most are in the public domain, their use is not restricted to a place in a sequence of sessions documented within copyrighted
programs, and there is no need to purchase expensive program manuals and training materials. For this reason, they suggest, training in their use can be accomplished simply and cheaply by defining and modelling.

Sensitivity to context

Within large organisations different service units often vary in the type and amount of therapeutic care they provide to clients and the skills and expertise of staff to deliver evidence-based or evidence-informed practice. In some settings or modalities of service delivery, practitioners have the need and opportunity to provide a relatively large amount of sophisticated therapeutic input through their interactions with clients. In other settings staff may be able to deliver a high quality service using basic foundational skills.

With the modular practice elements approach, service units can select groups of practice elements or modules that are particularly suited to the modalities of service offered, the needs of clients in those settings (Chorpita, Daleiden, & Burns, 2004; Chorpita, Daleiden, & Weisz, 2005b), and the skill sets of their staff members. As contextual factors and needs shift, practice elements can be added, subtracted or enhanced. This is not easily done with integral programs (unless they are broken down into smaller components).

Even if an organisation decided to implement three or four different evidence-based programs, and to offer training to only those staff falling below a specified level of expertise, this may still not be sufficiently flexible to ensure that practitioners are supported in the most important areas of skill development. There would still be many areas of practice relevant to the needs of children and young people in Out-of-Home Care that are not covered by these programs.

Embry and Biglan (2008) argue that one of the key uses of ‘kernels’ is to fill in the gaps around programs. For example kernels addressing issues of concern can be added to programs or integrated into other daily routines in the organisational context. They also argue that the reach and generalisability of programs could be extended by teaching kernels drawn from these programs to a wide range of people in regular contact with young people (behaviour influence agents) who can use them on a regular basis.

Evaluation and continuous quality improvement

Usual care is poorly described and its components poorly understood (Weisz et al., 2006). What we do know is that it is very eclectic – practitioners use a broad array of interventions (Garland et al., 2006; Lyon, Charlesworth-Attie, Vander Stoep, & McCauley, 2011; McLeod & Weisz, 2010) - and that it is sometimes just as effective as new evidence-based treatments (Weisz et al., 2006). The key word here is ‘sometimes’. There is much variability in the quality of care across settings. Without knowing more about what is delivered, when and how often, it is very difficult to know how far removed usual practice is from evidence-based or evidence-informed practice.

In the real world where few practitioners adopt and adhere to a single model of practice, simply listing and endorsing a set of such models does not provide adequate guidance. Nor does it help us monitor or evaluate for the purpose of practice improvement.

Defining a set of evidence-informed modules and practice elements that are widely agreed to be appropriate for use within particular types of practice setting (e.g. residential care, youth AOD services etc) can provide a very valuable platform from which to begin the task of describing usual care. Many practitioners, particularly those who work with young people and who lack higher qualifications, have difficulty describing their practice. Clarifying the type of practice aspired to, in concrete terms and with precision would provide practitioners with a language to describe their work, and a set of benchmarks with which to systematically explore the extent to which current practice is consistent with best practice.

---

5 While this is true, it will still be necessary to define and describe the practice elements to be used in any particular setting, and organisations need to invest in making this material available in an accessible and digestible format for their workforce.
Discussion of these issues can be used to identify practice elements that need to be introduced, developed or dropped. Informed revision of training and organisational support can be undertaken.

Interagency collaboration

Increasingly, practitioners in Out-of-Home Care are being asked to work collaboratively with practitioners in other sectors such as mental health, alcohol and other drugs, and youth justice.

There is little guidance in the evidence-based practice literature to help service planners design collaborative practice approaches for supporting the delivery of evidence based interventions across multiple service settings. Factors such as professional values, philosophy and organisational culture that differ across sectors are likely to be major barriers to design of integrated practice models unless ways can be found to recognise and accommodate different contributions.

Defining evidence-based practice solely in terms of whole programs does not provide any assistance here. Services within particular sectors are likely to adopt programs that are closest to their core business, and if the roles of different sectors are well differentiated, they are likely to adopt different programs. For example, mental health services are more likely to adopt programs that provide effective treatment for common mental disorders such as depression or anxiety disorders, while youth justice services are more likely to adopt programs that are known to reduce offending behaviour. There is actually some overlap in the cognitive-behavioural content contained within such evidence-based programs targeting these issues, but these overlaps are not transparent to program users, and may be missed even if two services offering such programs share clients.

At the system level, a common language around practice elements could be used to build shared understanding of the interventions that are unique to a particular service or shared across multiple services. This will help clarify points in a client’s journey at which referral versus collaborative care are indicated.

2.4 Limitations of practice elements

Limitations in the domains of impact

As with most evidence-based programs, practice elements only target individuals and families, they do not address directly structural risk and protective factors (Axford & Morpeth, 2013). As such, practice elements as currently conceived are primarily ‘therapeutic’ in nature. For Axford and Morpeth (2013) this means that without wider structural reforms (e.g. those addressing unemployment or housing affordability), ‘evidence-based practices’ will always be swimming against the tide in the efforts to improve child wellbeing.

It is conceivable however that the practice elements approach could be extended to include practices targeting communities such as building community connectedness. Modules of elements could be packaged together to address factors such as ‘developmental relationships’ (Li & Julian, 2012) and ‘nurturing environments’ (Biglan, Flay, Embry, & Sandler, 2012). Also, Axford and Morpeth (2013) point out that ‘evidence-based practices’ can contribute to narrowing the gap between children in greatest need and their peers, because children with the most serious problems often make the largest gains (Tolan, Gorman-Smith, & Henry, 2004).

Practice elements cannot stand in isolation

Many workers in child, youth and family services have low levels of training, and are relatively young and inexperienced. Practitioners who are less able need and appreciate more explicit guidance, and this can be provided in carefully constructed programs (Axford & Morpeth, 2013; p273).

In themselves, practice elements do not help workers to choose the right practices to use with particular types of clients, in the right circumstances. Manualised evidence-based programs do help with this. For organisations with highly diverse client needs and a relatively low skilled workforce, however,
manualised programs may not be suitable or sufficient. In these circumstances common practice elements may provide a feasible alternative, but it is not sufficient to merely provide the workforce with detailed descriptions of the practice elements. Ways need to be found to provide guidance about when, where, who with and how to use them.

Fortunately, researchers in the common practice elements space are beginning to develop and describe decision support processes and resources (Chorpita, Daleiden, & Collins, 2014).
3. Australian and international application of the common practice elements approach

3.1 The Stronger Families Project 2009-2011

This work took place within a project originally called Stronger Families: A blueprint for family support intervention.

3.1.1 The project context

The Stronger Families Project involved collaboration between the North East Metro Child and Family Services Alliance (the CSO Alliance or NEMC&FSA) and the Parenting Research Centre.

The NEMC&FSA is a partnership involving nine CSOs, or ‘integrated family services providers’ and the Department of Human Services, including Child Protection, in the North and West Metropolitan Regions of Melbourne. Established under the Victorian Child Welfare legislation reforms in 2007, it covers the North East DHS Catchment areas including the LGAs of Banyule, Darebin, Nillumbik, Whittlesea and Yarra. Berry Street is a member of the Alliance.

The Parenting Research Centre is Australia’s only independent national centre dedicated to research and development in parenting support.

The project was funded for 2 years from 2009 to 2011 by the Ian Potter Foundation ($70,000) and the Department of Human Services ($24,650), and the Project Manager was Julie Boffa.

The target client population was approximately 4,500 vulnerable families referred to the $4.7 million Family Services programs of member CSOs, and more specifically, 1250 allocated to intensive casework over the three year framework the project was originally envisaged as running. Most of these families were referred for reasons of chronic neglect of a child or children. These families had often been referred to family services or Child Protection a number of times, and had made sufficient progress for children to remain in their care, but were unable to sustain the change over time.

Project tasks were to: (1) document current practice; (2) research alternative models; (3) identify a blueprint for effective intervention to improve the life chances of the children; (4) support workers to implement the intervention model, and (5) evaluate the impacts.

3.1.2 Conceptual work

Stronger Families was the first project of this nature undertaken in Victorian Family Services. For this reason a considerable amount of conceptual work was required to clarify the parameters of the work.

One of the foundational concepts addressed was the difference between ‘programs’ and ‘practices’ (see Progress Report, p2-3). Programs were defined as “an agreed series of features that, if implemented in a clearly prescribed way, will lead to a particular effect or effects. All stages – the required features, the implementation and the effects – are documented and supported by research evidence” (Progress Report, p2).

In describing the rationale for the approach taken several problems were noted with the nature of the research evidence in terms of its relevance to the Victorian child protection context. Most importantly it was noted that research about evidence-based practice focuses primarily on ‘programs’, and the ‘programs’ supported by research evidence in the child and family welfare field mostly target only specific sub-groups or problem types.

In contrast to this, Victorian Family Services have a very wide client base, with a very wide range of presenting problems and circumstances. The target population for this project specifically were families with a multiplicity of complex issues including a mix of mental illness, family violence, disability, sexual assault, emotional and behavioural difficulties and disrupted development in children, coupled with family and social factors such as isolation, poverty, inadequate or unstable housing, under-developed parenting skills. In addition the practitioners represented by the Alliance are very diverse in their occupations and skill set.
Given this it was recognised that no single program would suffice in the quest to bring more evidence-based interventions to the target population.

With advice from the Parenting Research Centre the project turned away from programs and based on the work of Embry and Biglan (2008) the project assumed a focus upon ‘evidence based practices’, ‘kernels’ or ‘active ingredients for change’ that can be identified across many successful programs, but which unlike programs, can be applied across a diverse range of client groups and circumstances.

In its work across Australia, the PRC has established a database of such ‘kernels’ associated with successful outcomes when working with families, including the highly vulnerable and complex families of most concern to the North East Metro Child and Family Services Alliance. The PRC criterion for inclusion in the ‘kernel’ database is that the practice be supported by more than one program that is empirically validated or supported by meta-analysis or systematic review. However, some practices are also included on the basis of extensive clinical support and widespread application.

The Stronger Families Project team also noted that evaluations of programs, and the assessment of outcomes, frequently exclude clients who don’t complete programs, while these are in fact the very clients of most concern to Family Services, and this project. Because of this it is vital for practitioners to consider and incorporate processes such as proactive efforts at engagement and the building of a therapeutic relationship.

The overall assessment was that research evidence alone is not sufficient to inform the design and implementation of interventions fit for context. Hence, the project moved towards a more integrative approach to evidence, known as ‘evidence-informed practice’ and defined as “[c]urrent best evidence combined with the knowledge and experience of practitioners and the views and experiences of service users in the current operating environment” (Mildon, Bromfield, Arney, Lewig et al, 2012).

### 3.1.3 Contextual work

Consistent with recognition of the need to design a strategy that was sensitive to context, including practitioner views and client characteristics, the work program in the next stage focused on several tasks aimed at better understanding these contextual factors, and clarifying the outcomes to be achieved. Some of this work was also intended to contribute to evaluation of change.

**Audits of client profiles and engagement outcomes**

This work took place alongside but independently of the Stronger Families Project with the data from the audits informing the Project goals. The 2010 audit of families’ engagement outcomes that was undertaken across the NEMC&FSA, led to the development of a coding system to categorise different levels of family engagement. This was then incorporated in routine practice, with data returned 6 months after families were allocated to a team. An earlier audit examined a structured sample of 42 cases referred to North East Child FIRST between April and December 2007. Both audits also collected data about the range of problems experienced, reasons for seeking help, child protection involvement and referral sources. These data served to document the multiplicity and complexity of the needs of the target population. In combination with this, the engagement data helped to build a picture of how clients with different kinds of issues moved through the system after initial referral.

**Foundations of an outcome measurement framework**

A system to measure outcomes was initially prioritised as part of the Stronger Families Project due to recognition that regular structured feedback (a) contributes to positive impacts for clients, and (b) is necessary to ensure that current and emerging practitioner and client experience are able to be integrated into ongoing evidence informed practice development. The intention was to build upon
existing data collection as much as possible including the data collected in the DHS Family Services database (‘IRIS’), and to pass the minimal ‘common sense’ test as described by Friedman (2005). Three main domains of outcome were anticipated:

i. Engagement – using the family engagement audit coding system

ii. Client experience – a number of tools were mooted including the Session Rating Scale (SRS) and the Outcome Rating Scale, or the Strengths and Stressors scale.

iii. Goals reached – using data currently collected in the IRIS database

Some data on engagement and goals reached were collected and collated centrally but the full outcomes framework was never completed or implemented. Such an exercise would have required organisational commitment and substantial investment of time from staff to systematically record the information. At the time the Stronger Families Project was being conducted there were very heavy demands on the time of staff and a shortage of Team Leader level staff. Moreover, there was not agreement across the nine members of the CSO Alliance about the introduction of a common assessment tool as would be required to achieve Step ii above. This additional work was deemed beyond scope and the capacity of existing resources.

Knowledge exchange

Project partners from the Parenting Research Centre (PRC) met several times with Team Leaders and senior practitioners to gain an understanding of current approaches to intervention and the views of these practitioners about ‘what works’.

At the same time the PRC conducted a detailed literature search and review of the evidence for parenting interventions. This review, funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs, was also used to contribute to other projects of the PRC. It was published in 2012 (Wade, Michelle, Falkiner, Devine, & Mildon, 2012).

At the end of this initial process a full day Practice Workshop known as Model Development Day was held in March 2010 to scrutinise and select evidence from the review that was most applicable to the Stronger Families Project context.

3.1.4 Selecting the evidence informed practices

The Model Development Day identified a number of practices supported by research evidence as active ingredients for change common across Victorian child welfare programs. This list was refined by further scrutiny in the light of evidence and further consideration of priorities in the context of the Stronger Families project.

The key question informing this analysis and selection process was ‘What can we do to help children when parents don’t change?’ However, many of the evidence informed actions (EIAs) selected involved practices that are meant to be performed by parents or persons in alternative parent-like roles.

It was not envisaged that the evidence informed actions (EIAs) would provide a comprehensive list of all practices, but rather provide “detailed support in high impact areas most likely to affect outcomes” (Progress Report, p8).

An important set of parameters used to guide thinking about the evidence-informed actions was the list of Family Services roles. These were developed internally by the project Steering Group. There was a process of internal consultation and external consultation with a panel of sector experts. These role categories are outlined in Table 3.1a.

