Preparing Social Workers for Evidence Informed Community-Based Practice: An Integrative Framework

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Abstract
Social workers have an ethical obligation to the consumers and communities they serve, to draw upon practice-relevant research evidence in the planning and execution of interventions. A model for using evidence in social work practice is proposed which rests on a foundation of competence in the Common Factors of helping relationships. The model integrates the use of evidenced-informed resources in executing a treatment plan created through a modified evidence-based practice (EBP) process. This practice framework is presented, followed by a discussion of how relevant training can be incorporated into both generalist and specialist educational curriculums, while fulfilling requirements of the Council on Social Work Education accreditation standards.

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For almost two decades, social work scholars have debated the merits of evidence-based practice (EBP), its distinction from empirically supported treatments (ESTs), and the challenges in implementing both approaches in home- and community-based practice (Kazak et al., 2010; Norcross, Beautler, & Levant, 2013). With few notable exceptions (Barth et al., 2012; DePanfilis, 2014), these literatures and discussions have remained siloed between those advocating the use of the EBP process and those supporting the use of ESTs. In an effort to connect the two approaches in social work practice, we propose an integrative model of Evidence Informed Social Work (EISW) and an educational framework for preparing social workers for evidence-informed community-based practice. The model builds upon three core concepts: the process of evidence-based practice, the role of empirically supported treatments, and intervention portability. The EISW model includes a modification of the five-step EBP process (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996) and incorporates explicit discussions on how to manage barriers to using the process in home or community settings. This model addresses the need
for social work curricula to equip direct-practice graduates with transportable evidence-informed tools, such as: 1) the Common Factors (Wampold & Imel, 2015), 2) practice guidelines (Kirk, 1999), 3) common elements (Chorpita et al., 2011), 4) behavioral vaccines and kernels (Embry, 2004) and 5) relevant clinical and practice theory (Gambrill, 2012). The EISW model can support social work education by providing training to direct/clinical practice graduates in selecting and adapting these resources for treatment planning and intervention in any service delivery setting, and prepare administration/policy students to engage in the development of administrative infrastructure to support knowledge transfer and the implementation of empirically supported interventions.

The EISW model and teaching framework will be described in detail after an overview of key concepts related to the use of evidence in community-based social work. The framework will be described in detail, including implications for teaching, curriculum development (for both general and specialized practice), and university-community partnerships.

Evidence in Social Work Practice

The Process of Evidence-based Practice

In response to rising concerns at how medical practices failed to apply current research, a new paradigm for practice was advanced by Guyatt and colleagues in an international working group based at McMaster University in Ontario (Guyatt et al., 1992). This approach to clinical decision-making, centered in evidence from clinical research, was encompassed in the five steps of Evidence-Based Practice (Sackett, Richardson, Rosenberg, & Haynes, 1997). The EBP model encourages practitioners to pose specific practice-related questions, seek empirical information that addresses those questions, and critically appraise that information for themselves (or rely on high quality systematic reviews). Practitioners attempt to integrate clinical evidence with client circumstances, values, and preferences, as well as their own clinical expertise, in order to decide the best course of treatment (Sackett et al., 1996). The EBP process provides a concise model for human service professionals to guide their efforts to
bring current research knowledge into everyday practice. Many social work scholars and practitioners advocate the use of the EBP process as a flexible and consumer-focused approach to incorporating evidence into social services (Gambrill, 2006). To support the broader use of the EBP process, social work scholars have adapted key concepts from technology adoption theories (i.e. knowledge transfer, translation, and exchange) to study the nature and quality of evidence, its internal and external validity, and the extent to which it can be adapted to user contexts (Kitson, Harvey, & McCormack, 1998). This has encouraged the development of practitioner skills and organizational supports that cultivate values, practices, and processes that encourage practitioners and program teams to acquire and apply new knowledge in their work (e.g. building knowledge-sharing systems, communities of practice) (Austin, 2008; Straus, Tetroe, & Graham, 2013).

