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Teaching Evidenced-Based Practices: Strategies for Implementation

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## Abstract

This paper builds on the papers of Proctor (2006) and Mullen, Bellamy, Bledsoe & Francois (2006) suggesting practical principles on how to implement evidenced-based practices in teaching and training. The first part of the paper encompasses a discussion about knowledge building strategies and teaching tools that are most needed to teach evidenced-based practices to students and presents a case in favor of focusing on process learning tools for knowledge retrieval and principles for learning instead of content alone. Clinical decision support tools were also illustrated as being the most relevant process learning tools to add to curriculum. The second part of the paper speaks more specifically to building agency partnerships and relationships for effective, evidenced-based teaching. Finally, the paper addresses how to provide faculty the professional development necessary to carry out the implementation of evidenced-based practices in teaching and training.

## Introduction

### Teaching Evidenced-Based Practices: Strategies for Implementation

Proctor (2006) and Mullen, Bellamy, Bledsoe & Francois (2006) have produced scholarly and timely papers that provide guidance on the advancement of evidenced-based practice teaching and training within schools of social work. Both authors suggest that faculty deliver evidenced-based content knowledge within classes and teach process learning strategies so that students are able to keep abreast of evidenced-based, knowledge. The implementation of evidenced-based practices was identified as the key concern for teaching and training of students and practitioners. Proctor defines implementation as "putting evidenced based practice into practice". Numerous examples suggest that the implementation level for student development cannot be accomplished independent of the professional and infrastructure development of faculty, field instructors, and field agencies. My comments will expand on important points made in both papers because I am in agreement with the directions suggested by the authors in relationship to what is needed for effective, evidenced-based, practice, teaching and training. I am especially in favor of pursuing the implementation direction and in a previous paper I already discussed my belief that the implementation issue in the community-based agencies is of critically significance to the training mission in schools of social work (Franklin & Hopson, under review).

My goals for this reaction paper are to offer practical principles and teaching strategies for teachers and program directors that might further the mission of implementation. My suggestions and discussion are organized into two parts. The first part of the paper encompasses a discussion about knowledge building strategies and teaching tools that are most needed to teach evidenced-based practices to students and presents a case in favor of focusing on process learning tools for knowledge retrieval and principles for learning instead of content alone. Clinical decision support tools are also illustrated as being the most relevant process learning tools to add to curriculum. The second part of the paper speaks more specifically to building agency partnerships and relationships for effective, evidenced-based teaching and training. Finally, the paper addresses how to provide faculty the professional development necessary to carry out the implementation of evidenced-based practices through teaching and training. My suggestions come from reading the literature on evidenced-based practices in my substantive areas. In addition, my ideas and questions about how to best implement evidenced-based practices are based on my experiences working in the public schools and community agencies for the past twenty-five years.

#### Student Knowledge Building: Content Verses Process Strategies

The two papers under review covered the importance for faculty to build student knowledge about evidenced-based practices through content strategies, and the need for schools to develop appropriate resources to do so. Adding evidenced-based articles to one's syllabus, availability of treatment manuals, improving library resources and inviting outstanding evidenced-based speakers are all examples. As suggested by the two papers these are excellent teaching strategies and must be a part of a good evidenced-based education but they are also limited for practice training. Previous research on training suggests, for example, that these kind of teaching strategies when implemented alone will not be sufficient to produce practitioners that are competent to implement evidenced-based practices (Franklin & Hopson, under review).

Process strategies for learning are another level of knowledge building that were suggested by both authors and these teaching strategies include how to learn how to retrieve timely, evidenced-based information. I found Mullen and colleagues suggestion that we incorporate problem-based learning into this type of learning process to be a very compelling idea for teaching practitioners. Both Mullen and colleagues and Proctor recommend that we focus on teaching knowledge-construction methods such as how to quickly do advanced literature searches, use evidenced-based databases, and how to use on-line journals, for example. These learning tools can help students master the rapid, life-

long learning that is required to keep-up with the ever-changing landscape of evidenced-based, practice knowledge. I agree with Mullen and colleagues that these learning tools are most important to today's students and to the future of evidenced-based practice and can help sustain students once they get into the real world of practice.

### *Some Ideas for Teaching Process Learning Strategies and Tools*

My goals for teaching process learning tools is to help students gain experiences learning how to quickly find and synthesize information, as well as, how to make quick judgments about that information. I also believe that the demands of ever increasing knowledge makes it imperative that we give more attention to how students think and use knowledge to be effective in the 21st century and for this reason it is important to give students a framework for focusing on why they need to learn how to learn.

### Give Students a Transdisciplinary Framework for Knowledge

One of the issues I have written about when training school social workers is the fact that knowledge will not completely be bound by discipline in the 21st century ( Franklin, 2000; 2005). Knowledge is valuable and is becoming more available and open. Information is a commodity and may be packaged, bartered and traded like stocks. Historically and theoretically social work has been a transdisciplinary discipline that has been heavily invested in different types of knowledge. That approach could give us an advantage if we would build upon this strength. In the past, we have been concerned that we have not been effective enough in building our own knowledge-base but have relied on other disciplines for our knowledge but I believe as we move forward into the 21st century this transdisciplinary nature of our discipline is a strength and we should certainly not give it up but continue to teach our student to embrace it. It provides them the framework they will need to be evidenced-based and use knowledge to solve problems effectively because answers to complex problems may not be limited to any particular knowledge base or field of practice.