In addition to considering the evidence-base and scoping the role categories, a set of principles or considerations was articulated to inform selection of EIAs. These specified that the EIAs must:

- Be achievable and realistic – for the workforce to implement within existing resources.
• **Complement existing theory and practice** – evidence informed actions complement but do not replace a body of existing theory and practice wisdom that guides the work of family services.

• **Recognise the importance of the worker-client relationship** – as the strongest predictor of positive change.

• **Provide for diversity and flexibility** – professional judgement is key to deciding when and what evidence-informed actions to use in practice with families.

### Table 3.1a Family Services role categories

<table>
<thead>
<tr>
<th>Role Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establishing and sustaining relationships with families</td>
<td>Nurture motivation to change, join with the family, build trust, hold hope.</td>
</tr>
<tr>
<td>2. Agreed roles, goals and feedback</td>
<td>Clarity of roles and purpose, feedback driven assessment(^6), documenting strengths</td>
</tr>
<tr>
<td>4. Practical support</td>
<td>Material aide, immediate supports, referrals and advocacy.</td>
</tr>
<tr>
<td>5. Strengthen inclusion and healing</td>
<td>Family, community and professional connections, counselling, multi-agency work.</td>
</tr>
<tr>
<td>6. Emotional support</td>
<td>Strengthen positive self-attitudes and activities, demonstrate warmth.</td>
</tr>
<tr>
<td>7. Helping parents provide physical and emotional safety</td>
<td>Interface with specialist focused services, safety plans</td>
</tr>
<tr>
<td>8. Unravel blocks to change</td>
<td>Personal, inter-generational, systemic, organisational</td>
</tr>
</tbody>
</table>

Most of the 8 role categories listed in Table 3.1a are well established areas of practice that sit outside of the relatively recent concern with evidence-based practice. For example the work of ‘establishing and sustaining relationships with families’ is best understood as addressing one of the ‘common factors’ (see Section 2.1.3), while ‘providing practical support’ is a well-established role in all social work and welfare settings. Evidence-informed actions in the sense of kernels or practice elements (or at least the ones that have already been documented) are particularly relevant to the roles of ‘multi-modal developmental guidance’, ‘emotional support’, and ‘unravelling blocks to change’. The extent to which practice elements can be applied to the other role categories is presently under exploration.

The evidence-informed actions selected by the Stronger Families Project were drawn from a database of kernels that the Parenting Research Centre was beginning to develop at the time. This database included the 52 kernels of Embry and Biglan (2008) and the 41

### Table 3.1b Evidence Informed Actions (EIA) of the Stronger Families Project

<table>
<thead>
<tr>
<th>Category</th>
<th>Name of evidence-informed action</th>
<th>Rationale and other details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Underlying skills of the Evidence Informed Actions</td>
<td>1 OARS</td>
<td>Open ended questions, Affirmations, Reflective listening, and Summaries</td>
</tr>
<tr>
<td></td>
<td>2 Observe, practice, feedback</td>
<td>Active teaching strategies to support development of new skills</td>
</tr>
<tr>
<td>2. Strengthening engagement and motivation to change</td>
<td>3 Readiness to change</td>
<td>Probes and scales parents’ belief about capacity to change</td>
</tr>
<tr>
<td></td>
<td>4 Agenda menu</td>
<td>Pictorially-based items (housing, parenting etc) to assist priority setting</td>
</tr>
</tbody>
</table>

\(^6\) Assessment in collaboration with the family during which conclusions are fed back, reviewed and changed.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Time sequencing</td>
<td>Looking back &amp; looking forward to envisage living out desired values</td>
</tr>
<tr>
<td>6 Decisional Balance Table</td>
<td>Examines pros and cons to change to assist in identifying client goals</td>
</tr>
<tr>
<td>7 Values Card Sort</td>
<td>Explores client’s vision of a better future</td>
</tr>
<tr>
<td>8 Appointment reminders</td>
<td>To decrease attrition rates</td>
</tr>
<tr>
<td>9 Problem list</td>
<td>Record all clients’ concerns in clients’ own words to better understand their needs</td>
</tr>
<tr>
<td>10 Creating S.M.A.R.T. goals</td>
<td>Simple realistic goals increase motivation to change. The SMART acronym helps a client remember the features of well-designed goals</td>
</tr>
<tr>
<td>11 Goals - 4Ws – What; Who; When; How well</td>
<td>Helps create very specific goals so that progress towards them can be assessed</td>
</tr>
<tr>
<td>12 Continuous (spoken) feedback</td>
<td>Regularly encouraging the client to comment on the content &amp; process of the interaction promotes engagement and confidence</td>
</tr>
<tr>
<td>13 Continuous (written) feedback</td>
<td>Using scales to track a client’s progress</td>
</tr>
<tr>
<td>14 Continuous written feedback SCALES</td>
<td>Uses Session Rating Scale to track therapeutic alliance, and Outcomes Rating Scale to track perceived benefits</td>
</tr>
<tr>
<td>15 Teachable moments</td>
<td>Using opportunities that arise in everyday activities to extend a child’s knowledge and skills</td>
</tr>
<tr>
<td>16 Following your child’s lead</td>
<td>Watching the child and responding to what she says or does in a meaningful way. Helps build confidence and trust</td>
</tr>
<tr>
<td>17 Listening, talking and playing more</td>
<td>Encourages language development by making language fun</td>
</tr>
<tr>
<td>18 Descriptive praise</td>
<td>Making a positive statement to someone about something they did that you liked</td>
</tr>
<tr>
<td>19 Effective Instruction Giving</td>
<td>When instructions are given well they are more likely to be followed</td>
</tr>
<tr>
<td>20 When-Then commands</td>
<td>Motive a child to behave in a particular way by presenting a positive consequence for that behaviour. Increases independence, reduces need to threaten</td>
</tr>
<tr>
<td>21 Engaging an infant</td>
<td>Teaching parents the benefits of smiling at their infants encourages reciprocal and interactive communication</td>
</tr>
<tr>
<td>22 Three houses exercise</td>
<td>Child draws or writes in House of Good Things, House of Worries; House of Dreams. Aides in safety planning and goal setting</td>
</tr>
<tr>
<td>23 Safety House</td>
<td>Engages child in making themselves safe in situations where they have previously been abused or at risk</td>
</tr>
</tbody>
</table>

Practice elements distilled by Chorpita and his group using their Distillation and Matching Model. The Stronger Families Project chose 23 ‘evidence informed actions’. These are shown in Table 3.1b (above). They are organised into 5 different categories.

### 3.1.5 Implementation

The 23 evidence-informed actions listed above were each written up in a Practitioner Guide named ‘Helping Families Change: Evidence-Informed Actions’ prepared by the Parenting Research Centre (PRC).
Each EIA description is approximately 1 to 2 pages long and specifies the following items of information:

- Who it is targeted to (e.g. client / child or parent / caregiver)
- Where the action can be performed (e.g. home or agency office setting)
- How it is performed (e.g. one-on-one, practitioner led)
- Brief description and rationale
- Outcomes that the EIA aims to achieve or facilitate
- How you do it including step by step instructions
- Helpful hints and tips (e.g. problems that might arise and ideas for handling them)
- Key references for further reading

Prior to publication of the Practitioner Guide, all case workers in the CSO Alliance received two days of initial training in the Evidence-Informed Actions from the PRC. In some settings there was some post-training coaching in small group skill development sessions.

The production of the Practitioner Guide was the culmination of the Stronger Families Project and it did not proceed through to a full active implementation stage.

### 3.1.6 Reflections on strengths and weaknesses

The Stronger Families Project ended when the grant from the Ian Potter Foundation ended and the Project Manager left the position. No formal evaluation of the project was undertaken. The reasons why the work ceased and no further implementation was pursued by members of the Alliance are unclear, but it is of value for decision-makers within Berry Street to learn as much as possible.

The author of the present discussion paper spoke to several individuals who were actively involved in the project, seeking their reflections on the achievements, strengths and weaknesses.

The following points represent views expressed by the various persons consulted. They do not represent consensus. Some views are contested.

#### Table 3.1c Strengths and weaknesses of the project

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>The working relationship between the members of the CSO Alliance was well-established and provided a strong foundation for shared understanding and decision-making between members.</td>
<td>Involvement of nine different organisations meant that some resources were spread a bit thin on the ground (e.g. resources to support local champions and to conduct coaching).</td>
</tr>
<tr>
<td>There was a high level of enthusiasm and engagement among most stakeholders in the early stages.</td>
<td>There was a variable level of commitment to the core project ideas and agenda among members of the CSO Alliance.</td>
</tr>
<tr>
<td>The project team placed strong emphasis on working in partnership with practitioners including ‘co-production’ of the Evidence-Informed Actions (EIAs).</td>
<td>The project may have failed to capitalise on the early enthusiasm of CSO Alliance members, possibly because the collaborative process required substantial time commitments, and was too slow and drawn-out.</td>
</tr>
</tbody>
</table>
The consultants demonstrated commitment to understanding the practice context and ensuring that practice wisdom was included in the process. The consultants may have had insufficient starting knowledge of the organisational context of the Family Services Sector and this added to the length of time required for them to develop adequate understanding.

Developing knowledge and skills in the EIAs involved more than just a one-off training session. Post-training coaching support was provided for some teams of practitioners. Few of the necessary implementation components were present at a sufficiently intense level. For example, there were local champions but not local implementation teams, and there was some coaching provided after training but not enough.

Practitioners who used the Evidence Informed Actions reported that the content was helpful and relevant to the client population, and that they were easy to use. No negative feedback about the content of the EIAs was reported. Some practitioners reported a lack of confidence in using the EIAs and a lack of time to adequately prepare for their use before seeing clients. There may have been insufficient time allocated (by project managers and by participants) to learn and practice the EIAs/‘kernels’.

A project budget of $94,650 enabled the employment of a Project Manager and consulting services for 2 years, detailed documentation of the Evidence-Informed Actions, and the delivery of a 2 day training workshop for practitioners. The project budget was not sufficient to enable extended coaching for all teams of practitioners, follow-up training, or the execution of other implementation strategies.

In terms of achievements, at the very least, the Stronger Families Project raised awareness of the value of the practice elements / kernels approach among a large number of CSO practitioners, developed practical resources that can be used in future efforts, familiarised practitioners with the content of 23 useful Evidence-Informed Actions, and provided a generally positive experience of the process of implementation.

Due to a lack of data from a wider sample of participants it is difficult to make firm conclusions about the reasons why the Stronger Families Project did not lead to ongoing implementation of the Evidence Informed Actions throughout the participating organisations. What is clear is that several interacting factors played a role. The following tentative hypotheses have been elaborated by the author of this Discussion Paper based on synthesis of the various conversations and consideration of the implementation science literature.

### Table 3.1d Hypothetical conclusions

<table>
<thead>
<tr>
<th>Cultural mismatch</th>
<th>Expectations and leadership buy-in</th>
</tr>
</thead>
<tbody>
<tr>
<td>There may have been a cultural mismatch between the CSO Alliance and the Consultants in terms of the relative value placed on (i) adherence to ideal process, and (ii) pragmatism.</td>
<td>It is possible that CSO participants or their seniors (who were not actively involved in project discussions) had expectations that because practice elements or kernels seem so simple and concise, that their adoption would not require significant changes to</td>
</tr>
<tr>
<td>The PRC demonstrated strong adherence to an ideal process of trying to ensure that practice wisdom and information about the organisational context was captured and used to help guide decisions about content of EIAs and implementation strategy. However this type of process requires the commitment of considerable time and resources by all parties. If the consultants began the project with insufficient background knowledge about the organisational context and local practice wisdom, the process of documenting and considering this knowledge may have added more time than was ideal. There are differences of opinion about how committed the senior leadership of the CSOs were to the ‘long haul’ process of implementation. Perceptions from leadership that the process was longer than necessary could have weakened enthusiasm and commitment.</td>
<td></td>
</tr>
</tbody>
</table>
The CSO Alliance and the PRC may have had different expectations regarding the length and difficulty of the processes involved in implementing new evidence-informed practices.

<table>
<thead>
<tr>
<th>Budgetary constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>The small budget available for the project may have limited the capacity to commit to extended process, but commitment may also have been limited.</td>
</tr>
<tr>
<td>With a budget of only $94,650, an extended development process may have consumed a greater than expected proportion of resources available for consulting. This may have left insufficient budget available for implementation processes that came later such as coaching / group supervision. ‘Commitment’ is a phenomenon that is highly relative to context and the balance of incentives and barriers. If the project ended because the designated funds were exhausted, it is possible to make a case that organisational commitment within participating CSOs was insufficient. Any permanent change to practice requires investment in maintenance processes beyond the initial change effort. It is possible that the 2 year project did not achieve sufficient skill development or process change for participating organisations to be ‘ready’ to move forward with ongoing maintenance on their own without focused project management support. When the project finished the project manager left the role.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mismatch between EIAs and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is interesting to note that there appears to be a mismatch between the EIAs actually selected (see Table 3.1b) and the role and outcome categories that were prioritised in the contextual work.</td>
</tr>
<tr>
<td>The contextual work focused very strongly on the role domain of engagement (or establishing and sustaining relationships). Furthermore, instead of selecting any additional role categories such as ‘multimodal developmental guidance’, or ‘emotional support’, the outcomes framework became oriented to quite different processes, specifically ‘client experience’ and ‘goals reached’. The outcomes work did not move in the direction of specifying any particular types of client experiences or client goals as desired outcomes. One of the key assumptions underpinning an orientation towards outcomes (i.e. an outcomes focus) is that adopting an appropriate outcomes framework will facilitate therapeutic activity consistent with it (Wandersman, Imm, Chinman, &amp; Kaftarian, 2000). If this assumption is correct then a mismatch between the concepts embodied in the outcomes framework and the specified therapeutic activities may not be helpful.</td>
</tr>
</tbody>
</table>
3.2 The Benevolent Society Project 2009-2014

3.2.1 The project context

The Benevolent Society (TBS) is a not-for-profit and non-religious organisation that provides services across the life span. In the child and family service area they provide early intervention, prevention, intensive family support and out-of-home care services throughout NSW, Queensland and South Australia.

Interest in the idea of practice elements at The Benevolent Society emerged gradually following a process of developing and adopting an organisation-wide practice framework based on the central construct of resilience (Daniel & Wassell, 2002). This in turn emerged from a collaborative research project.