Empirically Supported Treatments

In 1992, as the McMaster University workgroup was developing the process of evidence-based practice, the American Psychological Association started work to develop standards of evidence for identifying effective clinical interventions. These standards are used to assess the effectiveness of specific interventions (e.g. assessment tools, treatment protocols, or multi-faceted or multi-media manual-based interventions). Interventions that meet this threshold of scientific validity, are considered Empirically-Supported Treatments (Thyer & Pignotti, 2011). Lists of ESTs have been assembled and disseminated via the APA website, classified by the DSM diagnoses addressed by each treatment. Similar practice guidelines, based on research findings or professional consensus in the absence of empirical literature, have been developed to provide specific direction for assessment and treatment of various presenting conditions (Howard & Jenson, 1999). As support for the development and identification of ESTs and practice guidelines gained momentum, a body of research emerged to develop theories of intervention adoption and implementation. This science of implementation draws from numerous social sciences to understand how human service organizations and practitioners adopt
or implement ESTs or practice guidelines. Integrating psychological theories of behavior change (Cane, O’Connor, & Michie, 2012) and theories of organizational change (Glisson & Schoenwald, 2005) with key elements of diffusion theories (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005), implementation scientists attempt to identify key points of leverage for transferring specific, manualized ESTs from research and development centers into the hands of practitioners and organizations. These theories are primarily concerned with EST fidelity, and with the ability of practitioners and organizations to sustain the use of the innovation once external facilitators have been removed (Chamberlain et al., 2012).

The Research to Practice Gap in Community-based Care

Even with the energy and resources invested in promoting the process of evidence-informed practice in social work practice settings and disseminating ESTs and practice guidelines for social work populations, adoption remains low—particularly in community-based care settings (Garland et al., 2013). A recent study of public behavioral health systems revealed that states are investing minimally in the promotion of evidence use in community settings, resulting in unchanging or declining trends in adoption (Bruns et al., 2015). One reason for this gap may be found in social work training programs. Although a 2015 report found that the majority of social work programs report teaching empirically supported treatments and the skills needed to find, appraise and apply research evidence in practice (Bertram, Charnin, Kerns, & Long, 2015), community-based administrators and supervisors feel that most recently graduated social workers are not well trained in the use of evidence in practice (Barwick, 2011). Barriers to evidence-informed instruction are inherent in the structure of professional social work training (e.g. field placements and limited resources), and existing degree requirements and the competencies set forth in the Educational Policy and Accreditation Standards (EPAS) of the Council of Social Work Education (CSWE) limit opportunities for faculty to restructure curricula to include evidence-informed practices and skills (Figure 1) (Bertram et al., 2015).

[Insert Figure 1]
Impediments to preparing emerging social workers to use evidence-informed practices are similar to those cited by practicing professionals. Social work faculty, scholars, and practitioners assert that the EBP process is simply not practical for application in the resource-restricted environments of social work (Bertram et al., 2015). Unanswered questions persist about how these approaches would look in the day-to-day operations of a community-based agency or organization: what if current research suggests using an intervention in which the therapist is not trained, and there are no other providers with the needed training? What if the only programs available in the community, or covered by the client’s insurance, are ones not supported by evidence? In the situation when the best-practice EST simply isn’t feasible in a given service setting, or in the context of the client’s circumstances, how much can it be adapted?

Most ESTs have limited support for clinical work with complex clients in community settings; clinicians would need to know numerous protocols in order to address the diverse service needs of the clients they are likely to encounter, and protocols often needed to be embedded in service arrays spanning multiple agencies and funding streams (Cheung, Ma, Thyer, & Webb, 2015). Moreover, ESTs are grounded in classic models of clinician-client interactions, making them incompatible with home- and community-based models that prioritize decisions made collaboratively with the client and a team of service providers (Jensen & Foster, 2010). Finally, as such interventions require intensive training for staff and rigorous tracking of outcomes and model fidelity, the heavy resource burden on constrained social service organizations makes it difficult for the organizational structure and adjacent system processes to support adoption and delivery of ESTs (Fitzgerald et al., 2015; Lang & Connell, 2016).