Transdisciplinary knowledge is a subject that is implied within evidenced-based medicine. In the book *Evidenced-based Medicine*, Straus, et. al. ( 2005), for example, points to the need of searching many different data sources across fields of medicine to find the best evidence. They also suggest investing in the best databases and statistical decision technologies available to help guide practice. The applicable idea from evidenced-based medicine is to be able to make the best knowledge quickly available across fields, to come-up with the best evidence in a timely fashion, and to feed that back to the clinicians to aid practice decisions. Mullen and colleagues also agree that statistical decision support tools may be the most helpful tools for parishioners to apply as far as retrieval and applications of evidenced-based information goes. It is important for schools of social work to provide students experiences with these types of evidenced-based information tools. It is time to add one or more of the statistical decision support technologies to our learning labs and perhaps an elective class exploring these technologies could be offered as a resource.

### Use Technologies to Show Practical Results

Most students and practitioners are not likely to want to learn how to retrieve evidenced-based knowledge from data sources for the sake of just knowing or even read an on-line journal just to find out what works. One of the pertinent issues that I have found in training students and clinicians is they need evidenced-based information in real time for practical reasons as issues come-up with their clients, and in a hurry. Clinical support technologies are developed to coach and provide help with practice in this way, as well as, to improve practice ( Jordan & Franklin, 2003). This is why I agree with Mullen and colleagues that the statistical support technologies show promise for practice applications. Clinical decision support tools provide physicians, for example, with the ability to make decisions in real time. Physicians in hospitals are provided Palm Pilots where they can key in symptoms, and in a few moments the hand-held computer comes-up with a set of three best courses of

action given for those symptoms. These types of clinical tools may be used in a classroom demonstration, for example, to show students that information tools can be practical.

Proctor further reviews literatures on measurement-based quality improvement systems that also demonstrate the potential to provide information and feedback to clinicians in real time but at this point these systems appear to be mostly used for quality improvement in management systems and their outcomes are not tied directly to evidenced-based practices or outcome measurement. These types of mental health, behavioral health quality improvement systems show potential, however, for providing information and feedback on evidenced-based practices and are already being used for benchmarking, accountability, and measuring performance outcomes (Hermann, Chan, Zazzali, & Lerner, 2006). Students certainly may encounter mental health, behavioral health quality improvement systems in their employment. Work is currently moving forward to integrate these quality improvement systems more with evidenced-based practices.

Springer and Franklin (2003) discussed a set of similar outcome-based, quality assurance tools that are being used to improve outcomes in clinical practice and managed behavioral health care and this review seems especially important in light of what Proctor is telling us about the mental health, behavioral health quality improvement systems. It might be to our advantage to pay attention to convergent trends across clinical and management literatures so that we can be ready to use these new technologies because these systems are also being used to train clinicians, measure outcomes, and implement some evidenced-based practices in community-based systems. Quality assurance and outcome measurement systems, for example, have been used in the United States and Europe to study the effectiveness of psychotherapy and as alternatives to group-oriented outcome studies. In 2001, *the Journal of Consulting and Clinical Psychology* reviewed four standardized, assessment measures associated with these quality assurance systems (Beutler, 2001).

The most popular of these four measures reviewed and now widely used in clinical practice is the Outcome Questionnaire (OQ-45.2). I have demonstrated this measure in my classes and found that it was well received by students and was an effective method for introducing ideas about clinical feedback, outcome measurement, and practice improvement. The OQ-45.2 is a computerized, self-report measure belonging to a family of outcomes measures. The measure is available on-line so I am able to have a student take this measure on a large screen pretending to be a client and role-play a client demonstration of the measures use and the clinical support tools that it offers. The measure is instantly scored and the relevant clinically information is provided and this shows the direct feedback and the practicality of the measure. The OQ-45.2 further has a clinical support technology, known as a signal detecting device and this signal detecting device has the capabilities of alerting clinicians to treatment progress or failure and is used this way within a quality assurance system (Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996), [www.oqsystems.com](http://www.oqsystems.com)).

The OQ45.2 is also one of the first standardized measures associated with a quality assurance system to demonstrate that providing clinicians with feedback about their practice can make a difference in client outcomes (Lambert, Hansen, & Finch, 2001; Lambert, Whipple, Bishop, Vermeersch, Gray, & Finch, 2002; Lambert, Whipple, Vermeersch, Smart, Hawkins, Nielsen, & Goates 2002). Recent experimental design studies also indicate that when combined with other clinical support tools that the OQ-45.2 and its' signal detecting device is even more effective in improving the outcomes of treatment (Whipple, et. al., in press). An example of the clinical support tools used in the study on this measure was an empirically based problem solving strategy that was arranged hierarchically in a decision tree and then available to clinicians at signs of treatment failure with their clients. This decision tree focused clinician attention on key factors found to be important in clinical outcomes. All these factors were derived from comprehensive study of the psychotherapy literature on what makes a difference in therapy outcome. Key factors identified and included in the decision tree were the quality of the therapeutic relationship, client motivation and its match to treatment interventions based on the empirically derived, stages of change model, the strength of the client's social support network, the importance of reevaluating diagnostic formulations, and an indication for medication referral.