In 2007, The Benevolent Society was approached by the Australian Centre for Child Protection to participate in an international study with Stirling University and Barnardos, UK. The aim of the study was to explore how organisations with the explicit aim of nurturing resilience in vulnerable children actually put the concept into practice. The study identified gaps in practice, and it was recognised that work was required to clarify what was expected of practitioners in this regard. The aim of adopting an organisation-wide framework was to achieve a shared approach to the child and family across diverse services and geography, and to improve consistency and quality of service7.

Although still under development, the Resilience Practice Framework was formally adopted in 2009, and is comprised of four main components:

1. Resilience domains;
2. Resilience outcomes;
3. Resilience practices, and a

The practice elements (called ‘Evidence Informed Practices’ in this context) fit within the third component of the Resilience Practice Framework, but articulate with the other components.

3.2.2 Conceptual work

The work on practice elements conducted by TBS was guided by the idea of ‘evidence-informed practice’ (EIP) which is defined as the use of current best evidence combined with the knowledge and experiences of practitioners and the views and experiences of service users in the current operating environment (Petch, 2009). Consistent with this, the term ‘evidence-informed practices’ (EIPs) was adopted to refer to the practice elements.

In addition to scoping a set of EIPs that could be adopted at the organisational level, the project leaders wanted to provide a systematic way for practitioners to choose EIPs that are closely linked to the desired client outcomes, and to embed this way of working into practice.

For these reasons, work on EIPs was conducted in parallel with work on a set of outcomes domains (also within the Resilience Practice Framework), and the use of a research-based model of implementation (Meyers, Durlak, & Wandersman, 2012; Wandersman et al., 2000).

Resilience is a construct that has gained strong and widespread use in child, youth and family services throughout the world. Although it is a complex and contested construct, there is common understanding that resilience is a process that reflects relatively positive adaptation despite adversity and trauma (Daniel & Wassell, 2002; Luthar, 2006). Different writers and organisations have developed somewhat

---

7 The information presented in Section 3.2 is drawn mainly from an unpublished article written by members of the project team (Antcliff, Mildon, Michaux, & Baldwin, unpublished), several additional references cited there, and personal communications with G Antcliff and R Mildon.
In collaboration with The Parenting Research Centre, TBS developed 5 outcome domains within their Resilience Practice Framework. These are:

- Secure and stable relationships
- Increasing self-efficacy
- Increasing safety
- Improving empathy
- Increasing coping/self-regulation

Managers and practitioners across the organisation were involved in the development of the outcome domains during a series of workshops facilitated by the Parenting Research Centre in 2011. Staff from all program areas across Australia contributed their understandings about what outcomes they were trying to achieve for children and families. Pooling and qualitative analysis of these ideas yielded the set of five high level outcome domains listed above. The intention was that all services would be held accountable for achieving these outcomes, and this set the scene for the identification of the practices that were needed to realise outcome achievement. All of the EIPs adopted by TBS are categorised into one of these 5 domains.

### 3.2.3 Contextual work

During 2010, training in the Resilience Practice Framework was provided to all staff across the organisation, followed by the establishment of learning circles. Participants in the learning circles discussed the evidence for each of the 5 outcome domains and how resilience was currently being operationalised in daily practice. In an organisation wide staff climate survey conducted in late 2012, 85% of practitioners reported using the Resilience Practice Framework in their daily work. While the training had a positive impact on raising the awareness of the concept of resilience, the resilience outcome domains were perceived as too broad and insufficiently linked to empirically supported practices. In turn, the training did not articulate the desired practice changes and did not include the tools or systems to monitor its implementation or achievement of client outcomes. This finding was one of the reasons why the Evidence Informed Practices (EIP) road was taken.

Another very important part of the work in the organisational context was conducting an assessment of organisational readiness for change. Organisational readiness for change refers to the organisation members having a shared resolve to implement change (change commitment) and a shared belief in their collective capability to do so (change efficacy). Organisational readiness for change varies as a function of how much the organisational members value the change and how favourably they appraise key determinants of implementation capability such as task demands, resource availability, and situational factors. When readiness is high, an organisation is more likely to initiate change, exert greater effort, apply greater persistence, and demonstrate more cooperative behaviour. The result is more effective implementation (Weiner, 2009). (The readiness assessment conducted at TBS is described below in Section 3.2.5 Phase One. It was conducted after the EIPs were selected and documented).

### 3.2.4 Selecting and documenting the evidence informed practices

TBS began their focal work on practice elements or evidence-informed practices using the approach of Chorpita and colleagues, and more specifically, the Distillation and Matching Model developed by Chorpita, Daleiden and Weisz (2005). This work has been captured and made available to users in a web-based application called the PracticeWise Evidence-Based Services (PracticeWise) database. The PracticeWise database contains a number of practice elements distilled from a large number of empirically supported treatment programs for children and families. The application allows users to
enter basic demographic data and information about desired outcomes in order to identify relevant practice elements.

A search of PracticeWise was supplemented by an additional search of well supported child and family interventions which were not included in the PracticeWise database, but which have been shown to achieve outcomes of the Resilience Practice Framework. The product of this work was a list of 44 elements or evidence-informed practices (EIPs).

The 44 EIPs were written up by the Parenting Research Centre (PRC). Those drawn from PracticeWise were based on the original guides prepared for United States users, but were adapted for the Australian context.

The format and content was essentially the same as for the 23 elements prepared for the Stronger Families Project (see Section 3.1). Each description is approximately 1 to 2 pages long and specifies the following items of information:

- Who it is targeted to (e.g. client / child or parent / caregiver)
- Where the action can be performed (e.g. home or agency office setting)
- How it is performed (e.g. on-on-one, practitioner led)
- Brief description and rationale
- Outcomes that the EIP aims to achieve or facilitate
- How you do it including step by step instructions
- Helpful hints and tips (e.g. problems that might arise and ideas for handling them)
- Key references for further reading

The EIPs have been published in a series of 6 booklets called Guides. The first guide, called Practitioner Skills describes 5 practices consisting of highly generalisable or foundational skills that are applicable across all of the 5 outcome domains. Guides 2 to 6 correspond directly to the five outcome domains of the Resilience Practice Framework. Table 3.2a shows the practices from Guides 1 and 2.
### Table 3.2a Evidence Informed Practices (EIPs) from Guides 1 and 2 of the Benevolent Society’s Resilience Practice Framework

<table>
<thead>
<tr>
<th>Guide 1: Practitioner skills</th>
<th>Name of evidence-informed action</th>
<th>Rationale and other details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement of families</td>
<td>Establishing a collaborative relationship with the parent.</td>
<td></td>
</tr>
<tr>
<td>Motivational interviewing techniques</td>
<td>Motivational interviewing techniques are used to engage parents/caregivers who are reluctant or ambivalent about change (e.g. reflective listening, affirming, open-ended questions, rolling with resistance).</td>
<td></td>
</tr>
<tr>
<td>Creating S.M.A.R.T goals</td>
<td>Tips for helping the client develop well-designed goals that are Specific, Measurable, Achievable, Relevant, and Time sensitive.</td>
<td></td>
</tr>
<tr>
<td>Parent skills training</td>
<td>Five steps that help the practitioner teach parents any practical skill: Observe, Set a goal, Introduce the skill, Practice, Feedback.</td>
<td></td>
</tr>
<tr>
<td>Writing your own checklists and task analyses</td>
<td>Tips and tools for helping practitioners research and write their own task analyses, to help them teach specific skills to parents.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guide 2: Secure and stable relationships</th>
<th>Name of evidence-informed action</th>
<th>Rationale and other details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachable moments</td>
<td>Use of everyday activities and routines to extend a child’s knowledge and skills (e.g. sharing books and stories; thinking aloud).</td>
<td></td>
</tr>
<tr>
<td>Following your child’s lead</td>
<td>Involves watching the child and responding to what they say or do in a meaningful way. Allow child independence over activity choice; comment on child’s activity; praise child’s ideas and creativity. Helps build confidence and trust.</td>
<td></td>
</tr>
<tr>
<td>Attending to your child</td>
<td>Attending means tuning in to whatever the child is doing without asking questions or giving instructions. Use eye contact and open body language to let the child know that the parent is paying attention. Sends message to the child that the parent is interested in them and thinks their play is valuable.</td>
<td></td>
</tr>
<tr>
<td>Listening, talking and playing more</td>
<td>Describe activities and introduce new words. Reflective and elaborative statements. Simplify language. Pause regularly. Encourages language development and imaginative ideas, increases conversation.</td>
<td></td>
</tr>
<tr>
<td>Engaging and infant</td>
<td>Smile at the infant and wait, watch for response. Extend the interaction with other expression. When babies see an adult smile it causes opiates to be released, provides sense of wellbeing, and helps babies’ brains to grow.</td>
<td></td>
</tr>
<tr>
<td>Descriptive praise</td>
<td>Descriptive praise involves making a positive statement to someone about something they just did that you liked, in which the action is specified. Encourages desirable behaviours to be repeated and models pro-social communication skills.</td>
<td></td>
</tr>
<tr>
<td>Family time</td>
<td>Family time creates happy memories, builds strong relationships and provides the opportunity to talk about things. The critical aim is for parents to make the most of everyday moments they share with their kids, as well as planning special times.</td>
<td></td>
</tr>
</tbody>
</table>

### 3.2.5 Implementation

To inform the choice of strategies to drive uptake of these practices throughout the organisation, the Benevolent Society adopted the Quality Implementation Framework (QIF) developed by Meyers et al (2012). Based on a review of 25 different implementation frameworks spanning multiple areas of research and practice, the QIF is a comprehensive attempt to synthesise implementation theory and the core components or steps in a high quality implementation process. The QIF describes 14 critical steps...
of quality implementation, four implementation phases, and explains how good implementation is a systematic process that requires a coordinated series of related elements.

Table 3.2b Four phases and 14 critical steps of the Quality Implementation Framework

<table>
<thead>
<tr>
<th>4 phases</th>
<th>14 critical steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: Initial considerations regarding the host setting / organisational context</td>
<td>1. Conducting a needs and resources assessment</td>
</tr>
<tr>
<td></td>
<td>2. Conducting a fit assessment</td>
</tr>
<tr>
<td></td>
<td>3. Conducting a capacity/readiness assessment</td>
</tr>
<tr>
<td></td>
<td>4. Possibility of adapting the intervention to the host setting</td>
</tr>
<tr>
<td></td>
<td>5. Obtaining explicit buy-in from critical stakeholders and fostering a supportive community/organisational climate</td>
</tr>
<tr>
<td></td>
<td>6. Building general/organisational capacity</td>
</tr>
<tr>
<td></td>
<td>7. Staff recruitment/maintenance</td>
</tr>
<tr>
<td></td>
<td>8. Effective pre-innovation staff training</td>
</tr>
<tr>
<td>Phase 2: Creating a structure for implementation</td>
<td>9. Creating implementation teams</td>
</tr>
<tr>
<td></td>
<td>10. Developing an implementation plan</td>
</tr>
<tr>
<td>Phase 3: Ongoing structure once implementation begins</td>
<td>11. Technical assistance/coaching/supervision</td>
</tr>
<tr>
<td></td>
<td>12. Process evaluation</td>
</tr>
<tr>
<td></td>
<td>13. Supportive feedback mechanism</td>
</tr>
<tr>
<td>Phase 4: Improving future applications</td>
<td>14. Learning from experience</td>
</tr>
</tbody>
</table>

It is important to note that the four phases can overlap temporally and work on early phases can continue while work on latter phases is beginning.

**Phase One** Needs and fit assessment had been covered in earlier work including the research project with the Australian Centre for Child Protection, Stirling University and Barnardos UK, and the highly participatory process of developing the Resilience Practice Framework (see Sections 3.2.1 and 3.2.2). Early training in the Resilience Practice Framework also fits into this phase.

In terms of adapting the intervention to the host setting, the Director Research to Practice at TBS worked collaboratively with the Parenting Research Centre to ensure that the language used in each of the guides was relevant and consistent with language that was currently used within TBS.

Buy-in from senior operational managers was sought through presentation of the results of the Organisational Readiness Assessment (see below), and invitations to provide feedback on the product being developed. This was an area of significant challenge with relatively low levels of involvement.

The largest component of Phase One was an Organisational Readiness Assessment, which was conducted in 2012. This assessment focused specifically on the readiness of TBS to adopt the new evidence-informed practices (EIPs) across its child and family services in NSW and Qld. The study used the Holt (2007) Readiness for Organizational Change questionnaire, which is a validated 25 item survey that measures readiness in four domains:

- ** Appropriateness –** belief that the proposed change is appropriate to the organisation (e.g. I think that the organisation will benefit from this change);
- ** Management Support –** belief that leaders are committed to the proposed change (e.g. Our senior leaders have encouraged all of us to embrace this change);
- ** Change Efficacy –** belief that the organisation is capable of implementing the proposed change (e.g. I have the skills that are needed to make this change work), and
- ** Personally Beneficial –** belief that the proposed change will be beneficial to the respondents (e.g. I am worried I will lose some of my status in the organisation when this change is implemented).

All child and family services staff (approximately 300) were invited to participate in the online survey, and 150 (50 per cent) responded within the 2 week timeframe.
The results indicated high levels of readiness among Child and Family staff to make the changes necessary to implement the EIPs. Using a 7 point Likert-type scale with 7 indicating Strong Agreement with positively framed statements, ratings of the 7 questions on Appropriateness ranged between 4.8 and 5.8. For the 5 positively framed questions on Management Support, ratings ranged from 4.4 to 5.2, and very similar results pertained to Change Efficacy. The 3 questions on Personal Valence were all framed negatively and ratings ranged from 2.1 to 2.4 (i.e. low perceptions of negative personal impact).

Phase Two Work focused on three pilot sites and included the establishment of Local Implementation Teams (LITs) which then developed local plans relevant to their sites. Internal process evaluation has found that the Local Implementation Teams have been critical for ensuring that local implementation timelines, accountabilities, decisions and tasks were responsive to local needs and concerns. They were also critical for obtaining staff buy-in.

In addition to local plans, several different central plans were developed by the project team. There was no uptake of these plans however due to lack of resources and limited organisational buy-in at a central level. Nevertheless some coordination and capacity building functions were retained centrally. For example a new assessment tool was developed to fit the Resilience Practice Framework, and the local implementation teams were initially chaired by the Parenting Research Centre to build implementation capacity. Meetings were held every two weeks to address the implementation drivers before going live with training.