In spite of barriers to adoption in home and community practice, and the complications in curriculum integration for professional training programs, social workers are ethically obligated to use evidence informed practice to avoid harm to clients and maximize their autonomy (Gambrill, 1999). Social work practitioners, faculty, and scholars struggle to understand how to apply evidence-based
models, and are unclear on the differences between EBPs and the EBP process (Bertram et al., 2015). Because empirically validated interventions have become increasingly referred to as “evidence-based practices,” ESTs are now commonly referred to as Evidence-Based Practices, or EBPs—creating semantic and conceptual confusion between the process of EBP and ESTs (Gambrill, 2006).

**Alternative Models for Integrating Evidence into Practice**

Concerns raised by social work practitioners, educators, and scholars have yielded a body of literature in which human service scholars suggest alternative models for integrating research into practice (Epstein, 2009; Satterfield et al., 2009). Recognizing the limitations of the EBP process and ESTs, some scholars have proposed new frameworks for practice that account for the subjectivity and uniqueness of human experience and leave room for creativity between the practitioner and the consumer (Cohen, 2011). Others suggest practice approaches that place a higher priority on honoring the unobservable processes of the helping relationship and the practice-based knowledge generated through experience and longevity in a field (Dodd & Epstein, 2012). Still other human service researchers have been engaging in efforts to identify and distill common elements or factors within ESTs that can be easily learned and transported into home and community practice settings (Chorpita, Daleiden, & Weisz, 2005; Wampold & Imel, 2015).

**Common Factors.** The Common Factors model “proposes that there exists a set of factors that are common to all (or most) therapies… and that these common factors are responsible for the psychotherapeutic benefits rather than the ingredients specific to certain theories” (Wampold, 2006, p. 22). Common therapeutic elements have been found to account for approximately 15% of outcome variability, whereas the provider-client relationship accounts for almost 30% (Lambert & Barley, 2001). For this reason, many scholars promote focusing less on fidelity to treatment manuals and pre-packaged “evidence-based” interventions, proposing that their benefit is exaggerated, and refocusing on skills and techniques to enhance the helping relationship (Ahn & Wampold, 2001). Although no definitive list of
common factors has been identified, a variety of common factors have been listed across numerous publications (Duncan, Miller, Wampold, & Hubble, 2009). Wampold and Imel (2015) classify common factors into three main pathways of healing: The Real Relationship (an effective, warm therapeutic alliance, therapeutic empathy), Expectations (the client’s belief that they can be helped by the intervention), and Specific Ingredients (activities that promote healthy actions or decrease unhealthy habits in the client).

Common Elements. The Common Elements project arose from an effort to promote the use of evidence in child and adolescent mental health services (Chorpita et al., 2005). Using a distillation and matching model of analysis that identifies and codes specific practice elements within empirically-supported treatments, precise components of treatments found effective for particular presenting problems are identified and isolated, independent of a manualized intervention (Becker et al., 2015). For example, a clinician could search for practice elements in treatments shown to be effective for 5 year old boys with problematic aggression and inattention. The search would yield a list of common elements across ESTs that have been found effective with this population (e.g., time outs, breathing exercises) which could then be incorporated into the treatment plan for that client—without the need for the organization or practitioner to expend time and resources in selecting and adopting a new manualized treatment (Barth et al., 2012; Chorpita et al., 2005).

Kernels and Behavioral Vaccines. Similar to common elements, evidence-based kernels are “irreducible units of behavior-change technology” (Embry, 2004, p. 575) that can be used as an alternative to expensive, empirically tested community-based interventions that require increasing dosage, funding, or fidelity to improve effectiveness of such programs. A behavioral vaccine is any practice that reduces risk of poor outcomes, is low cost, easy to administer, and can be administered or encouraged across an entire population (Embry, 2004). For example, several youth group behavior management programs shown to be effective include practices such as using a universal signal for quiet
and transitions (kernel), or implementing a greeting and parting ritual when participants arrive and leave for the day (behavioral vaccine). Each of these can be used widely by group practitioners without purchasing or implementing an entire intervention program.