*Principles to Follow in Teaching Process Learning Tools and Applications*

Think Smaller to be Effective at Thinking Bigger.

Efficiency is the key to effectiveness. In fact, due to the complexities of transdisciplinary knowledge it might be a practical process principle that if we want to teach our students to see larger patterns in a timely manner that we must first teach them how to use information tools in an efficient way. Every piece of literature is not important, for example, but a few key pieces are what will help us quickly grasp the big picture and they must learn how to screen out irrelevant information and focus in on the relevant information. Students need to be taught how to search for key pieces that synthesize information in the literature across disciplines like the Rand Corporation piece cited by Proctor (Hermann, R.C., Chan, J.A., Zazzali, J.L., & Lerner, D. (2006). or the Proctor (2003, 2006) reviews for that matter. A place to start with beginning students may be simply to teach them some simple rules about how to quickly narrow sources of useful and scholarly information or to provide the data sources for them that we think are most scholarly and relevant and tell them why we think those are the best ones to consult and to keep consulting (i.e. Cochrane's collaboration).

Effective Use of Self is Resource Enhanced.

If students are going to become competent with the life-long learning of evidenced-based practices as suggested by Mullen and colleagues, and the continued innovations that are needed for evidenced-based practice training as was suggested by both authors they are going to have to gain expertise in constructing evidenced-based knowledge as a on-going self-narrative and continual guide for their practices. This is a learning process for most practitioners who depend on their own thinking and actions and words for most of what they do. As a first step, students must learn to see that their knowledge and decisions can be enhanced if they routinely turn to certain resources. Second, they must learn how to rely on those resources as extensions of the use of themselves in their clinical work. Social work practice training is familiar with the phrase "the use of self" with clients but what I am suggesting is to be evidenced-based in practice requires a practitioner to move beyond the "use of self" to learn a new concept in practice training. I will call this concept, the "resourced self" because the demands of evidenced-based practices requires us to learn to use knowledge and tools beyond the use of ourselves in our practices. We have to learn to incorporate extensions of ourselves into our practice routines. Extensions in the use of ourselves could be databases like Campbell's or Cochrane's, a statistical decision, support system, an on-line journal, for example. These tools provide us on-going resources that we need to make decisions about effective practice. We must teach students to learn to rely on those resources the same way that a physician relies on the Physicians Desk Reference (PDR) in their daily practice. Faculty must also be more astute at producing the types of evidenced-based, clinical resources that can be easily relied on and that can become second nature for clinicians to consult and use as resources and on-going guides.

We can help students gain experiences with resources and extensions of self in their learning by providing assignments asking them to answer clinical questions that cause them to construct data from evidenced-based sources. In such an assignment a student will choose an extension of self as a resource to help them answer clinical questions and that extension of self will become their personal problem solver or consultant and they will also select technical assistants to aid them, as well. Of course, in the final decision-making answers for what do with a client are always based on a practitioners own critical thinking and social work ethics, in consultation with clients and those perspectives always need to be reinforced with students, as well, as the concept of the resourced self. If we do not provide them classroom experiences, however, on how to use the extensions in the use of self as resources in practice decision-making, the students will not likely have the opportunities to learn the skills required to stay on top of the knowledge and innovations needed to sustain evidenced-based practice knowledge and life-long learning.

An example of an assignment for helping students learn to use knowledge resources beyond the self in practice decisions might be looking across disciplines for what is the best practice for a

particular disorder or problem? They may use a search engine to do so and that will become their technical assistant. All the NIH agencies and the Department of Education have a list of evidenced-based and promising practices for different problems, for example, and these websites will serve as the student's sources or consultants or coaches. Students can look on the Substance Abuse and Mental Health Services Administration (SAMHSA) or National Institute of Mental Health (NIMH) or National Institute of Drug Abuse (NIDA), and the Institute of Educational Sciences websites, for example, to obtain lists of the evidenced-based practices for different problems. This helps them gain experiences constructing data to decide on best practices and not just relying on how they feel or what they think is best. This might be thought of as a step in a learning curve as students learn to see practice decisions as resource-enhanced.