Phase Three A series of training sessions was conducted beginning with 2 days on the use of the Resilience Assessment Tool. Four weeks later training was provided in a selection of the EIPs, and four weeks after that group coaching structures took effect. These included managers, team leaders and the Practice Support Manager in each participating region. A formal coaching framework is still under development but it includes a 3 step process of Observe, Practice and Feedback linked to a selection of EIPs. The coaching process is working well in one region but difficulties have been encountered in the others.

Process evaluation and feedback are critical components of Phase Three of the Quality Implementation Framework.

Process and outcome evaluation of the RPF and the EIP component is being conducted within each of the 3 pilot regions. At the time of writing this case study, only an executive summary of the Western Region evaluation was available. The questions examined in the evaluation were: (1) How effective has the RPF/EIP implementation process been in the region? (2) How effectively are staff members implementing the RPF tools and Evidence Informed Practices? (3) Is the RPF effective in achieving outcomes for clients?

The following data collection procedures were used:

- An online survey to capture the Local Implementation Team’s and staff experience;
- Interviews with Local Implementation Team and staff to gather contextual information about the implementation process and how effectively the RPF was being delivered in that region;
- A Self-Reported Competency Checklist every six months to measure changes in staff competency in the EIPs;
- Analysis of data from online evaluation surveys distributed after the training sessions in the Resilience Assessment Tool (April 2013) and the Evidence Informed Practices (August 2013);
- Data about ‘dosage’ (the frequency that the practices are being delivered) entered into a client database by participating staff;

A Resilience Outcomes Tool was developed to assess client outcomes over time. This is designed to be integrated into standard case planning and review processes. Training was provided to staff in the use of the Tool from April to August 2013 at all sites. The Tool as used in the Western Region includes the following standardised measures:
- The Brief Infant Toddler Social Emotional Assessment (BITSEA)
- The Strengths and Difficulties Questionnaire (SDQ)
- The Protective Factors Survey (PFS)
- Social support and parenting questions from the Longitudinal Survey of Australian Children (LSAC)
- Personal Wellbeing Index (PWI)
- General Self Efficacy Scale (GSE)
- Home Physical Environment Measure

Sub-scales or single items relevant to all five resilience outcome domains (see Section 3.2.2) can be found across this set of measures.

**Phase Four** The fourth phase of the Quality Implementation Framework is learning from experience. TBS has compiled the results of the Western Region evaluation in an interim evaluation report, the Executive Summary of which is available. Outcomes data are not yet available.

### 3.2.6 Reflections on achievements and challenges

A major strength of the project in the Western Region was the realisation of the implementation activities listed above in a manner closely aligned to the Quality Implementation Framework. Because the implementation is relatively advanced in this project, the following achievements and challenges table focuses more on changes in practice at the staff level rather than the implementation process.

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most staff indicated that they felt confident using the Resilience Assessment Tool</td>
<td>• Staff reported difficulties completing the Support Plan (linked to the Resilience Assessment) within the specified timeframe; difficulties completing the ‘analysis’ section; and difficulties relating client goals in the Support Plan to the resilience outcomes and practices. The Tool was also experienced as difficult to complete with clients who had low literacy, mental health issues, or in crisis</td>
</tr>
<tr>
<td>• Staff valued the six month review process and were using outcomes data to initiate conversations with clients about how they were progressing</td>
<td></td>
</tr>
<tr>
<td>• Staff have the necessary content knowledge and technical skills to deliver the practices to clients</td>
<td>• Most staff were only delivering the practices that had been covered in training/coaching, or the practices they were most comfortable delivering.</td>
</tr>
<tr>
<td>• Self-reported competencies in delivering each of the practices increased between August 2013 and February 2014</td>
<td>• Some staff were still unsure whether they were delivering the practices in the way in which they were meant to be delivered, and few were delivering each step of the practices.</td>
</tr>
<tr>
<td>• Resilience practices had been delivered to 68 out of 137 clients who were active between Nov 2013 and Feb 2014</td>
<td>• Staff identified challenges delivering the practices to high risk clients with complex needs who are often in crisis.</td>
</tr>
</tbody>
</table>

8 It is possible this finding was at least partly due to staff not entering all relevant data about practices delivered in the database.
YSAS has developed an online resource based on practice elements called the Youth AOD Toolbox. This resource describes a large number of practice elements drawn from eight therapeutic models. Five of these eight models have moderate or strong evidence of effectiveness in addressing youth AOD issues, or other closely associated issues. Three additional models are included because they are supported by theory and practice wisdom, and the evidence-base is currently under development.

As well as being available on their own, the practice elements are organised into a series of modules based on focal practice issues of concern identified through a comprehensive process of qualitative research and consultation with practitioners in the field.

### 3.3.1 The project context

The Youth Support + Advocacy Service (YSAS) was established in 1998 as Victoria’s statewide youth alcohol and other drug (AOD) service response. Now serving children, adolescents and young adults aged 10 to 22 years of age, it is the largest such service in Australia.

Since inception YSAS has provided specialist youth AOD services in several modalities including outreach, acute residential, long-term residential rehabilitation and day programs. YSAS has always prioritised services for the most vulnerable young people. The client population reflects this because they experience very high levels of psychological, social, educational, legal, housing and mental health problems. Two-thirds have experienced abuse or neglect and two-thirds have had involvement in the youth justice system. Over recent years services have evolved to include direct care and early intervention services in mental health and youth justice.

The work of developing the practice elements approach adopted at YSAS began in 2011, but this work was built on a foundation of earlier work to document a comprehensive therapeutic practice framework. This began with a series of focus groups conducted with staff in 2008-2009. Focus groups were conducted with nine different groups of staff across different parts of the organisation (e.g. outreach staff, outreach managers, residential staff, residential managers, day program staff, residential rehabilitation staff, directors, research, policy and project staff in central office). This qualitative research sought to explore and document staff understandings along several dimensions that are essential to any comprehensive practice framework including:

- Organisational values and practice principles;
- The theories or conceptual frameworks that were being used to guide the work;
- The intentions that staff had in their work with young people, and
- The content of the interventions that were actually being used.

The data from the focus groups were audio-recorded and subjected to thematic analysis. The results showed that staff members were very clear and consistent in their articulation of the values (e.g. human rights, social justice) and practice principles (client-centred, relationship-based) that guided their work. They were less articulate in their description of intentions, and experienced substantial difficulties describing the types of interventions they were actually using in terms of concrete practices.

The detailed descriptions of organisational values and practice principles obtained in the qualitative research were written up, reviewed and refined by a Practice Framework Working Group and the YSAS Executive. They were eventually incorporated into several documents: some comprising a practice

---

framework adopted by YSAS, as well as a publication entitled ‘A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services’ (Bruun & Mitchell, 2012).

Prepared with funding assistance from FebFast and the Foundation for Alcohol Research and Education (FARE), the resource document (also called the Practice Framework Resource) integrated the findings from qualitative research with staff with an extensive literature review including evidence from research, theory, and practice wisdom. During 2009 and 2010 YSAS also conducted interviews and focus groups with 42 YSAS clients, and consultation with a range of leading Victorian experts in youth AOD and mental health. Insights gained from this work also informed the content of the Practice Framework Resource.

In areas or domains where practitioners had not been able to provide detailed information, more reliance was placed on the research literature to provide guidance about the appropriate content to be covered in the resource. This was particularly the case in the domain of effective psychosocial interventions.

### 3.3.2 Conceptual work

The literature review informing the identification of effective psychosocial therapeutic interventions found that there were few manualised programs of demonstrated effectiveness in the treatment of alcohol and other drug problems among young people. Another important consideration was the fact that YSAS clients experience a multiplicity of issues in addition to problems with substance use. Available manualised programs relevant to this range of issues include: the Adolescent Community Reinforcement Approach (ACRA) (Godley, Meyers, et al., 2001); Multidimensional Family Therapy (MDFT) (Liddle, 2010; Rowe, 2010), and numerous programs based on Cognitive Behaviour Therapy, targeting particular problems including depression and anxiety, substance use, offending behaviours and various other problem behaviours.

In considering the manualised programs that are available, the research team at YSAS identified several barriers to their use within the Victorian setting. For example, even though MDFT has a very strong evidence base for the client population, its implementation requires the employment of qualified family therapists, with the same therapist delivering all three parts of the intervention including those targeting adolescents, parents and the whole family. It is not economically feasible to employ family therapists within youth AOD services in Victoria. MDFT also involves a substantial component of office-based therapeutic intervention and this is not a modality that is widely used in this sector.

Frustratingly however, the team observed that there were numerous components of MDFT that could possibly be implemented by youth AOD workers. Careful consideration was also given to the Adolescent Community Reinforcement Approach. Even though it is widely used in youth justice and youth AOD services in the United States, no services in Australia have yet implemented this program. A trainer from the United States was brought out to provide a four day training course for 20 staff members in November 2011. Evaluation found that staff who attended training felt that the program was highly appropriate to the YSAS context and felt very comfortable with the training sessions in which skills were modelled and practiced. A large majority expressed intention to use the practices in their everyday work. They also indicated that further support, particularly supervision, would be needed in order to embed the new practices into routine work. Comfort and intention to use the new skills varied somewhat across the different practices. Some staff felt that the presentation of some practices and some messages within the manual required modification for the Australian context.

While ACRA comes close to being an acceptable program for implementation within Victorian youth AOD settings, a final barrier was the high cost involved in preparing the workforce for implementation. As there are no experienced trainers or supervisors in Australia, YSAS would have needed to send several senior practitioners to the United States to receive the additional training required to become trainers and supervisors in their own right. There were also additional costs to pay for supervision of these Victorian trainees by experienced US based clinicians. While these costs were not absolutely prohibitive, they were high enough to temper enthusiasm among decision-makers at a time when resources were
stretched, and very substantial changes to the AOD sector in Victoria were impending (Victorian Government Department of Health, 2012).

During the literature review that led to consideration of MDFT and ACRA, the YSAS team also discovered the work of Chorpita, Daleiden and Weisz and several other authors who were writing about practice elements and active ingredients. While it appeared prohibitively difficult to successfully implement either of these manualised programs in our settings, the idea of identifying and selecting specific elements that could be implemented by youth workers as part of everyday practice in YSAS settings captured the imagination of the team.

The Senior Research Fellow at YSAS reviewed the practice elements literature in depth and wrote two journal articles exploring the utility of a modular practice elements approach for application to services such as YSAS that serve young people with multiple and complex needs (Mitchell, 2011, 2012a). The modular practice elements approach is also discussed in the final section of the Practice Frameworks Resource, alongside consideration of several dimensions of organisational context within youth AOD services that will impact upon implementation of therapeutic practice frameworks including:

- Service modalities – e.g. outreach, clinic-based, day programs, residential, specialist programs etc
- Therapeutic vehicles – e.g. therapeutic relationships and environments
- Therapeutic intentions – e.g. engagement and building relationship, enhancing motivation and building confidence, modifying cognitions and building skills, strengthening relationships and enabling participation etc, and
- Processes to support decision-making – e.g. assessment, case formulation, care planning, case notes, supervision and case review.

### 3.3.3 Selecting the evidence-informed practice elements

#### Delimiting the pool of therapeutic content

Because there were so few evidence-based manualised programs appropriate to the needs of the YSAS client population, the team decided to broaden the focus of the search for relevant practices to therapeutic models that are widely discussed in the research and practice wisdom literature. A set of eight models was selected on the basis of three main considerations:

i. Evidence for effectiveness with the population of concern
ii. Coverage of the full range of therapeutic purposes within YSAS
iii. Ensuring that a range of styles or approaches to practice is available to meet the needs of a diverse client population

The eight models are:

i. Motivational Interviewing (MI)
ii. Cognitive Behaviour Therapy (CBT)
iii. Adolescent Community Reinforcement Approach (ACRA)
iv. Multidimensional Family Therapy (MDFT)
v. Dialectical Behaviour Therapy (DBT)
vi. Solution-Focused Therapy (SFT)
vii. Narrative Therapy (NT)
viii. Acceptance and Commitment Therapy (ACT)
Consideration of evidence - The evidentiary considerations included evidence from empirical studies of effectiveness (randomised controlled trials) in: (i) treating AOD problems among adolescents, and/or (ii) treating additional commonly associated psychosocial problems. All models were also required to be: (iii) consistent with key aspects of established theory about the development and maintenance of AOD and related psychosocial problems among adolescents. Finally, there was an imperative to ensure that the (iv) set of models collectively covered the set of ‘characteristics of effective services and programs’ identified as necessary for maximising positive outcomes for adolescents with multiple and complex needs (Bruun & Mitchell, 2012; Section 3, p45-71). Evidentiary justifications for inclusion of the 8 models are summarised in Table 3.3a.

Table 3.3a Evidentiary justifications for inclusion of therapeutic models

<table>
<thead>
<tr>
<th>Criterion for inclusion</th>
<th>Therapeutic models</th>
</tr>
</thead>
</table>
| (i) Well-established ‘evidence-based interventions’ for drug and alcohol (AOD) problems | • Motivational Interviewing (MI)  
• Cognitive Behaviour Therapy (CBT)  
• Adolescent Community Reinforcement Approach (ACRA)  
• Multidimensional Family Therapy (MDFT) |
| (ii) Well established and promising ‘evidence-based interventions’ for other commonly associated behavioural health problems | • Cognitive Behaviour Therapy (CBT)  
• Adolescent Community Reinforcement Approach (ACRA)  
• Multidimensional Family Therapy (MDFT)  
• Dialectical Behaviour Therapy (DBT) |
| (iii) Address other critical purposes combined with high level of consistency with characteristics of effective service provision | • Narrative Therapy (NT)  
• Solution-Focused Therapy (SFT)  
• Acceptance and Commitment Therapy (ACT) |

Coverage of all key therapeutic purposes - A second type of consideration guiding the model search and decision-process was to ensure coverage of all the important aims and objectives of therapeutic practice within YSAS. At this time these aims and objectives were conceptualised in terms of five major purposes. These were derived from the qualitative research with YSAS staff and clients. The alignment of the eight models with these 5 purposes is shown in Table 3.3b. As can be seen here, most of the 5 therapeutic purposes are well covered by the 8 models. However these 5 purposes are broad, and there is a wide range of issues experienced by the client population within each type of broad purpose. Some models touched upon these purposes narrowly, addressing only a few types of relevant issues.
### Table 3.3b Major purposes of different therapeutic models

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Therapeutic models</th>
</tr>
</thead>
</table>
| Engagement and building the therapeutic relationship | • Motivational interviewing  
• Multidimensional family therapy  
• Dialectical behaviour therapy  
• Narrative therapy |
| Enhancing motivation for change  
Instilling hope and confidence for the future Empowerment | • Motivational interviewing  
• Solution-focused therapy  
•Acceptance and commitment therapy  
• Narrative therapy |
| Modifying cognitions, perceptions and beliefs  
Increasing knowledge and understanding  
Building skills | • Cognitive behaviour therapy  
• Community reinforcement approach  
• Dialectical behaviour therapy  
• Multidimensional family therapy  
• Acceptance and commitment therapy  
• Solutions-focused therapy  
• Narrative therapy |
| Strengthening or restructuring relationships  
Modifying contingencies | • Community reinforcement approach  
• Multidimensional family therapy  
• Dialectical behaviour therapy  
• Narrative therapy |
| Navigation and negotiation  
Accessing health and social resources | • Community reinforcement approach |

### Ensuring a range of styles and approaches is available

In addition to their experience of particular issues, clients also vary in their preferences for and responsiveness to different styles of intervention. For example, there is strong evidence that children and younger adolescents generally respond best to behavioural styles of intervention, particularly those that provide active learning of skills (Arnold & Rotherham-Borus, 2009; Nation et al., 2003; Small, Cooney, & O’Connor, 2009). However there are exceptions to this rule. Practice wisdom tells us that some young people and families do respond better to talking-based counselling approaches that allow them to tell their story, reflect on past experiences, gain new insights and create new meanings. For this reason models such as Solution Focused Therapy and Narrative Therapy are very popular among practitioners, and so the YSAS research team decided to include them in the pool of models from which practice elements were drawn. Solution Focused Therapy (SFT) and Narrative Therapy (NT) are also the two models that are strongest in their embracing of the principle of ‘building on strengths’. This principle is widely and strongly endorsed in practice wisdom, and failure to include practices explicitly meeting this principle raises the risk that the work as a whole will be rejected by practitioners.