Unlike ESTs and the EBP process, in which the high threshold for training, information-seeking, and resource allocation can slow down and encumber dissemination in home and community practice settings, common factors and common elements require minimal temporal and fiscal resources to adopt and execute (Barth et al., 2012; DePanfilis, 2014; Embry, 2011); however, though a large number of common factors have been found and widely disseminated through a number of publications, the identification and distribution of kernels, behavioral vaccines, and common elements relevant to community-based work is still an emerging effort. Though Common Factors and elements address concerns about flexibility and adaptability at the core of many objections to the use of ESTs, questions remain about the use of evidence in the context of real-world settings.

An Integrative Model of Evidence-Informed Social Work Practice (EISW)

Although there is a vast body of literature about ESTs, the process of EBP, and Common Factors, elements, and kernels, these ideas have lived a separate-but-equal existence that can only be resolved by recognizing that the process of EBP, the use of ESTs, and the employment of Common Factors and elements are not mutually exclusive; rather, they are complementary. A revised model for using evidence in social work practice is presented here, the Evidence Informed Social Work (EISW) model, intended to address the time and resource constraints and persisting translational concerns raised by social work practitioners, educators, and scholars. This model aims to answer many of the questions about the use of evidence in social work practice in community settings, and includes guidelines for skill development that can be incorporated into both generalist and specialist curriculums fulfilling the Educational Policy and Accreditation Standards of the Council of Social Work Education (CSWE EPAS).
The Framework for EISW

Utilizing a complementary approach to evidence-informed practice can address many problems that arise when putting evidence-informed social work into practice in home- and community-based work. To deliver resource-efficient, home and community services that are both evidence-informed and person-centered, the Evidence Informed Social Work (EISW) model rests on a foundation of Common Factors skills and techniques and the execution of a care plan that emerges from the use of a modified process of EBP that integrates the use of evidenced-informed resources.

Common Factors: The Basics of Social Work Practice. The most fundamental tool for any practitioner is competence in the common factors of helping relationships. This includes building a 1) strong therapeutic alliance, 2) using empathy, 3) generating and incorporating client feedback, 4) showing positive regard, and 5) collaborative goal setting (Wampold & Imel, 2015). All evidence-informed work with clients should be delivered within the context of these factors. Listening to clients, privileging their experience, demonstrating authenticity and positive regard, avoiding critical statements or terminology, and asking them for feedback strengthens the therapeutic alliance and increases their belief that positive outcomes are achievable from the helping process. All social workers need skills in collaborating with clients in goal-setting and evaluating progress toward those goals. This activates client engagement in the process and aligns with social work ethical standards to support client self-determination (Gambrill, 2006). For practitioners focusing on macro-practice, such skills and techniques will achieve similar results in intra- and inter-organizational partnerships, community organizing and decision-making with community stakeholders, and policy development (Hoefer & Jordan, 2008).

A Modified EBP Process: Developing a working care plan. A social work practitioner should actively employ the Common Factors when executing the five step process of EBP; however, the five steps were created for work in medical clinic settings and require slight modification to be meaningfully executed in home- and community-based social work. Extending Sackett and colleagues’ (1997) five
steps and model for clinical decision-making, and incorporating the advantages of alternative models
and viewpoints (Regehr, Stern, & Shlonsky, 2007; Satterfield et al., 2009), the following five steps
outline the EISW process for developing an evidence-informed working care plan.

1. Convert the need for information into an answerable question(s).
2. Identify the best available evidence to answer each question.
3. Critically evaluate this evidence in terms of its validity, impact, and relevance to the client.
4. Collaborate with the client to integrate relevant evidence with the provider’s clinical expertise,
   knowledge of agency and personal resources, and client values and circumstances, in order to
   create and implement the treatment plan.
5. Evaluate success in conducting steps 1–4, and continuously evaluate client responses to
   interventions in the treatment plan, and adjust the treatment plan, revisiting step four, as needed.