#### Acceptance of constant learning and ambiguity in knowledge

Because knowledge is not stable and always changing and we are increasingly being made aware of this fact we must teach students to accept this state of affairs and they must use critical thinking and the best ethical decision-making to learn and keep learning evidenced-based practices. This is difficult for students who are starting-out and sometimes hope for simple, stable answers to questions like what are the evidenced-based practices for a problem area? Mullen and colleagues mentioned a similar issue about the problem of assuming stable knowledge when working with agencies. I have found in my experience that the complexity of knowledge and ambiguity in definitions and criteria for evidenced-based practices across disciplines is often perplexing to the students. Even within the school of social work, for example, a student will come to my class and I will tell them that a practice is evidenced-based and they will tell me that another faculty said it was not. Of course, this is normal given all the differing definitions and criteria for evidenced-based practices but it creates confusion in beginning students. For this reason, it might be helpful for faculty within a school to agree upon minimum standards for defining evidenced-based practices and a few practices that would be supported by those standards (Rubin & Parish, in press). Students also have to be taught to cope with changing knowledge and ambiguity because that will be the nature of their work in the public arena and it is certainly is the state of the evidenced-based practice literature, as well.

In order to make the assignment mentioned above about finding the evidenced-based practice for a problem more complex and to give students some practice at mediating ambiguity in evidenced-based knowledge students may be asked to further compare best practices information gained from the federal sources back to the lists that the state agencies are adopting because most states are moving to adopt their own list of evidenced-based practices and those vary across states and agencies, as well. Or at this point, it is possible, for faculty to help students to move to even a higher order process level by focusing their learning on the analyses of the criteria and decision-making processes that are behind those lists. A set of process questions can be used to guide such a study. What are the implications and limitations of the criteria, for example?

Faculty may wish to use state criteria for their home state because that is most relevant for student learning and may also offer the most cogent points for critique based on the evidenced-based practice process and definitions that the faculty may be teaching, and the state of complexity and ambiguity in that practice area. A case in point is the evidenced-based practice criteria being adopted in the state of Texas. Presently, as is also reflected, nationally, Texas does not have one unified criteria for evidenced-based practice. Currently, following federal guidelines and mandates Texas like other states is moving to adopt their own definitions and criteria for evidenced-based practices as they regulate and fund practices. The Texas Department of Health, for example, has adopted the SAMHSA criteria for an evidenced-based practice and uses their list of model programs that is on the National Registry ([http://www.modelprograms.samhsa.gov/template\\_cf.cfm?page=model\\_list#Model](http://www.modelprograms.samhsa.gov/template_cf.cfm?page=model_list#Model)). To obtain funding from that agency you have to offer a program that is on that list of model programs. Table 1 on the other hand, illustrates the criteria used by the Texas Department for Protective and

Regulatory Services for their Prevention and Early Intervention Division. This state agency circulates and evaluates RFP's for funding based of these evidenced-based criteria.

[Insert Table 1 about here]

Regardless of what we teach at the school of social work the state criteria for evidenced-based practices are the practices that that students will be asked to learn and use when they get out into the community and we have to help students both think critically about this criteria and process as well as prepare them to cope with the ambiguity and constant change that they will encounter. Of course, these state lists of evidenced-based practices are constantly being modified as they are hashed-out at the state and federal levels. The National registry criteria being used in Texas is currently being overhauled and will be changed in 2007, for example. The different national and state lists of evidenced-based practices also may not agree on the same interventions or may list different interventions reflecting their diverse criteria and political processes. What may be needed more than anything as we move forward with evidenced-based practices implementation is a valid and reliable source for ranking the current proliferation of lists of evidenced-based practices at the federal and national level or a greater consensus for criteria and practices across federal agencies. A greater consensus might also help the states because they are looking to the federal and national criteria and lists of approved, evidenced-based practices to guide them. The way evidenced-based practice is going at present, however, practitioners need a consumer reports of effective lists of evidenced-based practices to help them obtain the best information because most busy practitioners do not have time to critically analyze the practices appearing on the evidenced-base lists to see if they are what they claim to be, evidenced-based.

Given the current ambiguity in the evidenced-based practice criteria and definitions, students must be taught that researchers and policy-makers do not agree about which practices are evidenced-based, and more importantly selecting a practice off an evidenced-based, model program list does not assure it has considerable research support. Unfortunately, the whole area of evidenced-based practice dissemination has become highly politicized and linked with funding issues. States are also often applying a strict, rule based, decision-making criteria instead of a more flexible, critical thinking process by pre-selecting and mandating evidenced-based practices as has been pointed out by our colleague, Eileen Gambrill (2006). This process goes against the spirit of the evidenced-based practice movement and may not lead to the improvement of practices or the empowerment of practitioners to learn and apply evidenced-based practices. A practical process oriented case assignment for exploring these issues might be to ask students to use their field agency as an experiment analyzing state practices against Cochrane Collaboration guidelines for evidenced-based practices. This could be a useful assignment for helping students think about what is going to be required to sustain what they are learning in school against state agency mandates.

#### Preparation for Transdisciplinary Influence and Leadership.

In today's practice world the types of practices that a social worker may be ask to provide may be frequently be selected by state and federal mandates, funding agencies, or other training and funding requirements. This practice reality has implications for both the teaching and implementation of evidenced-based practices. Other disciplines also may dominate evidenced-based practice research and development, training, and dissemination. Transdisciplinary settings and issues also shape a social workers job and this can operationally mean coping with knowledge in fields as diverse as education, law and religion. Adolescent health services is a case in point, for example, where the services are often mediated by moral and value imperatives instead of evidence for what works. In order to influence evidenced-based practices implementation it is imperative to teach social workers to influence other disciplines even when they are not the formal leaders or decision-makers. Practitioners in public schools frequently ask me how to accomplish influence and

transfer of knowledge, for example, when they do not have direct control and yet wish to implement more effective practices in their work settings.