Seven of these models are described in detail in Section 4 of the Practice Framework Resource (Acceptance and Commitment Therapy was added after publication of the Resource), which also discusses:

- Theory and philosophy informing the model
- Relevance to client need and evidence for effectiveness in this regard
- How the model articulates with the characteristics of effective services and programs
- Limitations of the model (e.g. limitations in evidence, content, reliance on particular modalities, demands placed on clients)
- Application of the model to outreach and residential settings in youth AOD services (e.g. how readily it can be utilised in these settings).
Delimiting and describing the practice elements

On the basis of the 7 therapeutic models described and assessed as appropriate in the Practice Framework Resource document, a decision was made to develop a set of practice elements appropriate for use within YSAS, and to be made available to the broader Victorian youth AOD sector. With funding from FebFast and the Department of Health the work of identifying and describing the practice elements began in 2011.

The long term vision was to develop a comprehensive, practical, user friendly toolbox of evidence-based resources that:

- Integrate best available research evidence with practice wisdom, theory, and client values and characteristics;
- Are readily accessible to practitioners with a wide range of skills and experience;
- Can be used in training and supervision;
- Can support assessment, case formulation, care planning, and case review;
- Can be incorporated into web-based decision support systems, and
- Would be appropriate for use in other settings such as youth-focused mental health services, youth justice services, youth and family services, and programs addressing problems such as homelessness, and disconnection from school and work.

Information about the 7 models that formed the pool of therapeutic content is mostly widely available in the form of books, book chapters, journal articles, and an array of material published on websites. The exception was one of the manualised programs. The manual used in the Adolescent Community Reinforcement Approach (ACRA) is available for download free-of-charge from the internet, but no content is published in books, and little in journal articles (except for effectiveness studies). Multidimensional Family Therapy (MDFT) is not freely available. The manual must be purchased from the developers, and as a Copyright program, its use is tightly constrained. Because of these barriers to content access a decision was made to drop MDFT from the pool of therapeutic content used in the YSAS practice elements. The most critical ‘dimensions’ of MDFT largely include family focused strategies, cognitive behavioural strategies and youth and family engagement strategies. The YSAS research team was satisfied that the other models adequately covered most of this content, except perhaps in the area of family focused practices. While they are covered in ACRA and SFT, this content is underdeveloped. Based on this existing material, original content in the area of family focused practices was developed for this project.

In working with existing content material, the work followed the lead of Chorpita and colleagues in the sense that practice elements were ‘distilled’ from existing content, and that they had to be ‘common’ to more than one source (Chorpita et al., 2007; Chorpita et al., 2005a). Because we were using several very different models, the elements did not have to be common to all of them, but interestingly, there were areas of significant commonality between the models in important areas of content.10

The process of distilling the elements common to these sources was equivalent to content analysis of qualitative data.

The following steps were performed in distilling the practice elements:

i. For each of the 6 therapeutic models, a wide selection of content material was collected including program manuals (where available), numerous books, copies of book chapters, journal articles and content published on websites dedicated to particular models. The writer

---

10 This observation led the writer to conceive of a type of ‘module’ that contained elements from different models which performed highly similar functions (see Section 3.3.4 Developing the Modules).
ensured that numerous sources were used in order to gain multiple perspectives on the
content of the models.

ii. The reader searched for concrete actions or procedures that:
   a. were to be performed by practitioners with a young person
   b. targeted a particular theorised psychological or behavioural process
   c. were described in similar or analogous terms in multiple sources
   d. were potentially able to be performed by youth AOD workers without training in the
      source therapeutic model

iii. A coding frame was developed for each of the models and this was used to structure a ‘content
      analysis’ of the source material describing procedures or analysing features (e.g. theoretical
      constructs, objectives, theoretical rationale, indications for use, notes about when to take
      special care) of each of the elements. The coding frame (i.e. the names of the elements) was
      regularly updated to reflect ongoing evolution in the interpretation of the elements as new
      material was added.

iv. The final coding frame was refined to ensure that names of elements were:
   a. As plain English as possible or
   b. Only included model-specific technical terms when they were not readily reducible and
      were commonly used across different sources. In these cases it was judged acceptable
      to retain ‘jargon’ so that youth AOD practitioners may develop familiarity with language
      used by specialists (e.g. mental health professionals).

The coding stage of the ‘content analysis’ yielded a total set of 97 practice elements. After coding was
completed the material allocated to each ‘code’ or ‘practice element’ was synthesised in prose, in the
form of a set of dot points. These syntheses are brief, typically ranging from 200 to 500 words. The
structure varied considerably depending on the available source material, and the order of presentation
varied to maximise ease of communication, but features generally include:

   i. Brief definition of or introduction to the practice
   ii. Some theoretical explanation or definition of key constructs
   iii. The purpose or impacts it aims to achieve
   iv. Rationale or explanation of how it fits into the source model
   v. Rationale for use in the youth AOD context
   vi. Precise description of the procedures or techniques to be used
   vii. Explanation of when / in what situations it is most beneficial to use the practice
   viii. Notes on when the practice is contraindicated or when special care is needed
   ix. Mentions of other practice elements usefully employed prior to or following this practice
       element
   x. References to key sources of information (in the online toolbox this includes active links to
      web-based resources)

The initial set of practice elements written up in this format was published in a resource entitled
“Therapeutic practice elements for youth-focused alcohol and other drug services: Definitions,
descriptions, and practice notes” (Mitchell, 2012b). For each of the 6 models\textsuperscript{11}, between 8 and 26 practice elements were prepared.

A set of 9 practice elements was also prepared by the writer under the heading of ‘Family Focused Interventions’ using material sourced from the Adolescent Community Reinforcement Approach, Solution Focused Therapy, and consultation with senior YSAS practitioners.

After the first drafts of the 97 practice elements were prepared, the material was distributed to a panel of local senior practitioners for peer review. The peer reviewers had a reputation for high level expertise in one or more of the models covered in the resource, or in provision of psychosocial care for adolescents.

3.3.4 Developing the modules
Consistent with Chorpita et al (2005) modules were conceptualised as structured containers holding several practice elements. Modules are distinguished from one another by functionality. Practice elements can be grouped within a module when theory or practice wisdom suggests that they will add value to one another in achieving specific functions or therapeutic purposes.

The second part of the work involved in the Resource document was preparation of 3 prototype modules:

- Engaging
- Emotion regulation
- Creating healthy beliefs and values

These 3 topics were selected on the basis of two considerations or imperatives. The first was to demonstrate the possibility of creating modules on topics or ‘focal practice issues’ that are of high priority to stakeholders and which are presented in a language and format that is relevant to local context and practice modalities. The second imperative was to illustrate the construction of three different types of modules:

- A module derived from a single therapeutic model – ‘Emotion regulation’ was derived solely from Dialectical Behaviour Therapy.
- A module derived from several different therapeutic models – ‘Creating healthy beliefs and values’ was derived from Cognitive Behaviour Therapy and Narrative Therapy.
- A module that integrated practice elements drawn from one or more therapeutic models with supplementary information drawn from local practice wisdom - Engaging represents this kind of module. The YSAS Research Team formed a view that YSAS had established a highly sophisticated and effective approach to engaging young people, and that important aspects of practice were not adequately captured in the practice elements drawn from the 7 therapeutic models. These ‘aspects’ differ from practice elements in that they mainly take the form of principles that guide practice rather than being a set of concrete procedures. The Engaging module was written up so as to capture these practice principles.

As ‘containers’ all three types of modules involved packaging up practice elements with additional material that helps the reader to use the module effectively in their practice context. Components that are common to most modules include:

\textsuperscript{11} Elements for Acceptance and Commitment Therapy (ACT) were prepared later after the project moved to the stage of developing the Online Practice Toolbox.
• **Brief definition** of the core construct embodied in the name of the module – e.g. What is emotion regulation? What is engaging?

• **Where does the module come from** - Background information about the therapeutic model/s from which the practice elements are drawn.

• **Aims of the module** – Brief statement of the functions that it is designed to achieve?

• **When should this module be used?** – Explanation of the circumstances under which the module is most likely to be of benefit for clients.

• **Considerations for different practice contexts** – For the 3 prototype modules this section covered issues relevant to residential and outreach youth AOD settings. If a module is modified or adapted for use in other settings this content would be changed.

• **Core practice elements for this module** – This section starts with a table that lists the name of the core practice elements along with a brief description and rationale of approximately 50-70 words. Following this each of the core practice elements is presented (e.g. 5 core elements for ‘Emotion regulation’ and 7 for ‘Creating healthy beliefs and values’).

• **Supplementary practice elements** – The modules are designed to be as simple or streamlined as possible in terms of what is included as ‘core’ for achieving a particular function or therapeutic aim. However, clients and practitioners vary in their level of readiness to begin a module or to benefit from it. This section provides a list of practice elements that could be added to further facilitate or strengthen the function of the core practice elements. It is structured in the same way as Core practice elements.

### 3.3.5 Peer review and consultation

After the three prototype modules were drafted they were packaged up with the 97 practice elements sent out for peer review to a panel of senior practitioner representatives of the Victorian youth AOD service system and associated sectors including: mental health, family services, homelessness, and primary health care.

In July 2012 a series of eight training and consultation workshops was conducted with practitioners across Victoria including 3 metropolitan sites and 5 regional sites. Most participants were from the youth AOD sector but participants from other sectors who worked closely with youth AOD services were also welcome to attend. A total of 184 practitioners registered and 161 actually attended.

The workshops had a dual purpose:

• Updating participants on evidence-informed practice in the youth AOD field;

• Gathering feedback on:
  - the ‘modular practice elements approach’ as a way to think about evidence-informed practice;
  - the appropriateness of the structure and general content of the practice elements and the three modules;
  - what other modules might be a priority for development in future work.

At the workshops participants were all provided with a copy of the Resource. Approximately two weeks after the workshop all participants were invited to complete a brief online survey about the workshop, the contents of the resource generally, the usefulness of the three prototype modules, priority suggestions for making the modules and practice elements more user friendly, and their views on the most important topics for future module development.

The results of the survey indicated an overwhelming positive response to the contents of the resource. For most questions, over 95% of respondents agreed or strongly agreed with statements pertaining to
qualities such as usefulness, relevance to practice context, intention to use, and likely helpfulness of the
resources. The part of the Resource that was judged as most beneficial was the ‘presentation of the
systematic breakdown of evidence-based therapeutic models’, with over 60% of respondents endorsing
this as one of the two most beneficial parts of the Resource. This finding suggests that the approach
taken to delimiting the ‘practice elements’ (as described above in Section 3.3.3) was appropriate and
helpful for this population of practitioners.

The three prototype modules also received high levels of endorsement. On a five point Likert-type scale
of ‘relevance’, 40-50% of respondents rated the three modules as 5/5 for relevance to their practice
context, and a further 30-45% rated the modules as 4/5 for relevance. Ten out of 13 suggestions
canvassed for making the modules more user-friendly were strongly endorsed by between 50-70% of
respondents. One of these suggestions was making the modules available online. The other 9 strongly
endorsed suggestions have been incorporated into the Online Youth AOD Practice Toolbox (see Section
3.3.6 below).

The suggestions made by respondents to this survey regarding priority topics for future modules strongly
influenced the next stage of work.

3.3.6 Implementation

Following receipt of highly positive feedback from the consultation about the modular practice elements
approach, and clear guidance about additional module topics needed in the field, YSAS decided to invest
in moving the practice elements material onto a readily accessible web-based platform. The work was
supported by the funding agreement that YSAS receives from the Victorian Department of Health to
provide professional development for the youth AOD sector.

A practitioner with expertise spanning social work practice, professional development, and educational
website development has been employed internally for 3 days per week over the past two years to
develop the Online Youth AOD Practice Toolbox.

The design of the toolbox website was shaped by the need to cater for a variety of users and uses
including:

• Individual practitioners’ self-directed information-seeking
• Semi-structured use in supervision
• As the basis of more formal structured learning
• To facilitate collaborative practice and provision of consultation services

Because of this it was decided to present the content in the style of an Information Website. The aim
was to provide several different ‘windows’ or ‘portals’ through which users could view or approach the
practice elements, depending on their starting points. These included:

• Through the 9 therapeutic models from which the practice elements were drawn
• Through the modules
• Through searching the website using key words

Several enhancements were made to the content of the practice elements for the purpose of adding
accessibility to a variety of learning styles and literacy levels, and adding practice wisdom and applied
knowledge to deepen understanding of each element.