[Insert Figure 2]

Figure 2 presents an illustration of the EISW model for evidence informed practice for home-
and community-based social work, placing step four at the heart of the model with the modified first,
second, third and fifth steps surrounding it. The process is fundamental to EISW, including
collaborating with the client to craft the treatment plan by integrating the best evidence with
professional expertise, consideration of personal, agency and community resources, and the client’s
values. As the interventions included in the care plan are enacted with the consumer, it is essential to
evaluate the client response to the array of interventions. If the participant is not responding
positively or is experiencing difficulty in engaging in the planned interventions, step four should be
revisited to alter the treatment plan. Step four and five may be iterative, as the social worker and
participant collaborate to identify appropriate care approaches, apply them, evaluate progress, and
return to step four to identify an alternative intervention strategy if needed. Step five must also
include ongoing adjustment and modification of that plan to reflect the changing needs of the
consumer (Bruns et al., 2014).

For practitioners engaging in macro-practice, the EISW’s five step process, modified from EBP,
can be foundational in organizational decision making, process management and evaluation, as well
community planning and organizing (Gambrill, 2008). In step four of EISW, social work administrators’
decisions must emerge from the combination of 1) the best research evidence to answer the problem at hand (organizational or community), with 2) the professional expertise of all professional collaborators, 3) the limits of agency and community resources, and 4) the context of the population being served—identified through the active participation of consumer stakeholders (Roberts-DeGennaro, 2008).

The modifications from the EBP process to the EISW process start with the first step, in which the EISW model reflects McNeece and Thyer’s (2004) assertion that clients often present with complex concerns which require answering many questions. The EISW process departs from the EBP five step process by including consideration of the practitioners’ personal and agency resources in the decision-making process of step four (Regehr et al., 2007; Satterfield et al., 2009). Extensive research in knowledge transfer and implementation science demonstrate the influence of these factors on what interventions can be offered to the client (Fixsen, Blasé, Metz, & Dyke, 2013; Ganju, 2003). In the steps of EISW, step four also explicitly includes the implementation of the treatment plan. (Although this was included in the original model put forth by Sackett et al. in 1997, it was dropped by the Fourth Edition of Evidence-based Medicine by Straus et al., in 2011.) The fifth step of EISW is also distinct from the fifth step of EBP because it includes on-going evaluation of consumer response to the plan of care. In the most current edition of the five steps of EBP, step 5 focuses on practitioner self-evaluation of their use of evidence in practice and its global impact on their caseload (Straus, Glasziou, Richardson, & Haynes, 2011). While such practitioner self-assessment is important, when working with vulnerable populations that are at high risk of dropping out of treatment, this step must also include immediate and ongoing assessment of how the client is responding to each element of the care plan.

Evidence-Informed Resources. When navigating this process in practice settings with diverse service users or stakeholders complications will emerge. For this reason, a practitioner must have an arsenal of evidence, resources, and tools readily available to deliver a comprehensive array of evidence-
informed services in home or community-based settings, and to be prepared for the variety of barriers to EISW that may arise. This arsenal should include the following:

1. Skills in delivering a handful of ESTs for common presenting problems in the target population
2. Skills in delivering a variety of common elements, kernels, or behavioral vaccines relevant to common presenting problems in the target population
3. Familiarity with practice guidelines for common presenting problems in the target population
4. Familiarity with theories relevant to common presenting problems in the target population
5. Familiarity with finding and assessing high quality, current research evidence
6. Access to community-based ESTs offered throughout the service community

Ready access to these resources provides practitioners with guidance and choices for treatment planning throughout the EISW process. To assist in treatment planning, a practitioner should a) be familiar with practice guidelines related to common presenting problems for their focus population or community, b) have basic knowledge in finding, assessing and interpreting research to address practice and administrative questions as they arise, and c) have a thorough understanding of a variety of theories related to their field of practice. For example, a social worker specializing in children and families might develop familiarity with human development theories, attachment theory, family systems theory, trauma response theories, theories of mental health, or theories of interpersonal communication and conflict (Hooper, Thompson, Laver-Bradbury, & Gale, 2012).