Calvin Streeter and I suggested the use of transdisciplinary teams as one promising practice method for enhancing the transfer and learning of practices and the creation of program innovations (Streeter & Franklin, 2002). This method has been used in systems reforms and we successfully applied this model in our work in public schools. In the use of transdisciplinary teams the practitioner works collaboratively with other disciplines seeking to learn as much as they can from the other discipline's knowledge and perspectives. The social worker further provides teamwork with other disciplines on a problem that everyone is invested in solving and navigates a delicate balance of influencing the other disciplines by imparting and even directly teaching their knowledge-base to them while at the same time making use of the knowledge of the other disciplines, and accepting the influence of the other disciplines for the purposes of efficient and effective problem solving.

#### *A Final Word About Knowledge-Building Strategies in Teaching*

Knowing about an evidenced-based practice does not automatically translate into being able to do it well with a client or even having the confidence or special training credentials necessary for some evidenced-based practices to be able to apply the practices. Neither does a having a treatment manual in hand mean a student or a practitioner will have the basic skills to apply the practices within that manual (Franklin & Hopson, under review). To be effective requires on-going relationships with those who know how to implement the evidenced-based practices and direct links with immediate help in learning how to apply the new innovations in practices, and this usually translates into some type of hands-on supervisory and consultation model. The supervisory and consultation model has to be on-site or directly linked to the student and the practitioner through a telephone, or Internet-based, technical assistant. The research has shown over and over again that if we take the supervision, consultation, and technical assistance away that the fidelity of the evidence-base practices decrease and the effect sizes also decrease for the effectiveness of the practice being applied (Curtis, Ronan, Borduin, 2004; Henggeler, 2004).

#### Onward to Implementation of Evidenced-Based Practices

Both Proctor and Mullen and colleagues point out the timeliness of focusing on agency implementation. Mullen and colleagues cite the recent national survey on evidenced-based training conducted across psychiatry, psychology, and social work that defined the gold standard for teaching evidenced-based practice. The gold standard is for students to first receive instruction on the practice using a treatment manual in the classroom followed up with supervised training in a community-based agency. All fields need to improve in the area of the supervised training in the community setting. This gold standard of teaching speaks directly to the implementation issue in teaching evidenced-based, clinical practice, but this type of service learning model is at the very roots of social work education and training and I think it also applies to other areas of social work training, as well. Our first social work education programs used agency-based and hospital-based instruction in teaching practice and our first social work academics were skilled clinicians who could easily transfer learning from classroom to agency setting and often taught students in both settings. Although, the practices they used may not have been evidenced-based as we know that term now they were devoted to the gold standard in teaching technology: didactic instruction followed-up by supervised, field experiences. Our current field and classroom models, however, do not follow these types of protocols that logically and systematically flow from classroom to field settings. A student may be instructed in an evidenced-based practice in the classroom and not be supervised in the same practice in the field, for example, or visa versa.

The national survey completed by Weisman and colleagues (2006) supports the conclusion that the current day social work education does not follow the gold standard of teaching that includes

didactic classroom instruction followed by supervised, instruction with clients. This article went on to say that the very structure of social work education would have to change for this to happen because faculty were not committed to clinical training in this way, our accreditation does not fully mandate evidenced-based practices, and our field instruction programs do not easily allow for supervision and agency-based training on evidenced-based practices.

Proctor and Mullen and colleagues speak directly to the challenges of implementation but also cite literature and raise expectations that our profession could possibly be leaders in implementation of evidenced-based practices. I agree that our experiences in the community-based learning and research is a great asset in the implementation area ( Franklin & Hopson, under review). At the same time our rich experiences also inform us that it is not easy to help students learn and apply evidenced-based practices in their professional careers in the community-based learning settings and to sustain their development as professionals. Mullen and colleagues suggest that the use of teams may be an effective way to sustain evidenced-based practices in community agencies. The literature on transferring and sustaining evidenced-based practices in the community clearly supports the fact that most successful efforts at sustaining evidenced-based practices involves, teams, in the form of supervision and consultation, and technical assistance models but those models are highly resourced with additional infrastructure that is sold as a part of training packages (Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002; Franklin & Hopson, under review). Mullen and colleagues also report that the teams created for evidenced-based practice training involved more infrastructure and support to maintain the training. It is common with evidenced-based practice programs for developers of these programs to build in the cost and infrastructure for maintaining the teams in order to maintain the fidelity and to support the effective practices. A caveat of these intensive, training, supervision and consultation models have also been reported in the literature and some practitioners have similarly complained to me, stating, that the training and supervision structures are too restrictive, cost prohibitive, and time-consuming. Costly training and supervision components also keeps some agencies from adopting some evidenced-based practices ( Franklin & Hopson, under review).