Enhancements include:

• Audio of the core descriptive content being read aloud (also downloadable as podcast)
• Custom-made video of expert or experienced practitioner explaining the element, or discussing its use in the relevant context (youth AOD)
• Custom-made tools or resources applying to the element
• Active links to other tools or resources that are publically available (so worker doesn’t have to waste time looking for them)
• Related website links
• Links to PDFs of related articles or book chapters (or references if documents not available on the internet).

At 29th May 2014 a total of 18 modules were available online and the Youth AOD Toolbox had 1,225 Registered Users, from all states in Australia, with the largest proportion from Victoria. A redesign that was launched in March 2014 improved functionality on mobile and tablet devices. http://www.youthaodtoolbox.org.au/

There has not yet been any active implementation of the modular practice elements approach throughout YSAS or the wider youth AOD sector. To maximise the potential benefits of the Online Practice Toolbox it will be necessary to build a structured and systematic approach to supporting the widespread use of the modules/elements. This would require investment in most strategies listed below:
• A widely advertised public launch to publicise the availability of the Toolbox
• Introductory training workshop for a large proportion of the frontline youth AOD workforce
• Identification of change leaders within service sites and establishment of local implementation teams
• Ongoing training tailored to individual workplaces/teams focused on locally prioritised modules
• Re-develop case formulation, care planning and case notes procedures within youth AOD services to encourage, support and record use of the modules or practice elements
• Review and structure supervision and critical reflection processes to incorporate routine use of modules/elements
• Training of supervisors
• Institute regular professional practice development groups for coaching, discussion, practice and feedback on the use of the modules/elements
• Develop data systems to enable recording of the use of modules/elements
• Monitor and evaluate implementation including changes in knowledge, confidence and use of the modules/elements.

3.4 International work

The modular practice elements approach greatly expands the range of options available to providers of emotional and behavioural health care in designing a practice framework tailored to the particular needs of the populations served. It can be used variably, depending on those needs.

In settings such as specialist mental health services that serve a large proportion of clients with particular diagnoses, the practice elements approach may be incorporated alongside the use of ESTs that target discrete diagnostic categories.

This approach is being used in Hawaii’s Child and Adolescent Mental Health Division, where Multi Systemic Therapy (MST) and Multidimensional Treatment Foster Care (MTFC) were implemented to address the high prevalence of ‘delinquency’ among youths served in that service system (Nakamura et
al., 2011). The modular practice elements approach was developed subsequently to boost the effectiveness of usual care services for the substantial number of young people who were not eligible for those programs.

The Hawaii group has developed a variety of practical tools to support clinical decision-making based on the use of practice elements. These include a computerised database that allows practitioners to search for elements and modules that match search criteria based on problems and client characteristics. Ongoing review of empirical research keeps the content up to date and builds the pool of searchable content. The work began with a focus on practice elements for depression, anxiety and conduct disorders and has been expanding as partner organisations adopt the approach and contribute to the ongoing literature review effort (Nakamura et al., 2011).

Complementary tools include accessible descriptions of each practice element, decision-flow charts to guide care planning, and a tracking system to monitor use of elements and track client progress (Chorpita, Bernstein, & Daleiden, 2008; Daleiden, Chorpita, Donkervoet, Arensdorf, & Brogan, 2006; Nakamura et al., 2011). Ongoing maintenance, product development and marketing of these resources is now being managed privately by PracticeWise (Nakamura et al., 2011).

The work emanating from Hawaii is inspiring and supporting application of the modular practice elements approach in other settings. Emerging applications suggest that it is likely to be even more useful to evidence-based practice in non-specialist mental health care settings such as pediatric primary care (Wissow et al., 2008), school-based health services (Lyon et al., 2011), and the range of other community-based services that do not necessarily specialise in mental health care but nevertheless serve young people with a broad range of mental health needs. Wissow et al. (2008), for example, have argued that evidence-based treatments designed to treat singular diagnoses have limited utility in pediatric primary care settings because of the difficulty in getting a clear diagnosis, high levels of comorbidity, and the high prevalence of difficulties in functioning that do not meet diagnostic criteria.

To address this reality, they have advocated a stepped care model for pediatric primary care settings. Mental health care practices based on common factors (e.g. building a therapeutic alliance) should be offered to all children and families with mental health issues irrespective of focal problem or diagnosis, and a limited set of practice elements should be offered according to the nature of particular focal problems. In relation to diagnosis-specific ESTs, Wissow et al. (2008) recommend that primary care providers should have the skills to recognise when referrals should be made to providers with specialist expertise, and may choose to provide such treatments for one or a few conditions.

Somewhat consistent with this approach, Lyon et al. (2011) described a collaborative project in which researchers worked with therapists to adapt a modular practice elements approach to the particular needs of school-based health centres (SBHCs). Module selection was based on problem areas most commonly seen by therapists in these primary care settings – depression and anxiety.

Scaled-down versions of the tools provided by PracticeWise are being used for decision support and care planning. Workforce development and adjustments to organisational processes are being designed in collaboration with practitioners, guided by the Availability, Responsiveness, and Continuity (ARC) model (Glisson & Schoenwald, 2005). Evaluation of outcomes is yet to be reported, but results from a feasibility study demonstrate positive attitudes to the approach among practitioners. Those who participated fully in the training were also able to use the decision tools effectively and reported consistent use of certain modules with selected clients (Lyon et al., 2011).

The limitations of diagnostic categories as a basis for clinical decision-making caused a university-practitioner partnership to move towards a modular practice elements approach to implement evidence-based practice in public mental health services (Southam-Gerow et al., 2009).

They began with the intention of introducing three manualised treatments, but quickly realised the need for additional treatment content when parental and therapist feedback showed participants felt confused and overwhelmed by additional problems that were not being adequately addressed.

After deliberating about how many manuals they would need, the partnership decided to move towards a modular practice elements approach that would allow them to individualise treatment content to specific client problems and add new treatment content in the form of new modules (Southam-Gerow et al., 2011).
et al., 2009; p96). This group decided to use the functional analytic approach used in Multi Systemic Therapy (MST) to guide treatment planning and module selection. They are also developing new treatment content or modules that are not available in existing manuals, based on clinical literature and local practice wisdom (p97).

Adoption and implementation of a modular practice elements approach beyond the settings in which it was first developed is in the earliest stages and evaluation data are just beginning to emerge. Only one RCT testing its effectiveness compared with usual care and standard manualised treatments has been published (Weisz et al., 2012).

The setting was 10 outpatient services in Massachusetts and Hawaii involving 84 clinicians and 174 clinically referred youth aged 7-13 years. Clinicians were randomised to one of the three conditions. Treatment content focused on problems relating to anxiety, depression and conduct problems. Youth in the modular condition showed significantly faster improvement than youth in the usual care or manual conditions. The modular treatment also outperformed the standard manualised treatment in terms of outcomes at one-year follow-up. By contrast, the outcomes in the manual condition did not differ significantly from outcomes in usual care (Weisz et al., 2012).

Evidence is also emerging of the feasibility and effectiveness of importing the approach and implementing on a large scale in new settings. Following the early success in Hawaii, the State Mental Health Authority of Illinois adopted the common practice elements approach within their children’s mental health system. The decision emerged gradually over time as an Advisory Council grappled with the challenge of enhancing evidence-informed practice, which was defined as “a collaborative effort by children, families and practitioners to identify and implement practices that are appropriate to the needs of the child and family, reflective of available research, and measured to ensure the selected practices lead to improved meaningful outcomes” (Starin et al., 2014; p171).

Because of the diversity of mental health issues presented by children and families, and because it is impractical to train providers in a large number of manualised interventions, the Advisory Council decided instead to adopt two broad therapeutic models – Cognitive Behaviour Therapy (CBT) to respond to concerns relating to internalising disorders, and Behavioural Parent Training (BPT) to respond to concerns around externalising disorders. Training was provided to staff in 10 community mental health agencies in the first year and 10 additional agencies in each of 3 subsequent years. Agencies were selected for training on a competitive basis via expression of interest. Training was followed by clinical consultation based on the model developed for Multi-Systemic Therapy (MST). This focused on promoting skill development, case conceptualisation, problem-solving, and shaping interventions to the unique requirements of clients with complex needs. A key part of consultation was review and discussion of videotapes of client sessions (Starin et al., 2014).

Although evaluation after the first four years of training and consultation was positive, there was a clear recognition that the focus on the two separate models – CBT and BPT – was not addressing the full array of needs in the client population, and that clinicians were essentially being trained as specialists in either internalising (CBT) or externalising disorders (BPT).

This feedback coincided with the initial publication of the common elements approach by Chorpita, Daleiden and Weisz (2005), and the Advisory Council decided to modify the model to train the next two cohorts of clinicians based on the common elements approach. Thus rather than focusing on internalising or externalising based clinical skills, all participants were trained in 30 common practice element skills, as well as several of the decision-support tools developed in Hawaii to support the selection of the practice elements. Professional development proceeded in the same format as before with 8 days of in-person didactic training, followed by case consultation via telephone conference call for 60 minutes twice a month for 12 months.

Around the time the common practice elements approach was adopted, the State of Illinois also adopted routine outcome measurement using a personalised web-based system. This allowed outcomes for clients treated within the common elements initiative to be compared directly to outcomes for clients treated under usual conditions (TAU). Outcomes were recorded in terms of changes from intake to 90 days post-intake using three standardised measures of broad functioning (including externalising and
internalising among other domains) for children aged 5 to 18: the CAFAS, the Columbia Impairment Scale, and the Ohio Scales.

The common elements approach outperformed the statewide TAU data on externalising, internalising and other functioning, with effect sizes sometimes greater than twice as large (Starin et al., 2014)\(^1\). These effect sizes are at the upper end of the range, and well above the average, obtained in effectiveness trials of evidence-based psychotherapies for youth (Weisz, Ugueto, Cheron and Herren, 2013; cited in Starin et al, 2014). Thus the Illinois results are encouraging relative to other effectiveness studies.

### 4. Organisational contextual considerations

#### 4.1 Current use of evidence-informed practice

There are several aspects of current use of evidence-informed practice that are likely to impact significantly on the adoption and use of practice elements within any organisation.

**Consistency between new and existing practice** – New practices are more likely to be accepted if they are perceived as consistent with existing practice and as adding value (Mitchell, 2011). Even if an organisation is not using formal, well-described ‘evidence-based programs’, existing practices may still be informed by, and highly consistent with, the evidence-base. Knowledge of the extent to which this is the case is likely to be highly variable. Exploratory research aimed at assessing consistency of new and existing practice can have the unanticipated benefit of discovering previously hidden pockets of strength that may be vital to success in disseminating ‘new’ practices.

On the other hand, some parts of the organisation may be strongly committed to practices that are far removed from the content of newly adopted practice elements. If so these parts of the organisation are unlikely to embrace the new practices. Resistance may be active (e.g. managers will argue directly that the new practices are inappropriate to their context) or passive (e.g. staff members will not attend training or engage with new resources).

Some leaders in program areas already using evidence-informed practice consistent with newly adopted practice elements may also argue that the new approach is unnecessary. This attitude may be effectively countered if they can be convinced that new resources and any changes to procedures add value such as structure that assists less experienced staff (Aarons & Palinkas, 2007).

**Experience with using a structured approach** – The modular practice elements approach provides structure in that workers are asked to:

- Think in a systematic way about the needs of clients;
- Plan their responses to clients’ short- medium- and long-term needs;
- Regularly learn new practices that may not be in their current repertoire, and
- Reflect on the effectiveness of recent actions.

If an organisation has had experience such as a concerted effort to implement a new program that involves movement towards greater structure, and if this experience was generally positive, this will enhance the likelihood that a practice elements approach will be viewed favourably.

\(^1\) These effect sizes for the common elements approach were not as strong as those found for the Behavioural Parent Training (BPT) in relation to externalising, but were stronger than those found for Cognitive Behaviour Therapy (CBT) for internalising.
An advantage of the kernels or practice elements approach over other types of structured practice (such as empirically supported and manualised programs) is that practitioners (through self-directed learning) or teams or program areas (by prioritising content at a small group level) can organise learning efforts around small ‘bite-sized’ chunks of new practice as they identify the need.

4.2 Strength of client-focused decision support processes

Effective use of more structured practice approaches will be enhanced if strong decision support processes are in place. In clinical practice settings such as specialist mental health services these decision support processes are known as clinical governance.

There are at least six processes that support clinical governance in therapeutic services. Even though most Berry Street frontline workers are not providing clinical interventions, effective use of more structured practices will be greatly facilitated if:

- The more therapeutic programs within the organisation are using these processes systematically, and
- Processes approximating these are adopted in other program areas.

In Table 4.5 below these six processes are briefly: (i) described in terms of their most highly developed form in clinical settings and (ii) explored in terms of how they might be minimally applied in non-clinical settings.
<table>
<thead>
<tr>
<th>Decision support process</th>
<th>Clinical settings – maximal application</th>
<th>Non-clinical settings – minimal application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Making appropriate choices about intervention with a client begins with assessment involving comprehensive data collection about the client and their social ecology.</td>
<td>Workers should actively acquire working knowledge of a child’s or young person’s temperament, likes and dislikes, and the ways they typically respond to common challenges in daily life including strengths and weaknesses.</td>
</tr>
<tr>
<td>Case formulation</td>
<td>Theoretically informed analysis of assessment data, collaborative problem definition and goal setting with the client and/or carer.</td>
<td>Workers should regularly discuss their perceptions of clients’ emotional health, behaviours, personality, strengths and weaknesses in order to improve their understanding of clients’ needs.</td>
</tr>
<tr>
<td>Care planning</td>
<td>Building on assessment and case formulation, and in close collaboration with the client a plan or strategy for problem solving or change is developed. The plan specifies goals and the interventions that will be used in the coming weeks.</td>
<td>Time should be spent at team meetings and with the client/carer to reflect on available information about the child or young person’s needs and think about how best how to respond in ways that promote healthy development.</td>
</tr>
<tr>
<td>Recording case notes</td>
<td>Case notes involve a regular, detailed description of the work that has been conducted with a client over a specified period of time. The interventions used are specified and evidence of the effects is recorded. Good case notes aid reflection and a team-based approach to care provision.</td>
<td>A minimalist approach to case notes involves noting important details in the case file as needed. This would include critical incidents, major events in the biological family, milestones reached, referrals made to other services.</td>
</tr>
<tr>
<td>Supervision</td>
<td>Regular clinical supervision (fortnightly or monthly) guides practitioners to adopt a more critical and questioning stance in their reflection upon practice and to continuously challenge themselves to grow in understanding and skill.</td>
<td>A minimalist approach to supervision focuses on ensuring that workers are up to date with essential policies and procedures, are supported through critical incidents, and have access to necessary training opportunities.</td>
</tr>
<tr>
<td>Case review</td>
<td>A clinical approach to case review may involve a regular team meeting dedicated to presentation and discussion of a selection of cases. Key workers present a selection of information about a client highlighting challenges, achievements and areas of uncertainty. Discussion focuses primarily on problem solving.</td>
<td>Time should be spent at team meetings to reflect on the progress of particular children/young people over past weeks and months. Ideas about what else may be needed should be discussed.</td>
</tr>
</tbody>
</table>
Relatively structured assessment and case formulation processes would:

- assist workers to identify the practice elements that may be of most benefit to individual clients in working through issues and challenges that they are currently confronting.