Familiarity with practice guidelines provides a basic orientation to commonly agreed-upon directions for treatment. The ability to find, assess, and apply research to client problems assists providers when practice guidelines are inapplicable or questionable given particular circumstances. Fluency in several relevant theoretical models can assist practitioners in shaping questions for seeking information, as well as in creating interventions in the absence of empirical guidance. When there is no quality research available to guide interventions, the practitioner can share their theories about the presenting problems, provide the client with some insight about research relevant to aspects of their problem, and then the provider and the client can embark on step four, to co-create the intervention as they progress through services (Gambrill, 2012). The client and practitioner may have to proceed in a
similar manner if the interventions indicated by the best evidence, which fit with the client’s needs and values, are not readily available in the service setting or in the community.

To maximize the likelihood that consumers will have access to evidence-indicated interventions or programs, social workers should be trained and competent in several behavioral vaccines, kernels, and common elements most relevant to the target population and to the practitioner’s level of practice. Social work graduates, particularly at the Master’s level, should also have skill in a selection of key empirically-supported interventions (e.g., Cognitive Behavioral Therapy, Motivational Interviewing) most often highlighted in work with diverse populations (Hooper et al., 2012; Weisz, Sandler, Durlak, & Anton, 2005). If the intervention identified is an Empirically-Supported Treatment program (e.g., Multi-systemic Therapy, Functional Family Therapy, or the Positive Parenting Program) which the provider is unable to execute individually, the client can be referred to the existing program within the agency or elsewhere in the community. For this reason, a well-equipped community-based social worker also needs access to a number of Empirically Supported Treatments known to be effective for the population and presenting problems of concern in home- and community-based settings—either within their own organization, or available through other providers in their community.

To support the development of this type of service infrastructure, community-based social work administrators must collaborate with community stakeholders, practitioners, researchers, and policymakers, to assess community need, strategically plan, and carefully select and implement of a limited number of ESTs throughout the service community. Capacity for this work is expanded by skills in community organizing and inter-organizational collaboration, a full understanding of the core components of intervention implementation, and participation in formalizing institutional mechanisms to facilitate networking to accelerate the penetration of evidence across practice and policy settings (i.e. schools, criminal/juvenile justice, healthcare, etc.). Competence in organizational theories of knowledge transfer or exchange prepares social work leaders to build organizational infrastructure and cultures that
support access, absorption, and application of new practice and research knowledge in the daily habits of an agency.

**A Teaching Framework for Preparing Students for Evidence Informed Social Work**

While many ideas exist about how to integrate the use of evidence into established MSW and BSW curricula (Bellamy et al., 2013; Bertram, King, Pederson, & Nutt, 2014; Thyer, 2015), no teaching framework has explicitly discussed how to equip students with the knowledge and skills they will need to practice evidence-informed social work within the existing governance and service structures of home- and community-based practice. Evidence-informed practice curricula for social work students must take into account the types of questions that can arise in home- and community-based services, in addition to institutional services, and provide training and education that prepares new professionals to confidently and competently contend with a variety of circumstances.

**Learning objectives**

Social work training programs implementing the EISW teaching framework should be structured around three key learning objectives: 1) skill development in the Common Factors, 2) competence in executing a modified process of EBP, and 3) training in a variety of evidence-related practice tools. The learning objectives should be paired with explicit coaching in how to address common practice barriers for the use of evidence in community-based settings. These learning objectives support student development in the nine competencies identified by the Council on Social Work Education (2015), and indicate specific course requirements for both general practice at the Bachelor’s and first year Master’s level, and for specialized practice studied by advanced standing Master’s students. Suggested course work, and the competencies developed through each course, is summarized in Table 1.