Despite some limitations, teamwork between schools and agencies may be used adaptively to sustain agency training and improve supervision structures and enhance the delivery of evidenced-based practice protocols. To do so, however, is going to require more infrastructure and training from the schools of social work. Mullen, et. al. found that when the school of social work and the students provided more infrastructure that the agencies were able to carry out the teamwork and meeting activities that helped them with the evidenced-based practices, for example. Additionally, the research has repeatedly shown that as long as the researchers are present and providing the infra-structure, training and support, that the evidenced-based practices training sustains but when they leave then the practice cannot sustain itself in the hands of the practice agency independent of the university's support, and these findings may also have implications for evidenced-based, student training (Franklin & Hopson, under review ).

### *Implementing Effective Agency Partnerships*

Proctor suggests that we lead the implementation of evidenced-based practices by creating agency-partnerships so that we can teach the evidenced-based protocols to our students in the community settings. I agree that this is an essential idea for training purposes and this approach further helps us reach the gold standard for teaching evidenced-based practice. I am personally involved in facilitating an effort with the School of Social Work at The University of Texas at Austin to develop an evidenced-based, community-based practice center where both students and community practitioners may be trained. This is collaboration with a private, non-profit children's agency. Because I am committed to this idea and already directly involved in the process of building this collaboration I am also acutely aware of how resource heavy this undertaking is for a school of social work and its' faculty. I have already mentioned that the research on evidenced-based training supports the need for infrastructure, teamwork, and the establishment of supervision, consultation and technical assistance models. All these training efforts are costly and time intensive. Developing

a school- agency-partnership takes a considerable amount of faculty time and resources. I think the agency I am currently working with to develop a training center might also offer a similar perspective.

For this reason, it is perhaps impractical for schools of social work of all sizes and localities to provide the needed infrastructure. It is also not feasible for every school to support school-agency partnerships with resources to the extent that Mullen and colleagues described providing in their research project, for example. I also believe it would be impractical to sustain evidenced-based agency training through school of social work funds. This would require an extraordinarily enriched funding source for field programs and training, for example. Alternatively, schools may have to pursue creative alliances and external funding opportunities to sustain one or two agency partnerships for the purposes of developing the type of didactic-supervisory alliances suggested by Weisman and colleagues (2006).

In another paper, I also suggest that more thought needs to be given for how these school-agency partnerships are structured and supported. In particular, I believe that the role of the university, and research agencies need to be re-analyzed and that new systems for an office for supporting product distribution for evidenced-based interventions within community agencies should be considered ( Franklin & Hopson, under review). Researchers within children's mental health have also suggested that universities and funders of research take more responsibilities to assure that evidenced-based practices are implemented in the community and that larger policies and systems have to be formulated for this effort (Schoenwald & Hoagwood 2001 Hoagwood & Johnson, 2003 ). Schools of social work and universities do not have an office or a formal structure for making sure that evidenced-based practice interventions that are researched and developed at the university are implemented in the community. Perhaps, the time has come for one to be created because faculty and schools in their current state do not have the time or resources to disseminate and implement these practices in the community. It is a waste of money to create evidenced, interventions that are not being implemented. A different structure or office within a school or university structure needs to be created to make implementation happen in the same way that private businesses and companies have a marketing force with infra-structure and resources to support their product distribution (Leigh & Marshall, 2001). This new office would focus on relationship management between the research products and their community-based customers and the goal of this office would be to make sure that the interventions were being used in community-based systems, for example.

Proctor further suggested that faculty and schools form relationships with community agencies that follow research strengths for the purposes of implementing evidenced-based practices and this recommendation will likely make the most sense to research universities. While I think it is ideal for faculty to join their research agenda to the implementation of evidenced-practices, I have also discovered some incongruence in this process. I have personally found that the differing goals between research and evidenced-based practice implementation may sometimes make it difficult to find a common ground. The lack of congruence in goals that I have experienced has to do with the progressive goals of a developing research program regarding an intervention verses the need for practitioners to use the best, available products that appear today on the approved model program lists. Follow the advise given by Mullen and colleagues, for example. Example from my own experience may help to clarify what I am saying. I am involved in doing intervention research on and building research studies on the solution-focused, brief therapy (SFBT), and also on the Taking Charge group curriculum, a multimodal, cognitive-behavioral intervention for adolescent mothers. The conflict comes because SFBT and Taking Charge are not yet considered evidenced-based practices by most standards for evidenced-based practices even though there are some states that currently list SFBT as a promising model. If I am going to concentrate on implementing evidenced-based practices I feel a responsibility to concentrate on teaching the students and practitioners the interventions that have solid evidence. At the same time, practitioners often want me to teach them SFBT and Taking Charge because they know I am an expert in those models. It is

even a bigger conflict for me when I take the time to closely examine the lists of evidenced-based practices provided by federal agencies and realize that Taking Charge and SFBT have as much or better research support than some [not all] of the so called evidenced-based practices on the model program lists. Perhaps, however, by strict evidenced-based implementation standards, I would be a better evidenced-based practice trainer if I never taught SFBT or Taking Charge to the practitioners? The unfortunate consequence of that decision is I would not be pursuing my passion or research interests in training.