Establishing routines whereby the planned and actual use practice elements is recorded in care plans and case notes would:

- prompt workers to think about which evidence-informed practices they need to read up on and prepare for;
- make it easier to describe the work that is being done, and
- facilitate a more consistent and coherent approach across different staff members working with particular children.

More rigorous supervision and case review procedures would:

- provide moral support and ongoing knowledge and development around practice elements, and
- facilitate reflection on progress and troubleshooting in the use of practice elements.

4.3 Strength and flexibility of practice development processes

Effective implementation of a practice elements approach within any organisation would require well developed capacities to deliver training and skill-focused coaching to the workforce.

All staff members who are expected to participate in using new practice elements would need to attend an education session about what is involved in using the approach, and one or more training sessions focused on particular modules / practice elements / kernels that are adopted or prioritised by the program areas in which they work.

Smooth delivery of this training would be facilitated if:

- infrastructure for delivery of training is well established;
- all staff have an adequate amount of time allocated to education and training per annum;
- there is space within the training calendar to enable the practice elements content to be scheduled, and
- training is not scheduled too close to content from other challenging change initiatives.

Training sessions alone are insufficient to secure practice change in health and human services (Garner, 2009; Stirman et al., 2004). Evaluation of numerous efforts to disseminate and implement new intervention approaches has shown that training must be supplemented with ongoing support strategies such as:

- group supervision
- coaching
- consultation support from an expert throughout training and implementation
- periodic site visits from a change leader / expert
- monitoring of intervention fidelity and feedback
- change leader responsivity to worker concerns and willingness to adapt the intervention based on sound feedback
It is not necessary to adopt all of these strategies, rather a combination of two or three could be sufficient if other factors in the environment are favourable.

Competency frameworks are relevant to several important standards and processes that impact on the content of practice and practice development. Before embarking on a practice elements initiative it would be wise for an organisation to review its draft competency framework to identify aspects that could be usefully incorporated into a practice elements initiative, as well as aspects that may conflict and which could be usefully revised.

4.4 Organisational readiness for change

Overall organisational capability for change depends on favourable conditions in all of the six areas outlined above. Another important domain to consider is the attitude of the workforce towards the particular changes being proposed. Employee attitudes are a strong predictor of the successful implementation of evidence-based practice in children’s services (Aarons, 2004; Aarons & Palinkas, 2007).

Employee attitudes will be influenced by the objective characteristics of the initiative (in this case an evidence-informed practice elements approach) and other contextual factors discussed above (see Sections 4.1 to 4.3). But attitudes are also influenced by a variety of other factors that may warrant specific preparatory attention, or be beyond the capability of change leaders to effect. If attitudes are negative and are beyond the influence of change leaders it is probably unwise to proceed with the initiative in question at the time.

Readiness for change has been defined as “the extent to which an individual or individuals are cognitively and emotionally inclined to accept, embrace and adopt a particular plan to purposefully alter the status quo” (Holt, Armenakis, Feild, & Harris, 2007; p235). Further, these authors argue that readiness to change is “a comprehensive attitude that is influenced simultaneously by the content (i.e. what is being changed), the process (i.e. how the change is being implemented), the context (i.e. circumstances under which the change is being implemented), and the individuals (i.e. the characteristics of those being asked to change) involved” (Holt et al., 2007; p235).

Change efforts are often initiated by organisational leaders without adequately considering the readiness of the workforce that will be affected, and whose cooperation is necessary for success. Assessing readiness of the workforce enables leaders to identify gaps that may exist between their own expectations and perceptions about the proposed change, and the expectations and perceptions of others. If significant gaps are observed, then action can be taken to address them. If it is not, then resistance or lack of engagement would be expected.

Holt et al (2007) developed a Measure of Readiness for Organisational Change using a rigorous five step procedure including: item development, questionnaire administration, item reduction, scale evaluation and replication with an independent sample. More than 900 practising managers from private and public sector organisations participated in the development research. The final measure includes 25 items covering four factors:

Appropriateness – belief that the proposed change is appropriate to the organisation (e.g. I think that the organisation will benefit from this change);

Management Support – belief that leaders are committed to the proposed change (e.g. Our senior leaders have encouraged all of us to embrace this change);

Change Efficacy – belief that the organisation is capable of implementing the proposed change (e.g. I have the skills that are needed to make this change work), and

Personally Beneficial – belief that the proposed change will be beneficial to the respondents (e.g. I am worried I will lose some of my status in the organisation when this change is implemented).
5. Options for Common Practice Elements at Berry Street

Based on synthesis of the information in the sections above, this section outlines a number of options for consideration by Berry Street. Options are suggested within the following domains:

i. Types of content for practice elements / modules that are likely to be most beneficial including:
   a. Existing sources of content that could be used or purchased (e.g. Parenting Research Centre data base, PracticeWise, YSAS Youth AOD Practice Toolbox);
   b. New content that could be developed.

ii. ‘Packaging’ the content to make it attractive and accessible to Berry Street users.

iii. Further exploratory work recommended.

iv. Essential requirements and options for effective implementation.

The recommendations contained in Sections 5.3 and 5.4 are informed by the implementation science literature, especially the Quality Implementation Framework of Meyers, Durlak and Wandersman (2012).

5.1 Kernels and practice elements appropriate to Berry Street

5.1.1 Existing content focused on child outcomes

The Berry Street outcomes framework lends itself well to a range of practice content for which kernels and practice elements have already been developed. This content comes from two main sources: (i) a database of kernels developed by the Parenting Research Centre (see Section 3.1), and (ii) the Online Youth AOD Toolbox developed by YSAS (see Section 3.3).

The kernels and modules/practice elements from these two sources that align best to Berry Street are shown in Table 5.1.1a below.

Most of these kernels and practice elements are designed to be delivered directly to children or adolescents by an adult. They can be delivered directly by practitioners employed by Berry Street or taught to other adults who have more frequent and consistent contact with young people, including biological parents, kinship/foster carers, residential workers, and teachers.

There will be some variability in the extent to which kernels and practice elements are relevant to staff in Berry Street’s different program categories (Out-of-home care; Specialist case management and therapeutic services; Youth education and skills; Family wellbeing, family violence and capacity building, and Restorative and practical support). Staff in these program areas would need to review the content of the kernels/practice elements to assess their needs and priorities.

In addition to the content that aligns with particular child outcomes, kernels and practice elements are available that describe much more general or foundational practices that would be relevant to almost all direct care staff at Berry Street, as well as the adult carers they support. These kernels/practice elements are primarily concerned with the work of engaging children and young people in a nurturing relationship. They are shown in Table 5.1.1b.

5.1.2 New or adapted content focused on individual adult outcomes

Berry Street is concerned with two types of outcomes for adults.

---

13 Note: The PRC ‘kernels’ shown here are only those used in the Stronger Families Project. Additional kernels were used in The Benevolent Society (TBS) project, but these have not yet been made available to this writer. Berry Street would need to liaise with TBS or the PRC to access these kernels. Thus Table 5.1.1a only illustrates a partial range of kernels that align with Berry Street outcome domains.
First, one of Berry Street’s program areas (*Restorative and Practical Support*) provides support for adults who have experienced maltreatment during childhood, to help connect them with family, wider community and help build a culturally grounded identity. Outcome domains from the Logic Map for this program area are shown in Table 4.1b above.

Second, the *Family Wellbeing, Family Violence and Capacity Building* program area aims to enhance the capacity of parents to provide effective care and support for their children. The kinds of practices involved in targeting these outcomes include:

(i) Family support, family therapy and parenting programs to enhance the capacity of parents to provide effective care and support for their children;

(ii) Services for women and their children who have experienced or are experiencing family violence; and

(iii) Services to address relationships or build capacity of clients, many of whom are parents.

Relevant kernel or practice element content for Australian service context has only been developed for the first of these three areas. This content includes many of the kernels in the Parenting Research Centre kernel database (see Table 5.1.1a below), and a module called ‘Working with Families’ in the Online Youth AOD Toolbox. The aims of this module are to: (i) engage families with the services that are caring for their adolescent; (ii) motivate family members as supporters of their young person, and (iii) build the capacity of family members to provide emotional and practical support that assists the young person along a positive developmental pathway. Details of the practice elements and other components of this module are shown below in Table 5.1.2.
## Table 5.1.1a  Existing kernels and modules/practice elements that could contribute to Berry Street child outcomes

<table>
<thead>
<tr>
<th>Outcome domain</th>
<th>Mostly for children - Kernels from the Parenting Research Centre database(^{14})</th>
<th>Mostly for adolescents - Modules and practice elements from the Youth AOD Toolbox</th>
</tr>
</thead>
</table>
| **Safety**     | • Three houses exercise - Child draws or writes in House of Good Things, House of Worries; House of Dreams. Aides in safety planning and goal setting  
                 • Safety house - Engages child in making themselves safe in situations where they have previously been abused or at risk | • Protective strategies for young people  
                 • Harm reduction strategies  
                 • Controlling or ceasing substance use  
                 • Self-injury  
                 • Suicidality  
                 • Distress tolerance  
                 • Anger management  
                 • Managing aggression and potentially violent situations |
| **Healthy development** | • Listening, talking and playing more - Encourages language development by making language fun  
                           • Following your child’s lead - Watching the child and responding to what she says or does in a meaningful way. Helps build confidence and trust | • Building self-care knowledge and skills  
                           • Setting expectations and limits  
                           • Activity scheduling and creating opportunities for achievement  
                           • Emotion regulation  
                           • Creating helpful beliefs and values |
| **Age appropriate independence** | • Agenda Menu – Pictorially based items (housing, parenting etc) to assist priority setting  
                              • Creating S.M.A.R.T. goals  
                              • Goals – 4Ws – What, Who, When, How well  
                              • Decisional Balance Table – Examines pros and cons of change to assist in identifying client goals  
                              • Values Card Sort – Explores client’s vision of a better future | • Building self-care knowledge and skills  
                              • Setting expectations and limits  
                              • Goal setting |
| **Formal education and learning** | • Effective instruction giving  
                           • When-Then Commands  
                           • Teachable moments - Using opportunities that arise in everyday activities to extend a child’s knowledge and skills  
                           • Observe, Practice, Feedback – Active teaching strategies to support development of new skills | • Motivational Interviewing - *may be helpful here when there is active refusal or disengagement from education*
| **Stable and rewarding connections** | • Engaging an infant - Teaching parents the benefits of smiling at their infants encourages reciprocal and interactive communication  
                              • Descriptive praise - Making a positive statement to someone about something they did that you liked  
                              • OARS – Open ended questions, Affirmations, Reflective listening, and Summaries | • Working with families  
                              • Interpersonal effectiveness (Social/Communication skills, Conflict-resolution, Problem-solving skills)  
                              • Strengthening social networks |
| **Stable and robust identity formation** | • Following your child’s lead - Watching the child and responding to what she says or does in a meaningful way. Helps build confidence and trust | • Creating helpful beliefs and values  
                              • Various elements from Narrative Therapy - *e.g. Attentive Listening, Hearing the young person’s story, Unique outcome and exception seeking*  
                              • GLBTI young people |

\(^{14}\) Note: Only the most relevant kernels / practice elements are listed against each outcome domain. Most kernels / practice elements are relevant to several outcome domains.
Table 5.1.1b  Existing kernels and modules/practice elements that facilitate engagement

<table>
<thead>
<tr>
<th>Kernels from the Parenting Research Centre database</th>
<th>Modules and practice elements from the Youth AOD Toolbox</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engaging a child</strong></td>
<td><strong>Engaging an adolescent</strong></td>
</tr>
<tr>
<td>• Engaging an infant - Teaching parents the benefits of smiling at their infants encourages reciprocal and interactive communication</td>
<td>• Safe, welcoming and inclusive environments</td>
</tr>
<tr>
<td>• Listening, talking and playing more - Encourages language development by making language fun</td>
<td>• A flexible and responsive approach</td>
</tr>
<tr>
<td>• Following your child’s lead - Watching the child and responding to what she says or does in a meaningful way. Helps build confidence and trust</td>
<td>• Who you are and how you present matters</td>
</tr>
<tr>
<td>• Descriptive praise - Making a positive statement to someone about something they did that you liked</td>
<td>• Communication style</td>
</tr>
<tr>
<td>• OARS – Open ended questions, Affirmations, Reflective listening, and Summaries</td>
<td>- Person-centred guiding and active listening</td>
</tr>
<tr>
<td></td>
<td>- Attentive listening</td>
</tr>
<tr>
<td></td>
<td>- Reciprocal communication style</td>
</tr>
<tr>
<td></td>
<td>• Orientation and ground rules</td>
</tr>
<tr>
<td></td>
<td>• A practical and useful response</td>
</tr>
<tr>
<td></td>
<td>• Building a collaborative relationship</td>
</tr>
<tr>
<td></td>
<td>- Joining</td>
</tr>
<tr>
<td></td>
<td>- Collaborating with the client</td>
</tr>
<tr>
<td></td>
<td>- Hearing the client’s story</td>
</tr>
<tr>
<td></td>
<td>- Validation</td>
</tr>
<tr>
<td></td>
<td>• Energy and creativity</td>
</tr>
<tr>
<td></td>
<td>• Provide meaningful incentives for engaging</td>
</tr>
<tr>
<td></td>
<td>• Involve families and significant others</td>
</tr>
<tr>
<td></td>
<td>• Engaging clients under coercion</td>
</tr>
<tr>
<td><strong>Engaging an adult or adolescent</strong></td>
<td></td>
</tr>
<tr>
<td>• Descriptive praise - Making a positive statement to someone about something they did that you liked</td>
<td></td>
</tr>
<tr>
<td>• OARS – Open ended questions, Affirmations, Reflective listening, and Summaries</td>
<td></td>
</tr>
<tr>
<td>• Appointment reminders – To decrease attrition rates</td>
<td></td>
</tr>
<tr>
<td>• Continuous (spoken) feedback - Regularly encouraging the client to comment on the content &amp; process of the interaction promotes engagement and confidence</td>
<td></td>
</tr>
<tr>
<td>• Continuous (written) feedback - Using scales to track a client’s progress</td>
<td></td>
</tr>
<tr>
<td>• Continuous written feedback SCALES - Uses Session Rating Scale to track therapeutic alliance, and Outcomes Rating Scale to track perceived benefits</td>
<td></td>
</tr>
</tbody>
</table>
Table 5.1.2 Practice elements and other components of the ‘Working with Families’ Module of the Online Youth AOD Toolbox