One of the advantages that I see for a school of social work having a true training clinic is it becomes possible to teach and practice, and develop social work interventions that are not yet evidenced-based, as well as, offer training and research on those that are evidenced-based because you can add research components to that practice setting and clients might be expected to receive some experimental treatments, for example. However, the goals I am discussing for a training clinic are broader than the goals of implementation. In a typical training situation in the community with agencies and students involving implementation of evidenced-based practices faculty are expected to train practitioners with the best evidenced-based, practices. My concern is that faculty are not likely to give-up research programs in favor of devoting all their time to evidenced-based training programs and this issue could even detract from evidenced-based practice implementation in social work. More thought needs to be given to how to merge the goals of evidenced-based practice implementation and social work research.

#### Professional Development of Faculty

It is difficult to reach the gold standard for teaching evidenced-based practices unless the majority of our classroom and field faculty can teach evidenced-based practice at the process tools level or implementation level of practice training. The gold standard level of practice preparation identified by Weisman and colleagues (2006) also presupposes that most social work faculty would be teaching at the implementation level. Operationally, this means that we have many practice faculties that are competent to deliver the evidenced-based practices, and that they are licensed or certified in the evidenced-based practices. Faculty are prepared to teach the training manuals in the classes and as a practice faculty have further worked together as a team to sequence the practice curriculum in the classrooms with the supervised practices in the student field placements or service learning classes. From my viewpoint, this teaching standard should challenge us all and is the main impetus that has driven me to work with the faculty on developing the evidenced-based, community-based practice center at The University of Texas in hopes that we could more closely approximate this type of training model for some if not all of our students.

#### *Building Faculty Teams for Effective Implementation of Evidenced-Based Practices*

It is probable that most schools of social work like other professions may not have enough classroom faculty and field instructors that are trained to implement evidenced-based practices and that we must search for innovative ways to remedy this teaching trend. Here are some suggestions to consider for the professional development of faculty in the evidenced-based practices.

1. Schools may invest in the professional development of individual practice faculty that want to be trained in certain evidenced-based practices and construct teams between the faculty where this expertise can be shared between classes.
2. Faculty consultants may be hired that are currently trained in evidenced-based practices across departments or universities to mentor and train other faculty when the limits of licenses and certifications allows one to do so and then resource teams between the faculty may be constructed within their own school or across schools of social work that can support one another for further training and implementation of those practices with students and agencies.

3. Schools may hire community-based, adjunct faculty that have been trained in evidenced-based practices and construct a practitioner-faculty team for the purposes of teaching and training evidenced-based practices to students and other faculty.
4. Schools may hire national training groups and train their entire faculty on a particular evidenced-based practice. Current field instructors may also be included. As a result it might be possible for a social work faculty and field instructors to become the main trainers and experts in a community or state for a particular evidenced-based practice if schools put the right strategic planning into that approach. Schools and agencies could possibly cost share on this type of training if it met a community need.
5. Faculty may research and create their own evidenced-based practices and may operate professional training institutes or issue licenses and certifications for certain evidenced-based, practices. Under such circumstances it may become possible for their entire student body and faculty to be trained at a low cost.

#### Conclusion

There appears to be consensus across diverse academic literatures for the importance of implementation of evidenced-based practices, and an impetus for university faculty to become more involved in training community-based systems for the sake of students and graduates. Proctor exhorts us to champion this cause with "energy, motivation and innovation". Mullen and colleagues also believe that we now have many resources for evidenced-based practices within social work and need to implement evidenced-based practices. These authors believe that our practitioners are also ready to join with us in this effort.

I agree that our transdisciplinary knowledge base and community-based learning and research experiences provide us with tremendous strengths for implementing evidenced-based practices into community-based systems. Now is the time, if we choose, for us to take a position as leaders of leaders in the implementation of evidenced-based practices. Like any cause worth pursuing, however, the demands are high and we must set our goals realistically and strategically. The requirements of evidenced-based practice training, for example, will restrain faculty, from developing proficiency in implementing very many evidenced-based practices within their interest or specialties. The practical suggestion that I have for setting goals for implementation in teaching and training are for faculty to follow this heuristic about what each of us might be able to contribute individually and a caution about what we can learn and do realistically. It is conceivable that with effort and study that each of us might be able to learn and teach about a few evidenced-based practices but on the other hand my experiences tell me that we may only be able to personally invest in learning how to implement maybe one evidenced-based practice. Learning to implement one evidenced-based practice is enough, however, to make a contribution to student and agency implementation and this may make a significant difference to practice training for students and professionals in local communities and states. Only if we all unite together and truly invest in how to implement evidenced-based practices will we be able to work with agencies and students toward the goals of implementation, and form the model teaching and research programs that will set us apart as trend setters in the area of evidenced-based practice teaching and training.

The professional development of social work faculty in the evidenced-based practices is a necessary prerequisite if we are going to carry out the mission of implementation of these practices in the community. Faculty teams interested in implementation may be formed on a volunteer basis within schools to increase motivation and commitment toward professional development activities. Another first step is for schools to assess our motivation and readiness for building school-agency partnerships because all schools may not be ready to pursue evidenced-based teaching and practice training in community-based settings. Professor Proctor gave us some excellent advise when she told schools to assess our agency partners in relationship to their motivation, readiness for change, and innovations. We should also apply this assessment to our own selves before taking on any new training programs.

Finally, if we want to lead the leaders in the implementation of evidenced-based practices we also have to count the cost because this practice training will definitely be an investment of both time

and money for both schools of social work and community partners (Franklin & Hopson, under review). We also need to think broadly about the ways we might accomplish the goals of implementation and prepare ourselves more to work within transdisciplinary teams because implementation of evidenced-based practices will not be accomplished independent of other disciplines. Implementation of evidenced-based practices is a big International task that involves many voices and perspectives. We must also heed Proctor's broad systems perspective as we formulate strategies and goals for teaching and training.

Table 1

Evidence-Based Clarifications

Source: Texas Department for Protective and Regulatory Services  
for their Prevention and Early Intervention Division.

1. Evidence-Based programs as identified by a federal agency or other reputable entity. Programs are usually categorized into different levels based on the strength of the research methodology utilized and results achieved. For the purposes of CYD a program in any category of evidence-based is acceptable. Note: Programs must also be directly linked to prevention of juvenile delinquency, rather than some other condition. (RFP, page 12)

<b>Sample Categories of Evidence-Based Programs</b>			
<b>Blueprints for Violence Prevention</b>	<b>Office of Juvenile Justice and Delinquency Prevention</b>	<b>Promising Practices</b>	<b>Evidence-Based Programs Database</b>
1. Model 2. Promising	1. Exemplary 2. Effective 3. Promising	1. Proven 2. Promising	1. Model 2. Promising

**OR**

2. A program that has been evaluated. A strong evaluation is likely to be able to answer, “yes” to a number of the following questions:

- Did a credentialed professional conduct the evaluation?
- Did an external entity conduct the evaluation (the evaluation was not done by the agency providing or funding program services or otherwise invested in the outcome of the evaluation)?
- Was an experimental design utilized and described (control group method)?
- Was a quasi-experimental design (one that uses two or more groups to measure an outcome, but participants are not randomly assigned to groups) utilized and described?
- Was the method of data analysis described? If so, were the results significant (meaningful)?
- Was the evaluation conducted utilizing an adequate sample size? Very small sample sizes make it hard to generalize results of the evaluation.
- Was the evaluation conducted within an adequate timeframe; even better, was the evaluation a longitudinal study? Again, if the evaluation only covered a very short timeframe, it is hard to generalize results of the evaluation.
- Were multiple stakeholders included?
- Were there references to reliability and validity of evaluation data that showed?
- Were multiple, separately conducted evaluations referenced?
- Were replication results included (has the program been implemented in more than one area and been shown effective)?

In addition to answering “no” to most of the items above, some additional information that might indicate a poor evaluation had been conducted:

- The evaluation utilized a self-report design rather than objective data results. (Participants tell you if they feel they are doing better after receiving services, rather than measuring change. Their perceptions may not be accurate.)
- The evaluation was internally conducted rather than utilizing an objective external process. (If it is to the benefit of the evaluator to have positive results, this may color the process.)
- Anecdotal data was utilized as documentation of successful outcomes. (Positive success stories cannot substitute for actual measurement of change – they are fine in conjunction with objective, measured results.)

- Satisfaction surveys were utilized as documentation of successful outcomes. (Similar to the first bullet, satisfaction is not likely to be a valid measure of actual change in participants' attitudes or behavior.)

**OR**

3. The program must be made up of components of evidence-based programs, if those components have been independently evaluated and proven to be effective. If an agency is going to propose a service made up of components of evidence-based programs, each of those components must be delivered in the same manner in which they are delivered through the evidence-based program. Any component that has not been evaluated cannot be funded through CYD. For example, an agency could utilize the case-management approach implemented by Big Brothers Big Sisters (BBBS), which has been rated as a model program by Blueprints for Violence Prevention and an exemplary program by the Office of Juvenile Justice and Delinquency Prevention for a mentoring program, which would need to include and replicate the procedures utilized by BBBS:

- Orientation
- Volunteer Screening
- Youth Assessment
- Carefully made matches
- Supervision of the mentoring relationship
- A minimum of 4 hours, 2-4 times per month for a minimum of one year

Strength of evidence must be measured when scoring proposals submitted to local RFPs and preference must be given to those with stronger evidence, if there is more than one proposal addressing a defined funding priority. Proposals planning to implement a program that has been rated as an evidence-based program by a federal agency or other governmental entity will be eligible to receive more points than other programs. In general, proposals for programs that have been individually evaluated, if the evaluation meets the conditions to be considered "strong", will be eligible to receive more points than a program made up of components of evidence-based programs, since the combined elements have not been evaluated as a whole at this time.

**Note:** DFPS will not be reviewing Evidence Based information at the time of subcontract approval. However, if it is later determined during monitoring that services are not in fact, Evidence Based, costs may be disallowed.

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