<table>
<thead>
<tr>
<th>Practice element or component</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background components</strong></td>
<td></td>
</tr>
<tr>
<td>Introduction to working with families</td>
<td>This component provides workers with background information about the module including the rationale for working with families and the aims of the work within the youth AOD service context.</td>
</tr>
<tr>
<td>What is a family and who are family members</td>
<td>This component alerts workers to the fact that ‘families’ and parent figures of young people using AOD services are highly diverse. For the practical purposes of this module, they may include biological parents, foster/kinship carers, and other persons providing ‘parent-like’ support including residential workers.</td>
</tr>
<tr>
<td>When we should work with families</td>
<td>Outlines a range of circumstances in which involving family members may be beneficial in the context of youth AOD services. Explains that family involvement must be negotiated with the informed consent young person</td>
</tr>
<tr>
<td><strong>Practice elements</strong></td>
<td></td>
</tr>
<tr>
<td>Engaging, orienting and negotiating ground rules</td>
<td>Engaging caregivers requires similar practices to engaging adolescents including outreach, active listening, empathy, emphasising the positive and reinforcement.</td>
</tr>
<tr>
<td>Information provision</td>
<td>The purpose is to enable family members to understand the nature of the service being provided for the young person in a manner that invites and encourages their involvement.</td>
</tr>
<tr>
<td>Collaborating and building motivation</td>
<td>The aim is to build and maintain a strong collaborative alliance based on a shared goal, and to build motivation for pursuit of that goal.</td>
</tr>
<tr>
<td>Education for caregivers on young people, drugs and families</td>
<td>The goal is to enhance understanding of adolescent development and the role of the family in this development. A key focus is how healthy family functioning enables the family to be a source of strength for its members.</td>
</tr>
<tr>
<td>Holding a family meeting</td>
<td>Meeting face-to-face allows the worker to observe the young person and family member/s interacting, help them to set goals for behaviour change, model behaviours that can facilitate positive change, and provide timely reinforcement.</td>
</tr>
<tr>
<td>Family communication skills</td>
<td>Basic family communications skills involve formulating and verbalising requests for change in ways that facilitate listening, reciprocity and negotiation.</td>
</tr>
<tr>
<td>Family problem-solving</td>
<td>Problem solving in the context of relationships is a process that helps people find out what they want, and how to get what is wanted, in a way that respects other people’s wants.</td>
</tr>
<tr>
<td>Keeping the interaction positive</td>
<td>When relationships between young people and caregivers are strained, 3-way face to face meetings may become bogged down in negativity as the young person and caregiver play out communication patterns such as mutual blame and criticism. This practice element includes a range of techniques that can be used to break these cycles during meetings with the practitioner.</td>
</tr>
<tr>
<td>Setting expectations and limits</td>
<td>Assists parents / caregivers to: define a set of limits; consult and negotiate with the adolescent; be clear and consistent in applying consequences, and be prepared to continually review limits.</td>
</tr>
</tbody>
</table>
5.2 Packaging the content to make it more relevant to Berry Street users

5.2.1 The content of the modules

As can be seen from the content of the ‘Working with Families’ module from the Online Youth AOD Toolbox (see Section 5.1.2 above), the practice elements have been organised and embedded within a larger ‘package’ called a module that is designed for a specific service context.

A module is essentially a container that holds several practice elements. The practice elements are generally moveable and transferable in that they can be delivered independently of the module or applied to different contexts, but the ‘packaging’ of the module is context specific. This module packaging is designed to help potential users:

i. Recognise the relevance of the content to the work they are performing (by using language they recognise to describe the work they do);

ii. Find the most relevant content quickly (by placing it in proximity to functionally related content);

iii. Understand when particular practice elements are best used (by providing examples taken from their context), and

iv. To help potential users understand other related practice elements that can facilitate each other, or be used as substitutes (by placing functionally related content together).

If Berry Street chooses to begin a project involving the use of a modular practice elements approach it would be ideal to adapt selected modules to the Berry Street context.

This adaptation would generally involve editing the front end or background components of the modules, while the practice elements would remain standard. If judged necessary, practice elements could also be modified to make them more context friendly.

The background components to modules generally include the following:

• Introduction to the core psychological or behavioural process being targeted including explanation of how it manifests and why it is important within the service context;

• Where does the module come from? – including the therapeutic models from which the practice elements are drawn;

• Aims of the module within the service context

• When the module should be used within the service context

• Considerations for different practice contexts – including different modalities or program areas (residential services, home-based care, office-based)

For any particular module this material may range from 2-3 pages in length.

The steps involved in adapting a module to the Berry Street context could involve a combination of several or all of the steps below:

• 2-3 senior practitioners (1st Internal Reviewers) with most local and content knowledge review the module and provide suggestions for changes;

• Writer makes the edits to the satisfaction of the 1st Internal Reviewers;

• Revised module is sent to 3 independent content and local context experts who do not work for Berry Street (External Peer Reviewers);

• Writer makes the edits to the satisfaction of the External Peer Reviewers;

• Revised module is read by 3-4 prospective front line users in different parts of the organisation (2nd Internal Reviewers);
• Focus group is conducted involving 1st and 2nd Internal Reviewers and the writer to discuss the content and explore issues around the use of the module, especially considerations for different practice contexts;

• Writer makes final edits on the basis of the result of the focus group.

A collateral benefit of engaging in this local adaptation process is that it would act as a powerful learning process for the staff members involved. These employees would develop:

• Strong insight into the modular practice elements approach to evidence-informed practice;

• Refined and nuanced knowledge of the content of the particular modules that they review, and

• A sense of ownership and leadership of the content and the broader implementation process

5.2.2 Housing the content

Kernels, practice elements and modules are best housed in an online environment for the following reasons:

• The volume of the full range of material is substantial and carrying around hard copy is prohibitive;

• Searching for specific content is greatly facilitated by a website structure and a search function;

• Links can be provided to references and other additional material that is not housed integrally within the modules;

• Many of the modules and practice elements that Berry Street would choose are already available online.

5.3 Further exploratory work recommended

Finding, choosing and adapting practice content relevant to the needs of Berry Street clients is relatively straightforward and unproblematic. This can be achieved by a small group of highly engaged staff members. The major challenge is enacting a strategy that will engage a critical mass of the workforce in building the use of kernels or practice elements into their everyday work with clients.

In the light of general knowledge gained from implementation science, international efforts to develop and implement a practice elements approach, as well as local Australian experience with kernels and practice elements suggests that it would be wise for Berry Street to conduct some exploratory work before investing heavily in implementation efforts. There are at least two approaches that could be taken.

5.3.1 Option 1: Needs assessment and readiness research

A comprehensive exploration phase could involve the following aims/steps:

a. **Clarify the need for change** – This could involve a survey examining the qualifications and competencies of a sample of new staff, and focus groups exploring the extent to which targeted practices (or types/classes of practices e.g. Working with Families) are being competently used by relevant staff, and staff perceptions about the need for more structured support for these practices (types of practice). These focus groups could be preceded by a request that staff familiarise themselves with the PRC kernels and the Online Youth AOD Toolbox;

b. **Clarify commitment to the change** – This could involve a series of meetings with senior and middle managers in relevant program areas to report the findings of this discussion paper, the findings of needs analysis focus groups, and to gather views about the range of implementation strategies that these managers view as feasible and would be prepared to support;
c. **Distribute a concrete strategic proposal** – Based on the results of the needs analysis focus groups and the meetings with senior and middle managers, a concrete Draft Strategic Proposal would be prepared for consideration by the Executive. This could also be distributed to all staff or a selection of staff such as all senior/middle managers in relevant program areas;

d. **Conduct a staff readiness survey** – Following the distribution of the Draft Strategic Proposal, all staff or a structured sample would be invited to complete the ‘Measure of Readiness for Organisational Change’ (Holt et al., 2007). The Draft Strategic Proposal would be modified in the light of the results of the readiness assessment.

Completion of each step would be dependent on the results of previous steps.

### 5.3.2 Option 2: One or two small pilot projects

An alternative approach to conducting the necessary exploration would be to establish and evaluate one or two small pilot projects. These pilot projects could proceed with just 1 or 2 modules that have been adapted for Berry Street, or a small set of kernels from the PRC database.

a. One program area or several individual programs could be selected for participation based on expressed interest;

b. An implementation team could be established to choose priority content and develop a local plan;

c. Technical assistance could be provided regarding **essential strategies** such as training, coaching/supervision, and expert consultant support, versus **optional strategies** such as introduction of case formulation, integrating selected practice elements into care planning, case notes, and case review;

d. A quasi-experimental design could be used with the ‘**control**’ condition adopting the bare minimum implementation strategies, and the ‘**study**’ condition adopting additional implementation strategies, and

e. The evaluation would study changes over time in the level of use of the selected practice elements/kernels, participant views of acceptability and usefulness, and the necessity and feasibility of adopting more implementation strategies.

f. The experience of the pilot projects would inform the wider workforce about what a practice elements approach involves and would be required to effectively implement the within a program area.

### 5.4 Essential requirements and options for full scale implementation

If the needs assessment and readiness research (see Section 5.3.1) or pilot projects (see Section 5.3.2) indicate good levels of need and readiness, the organisation may decide to implement the approach more widely.

Consideration of evidence from implementation science, the particular demands of the practice elements approach, and the Australian case studies reviewed in Section 3, indicates that the following steps would be required:

1. **Initial training** - The first phase of training would introduce the basic concepts of a modular practice elements approach and kernels, familiarise participants with the range of content that is available and introduce the website or printed resources that house the content. This would involve a half day workshop. It would be important to get as many staff as possible through this training to facilitate development of a critical mass of staff with a shared understanding of the initiative. This
type of training would also support informed participation in subsequent steps of the process, particularly choosing content.

It would be important to integrate this, and any subsequent training into the regular Learning and Development Calendar.

2. **Formation of local implementation teams** - A small group of staff members at each participating site, program area or program (for large programs) would be needed to advise and to coordinate implementation in a way that respects local needs and contextual factors.

Centralised steering or advisory committees are also necessary, but insufficient to ensure local engagement, especially in large organisations.

3. **Review, choose and prioritise content** - The local implementation teams would review the range of content that is available and select content that would be the focus of implementation in their own areas. Ideally the local groups should also be asked to prioritise a smaller set of content that might be the focus of action in the coming 6-12 months. It is important not to be too ambitious early on.

In the first instance, local groups may choose 2-3 modules, and prioritise one or a small set of kernels for immediate uptake. Alternatively Berry Street may prioritise one or two modules to ‘roll out’ across the whole organisation.

4. **Second training** – This set of workshops would focus on modules, practice elements or kernels prioritised at the program level. The workshops would have a strong focus on skill development including modelling, small group practice and feedback.

These workshops are best co-facilitated by 1. An expert in the relevant content, and 2. One or two local senior practitioners who can provide ongoing coaching and supervision. It would be important to integrate this training into the regular Learning and Development Calendar.

5. **Regular coaching** – Following the second training, staff members must have access to regular ongoing coaching in the use of the selected practice elements / kernels. As with training the focus should be on skill development. Case review and problem-solving could also be incorporated. As the groups work through discussion of real-life issues, they would also identify, discuss and develop procedures to guide decisions about when to use practice elements.

There are a number of ways in which this could be configured. An ideal option would be Professional Practice Groups of 5-10 participants facilitated by a local Senior Practitioner, with occasional visits by an external content expert. Notes should be taken to facilitate process evaluation. Coaching leaders in the different program areas will also need training and

6. **Reflection on progress** – Local implementation teams should allocate time to reflect on progress soon after coaching gets underway. A key concern is to identify any formal procedures that may need to be adjusted to facilitate staff members using the new modules/practice elements/kernels routinely within their practice.

Formal procedures that might be reviewed include assessment, case formulation, care planning, case notes, supervision, case review, competency standards and job descriptions, among others.
7. **Procedure adjustment** – Changes in practice are facilitated or hindered by organisational procedures that govern how work is done. To support new practices it is best if important procedures are adjusted to recognise and accommodate them. If changes to formal procedures are indicated these should be clarified and organised centrally, in consultation with local implementation teams.

8. **Process evaluation** – Ideally an external evaluator or a central project coordinator should be employed to collate data from the local reflections on progress. Information should be reviewed to identify any shared suggestions for changes to procedures so that action can be taken centrally if necessary.

   Additional process evaluation data could also be collected at this time such as the Readiness Survey or a survey that examines knowledge, confidence, and changes in actual practice.

9. **Third training** – If process evaluation data are favourable further practice elements/kernels should be introduced. Local implementation teams may stick with or revise their initial choices.

10. **Ongoing coaching** – Coaching sessions would switch focus to the practice elements/kernels covered in the most recent training. Older elements would also be revised as necessary.

In the long term, more modules/practice elements could be introduced on a quarterly or on a biannual basis. This could potentially be achieved within the coaching or Professional Practice Groups. To keep the process focused and energised, it would be helpful at some stage to introduce client-focused outcome measurement. The process of revising the Berry Street Evaluation Framework and selecting outcome measures would reinforce the importance of maintaining practice enhancement, guide the selection of new practice content over time, and boost the contribution that the practice elements approach makes to improving outcomes.

---

15 Assessment, case formulation, care planning and review procedures are probably centrally important to effective large-scale use of a common practice elements approach throughout an organisation. The work of designing or re-designing these procedures is very substantial and this work is beyond the scope of the current discussion paper. Here it is assumed that a reasonable trial of the common elements approach can be pursued prior to formal revision of these procedures. Revised procedures could be explored designed and tested during the course of trialing practice elements. There is some literature available that can inform this, as well as local experience at The Benevolent Society.
6. References