[Insert Table 1]

**Generalist Practice**
At the Bachelor’s and first-year Master’s levels, preparing social work students to engage in Evidence Informed Social Work focuses on developing three skills: 1) competence in the Common Factors, 2) familiarity with the five-step EISW process, and 3) forming practice-relevant research questions and locating, assessing, and applying research findings to address those questions.

Competency in the Common Factors of building effective therapeutic relationships is central to the efficacy of evidence-informed practice, necessitating a foundational course focusing on developing these foundational skills and providing students a fundamental basis for all social work practice. Training in the Common Factors can include readings and problem-based learning in small groups, as well as live role-playing with class and instructor feedback. Ideally, role play exercises would include filming efforts and engaging in self-critique and reflection to build student awareness of self and how others respond to their interaction style (Bogo et al., 2013). Competence in the Common Factors can be seen in the creation of therapeutic alliances through the use of empathy, unconditional positive regard, and prioritizing client/community perspectives in goal setting (Wampold & Imel, 2015). Mastery of a variety of basic activities that can promote positive change in consumers or stakeholder groups will help students build competency in intervening with these groups. Coaching students in monitoring individual, family, or stakeholder response to the process builds expertise in evaluating their own practice.

The five-step EISW process can be taught through the creation of a research-to-practice course that teaches the steps of the process and trains students in activities necessary to execute each step. The course should focus on the formulation and resolution of practice-related questions, including how to locate relevant research evidence to answer those questions, how to critically appraise the quality and applicability of evidence found, and how to apply evidence to the practice problem at hand. The course should include also instruction on assessment of consumer or collaborator response to interventions. As such, education in advanced aspects of research design and data analysis should be reserved for social welfare students who plan to conduct research or evaluation as a career path.
Constructing practice-relevant questions and the review and analysis of evidence should emphasize the collaborative planning processes at the center of the EISW model—in which the practitioner considers the best, most relevant evidence in the context of their own professional expertise and the limitations of their organizational and community resources, and shares their thoughts about next steps with consumers or collaborators. In teaching emerging practitioners to apply this model in community-based settings, students need practical applications of the steps in the EISW process. Step four is a site of potentially difficult practice scenarios, so solutions for such complexities should be highlighted in the course. Problem-based learning, using case examples with role-playing and written reflections, may be an effective way of walking through potential barriers and ways to overcome them.

Acquiring and refining abilities in Common Factors supports development of social work students’ mastery of CSWE’s EPAS, specifically Competencies one, six, eight, and nine (see Figure 1). The emphasis on step four of the EISW process helps students to build skills in all nine CSWE EPAS competencies. The EISW approach to research education prepares to social work students to engage in practice-informed research and research-informed practice, while the process of EISW can teach students to evaluate their practice through person-centered collaborative care planning, amplifying the role of client self-determination, honing students’ ability to demonstrate ethical behavior, engage diversity and difference in practice, and promote human rights (Competencies 1, 2 and 3) (Gambrill, 1999, 2006). Finally, exploration of how the five step process can support policy development and advocacy advances student development of policy practice competency (Competency 5) (Gray, 2009).

Specialist Practice

For MSW students who have completed their generalist practice coursework and are developing specialization in their social work practice, the EISW model is most effective when delivered with at least two courses for specialized practice in a given program concentration: a practice course focused on
learning and practicing a small number of empirically-supported practices, and a theory course focusing on the common social problems faced in their field of practice.

The specialist practice course should provide opportunities for students to develop mastery in a small set of empirically-supported treatments. These treatments must be amongst the exemplar practices in the specialty field and, if possible, should provide students with opportunities to build competence and confidence in their specialized skillsets. This course sequence should also prepare students to deliver an array of common elements, kernels, or behavioral vaccines identified for their population and intervention setting of interest. This course expectation does not only apply to direct-service or clinical specialties; a practice course in administration or policy concentrations should focus on management and organizing skills that support the use of evidence in a variety of service delivery settings.

A specialist theory course, focusing on the common social problems faced in their field of practice, should familiarize students with basic clinical and practice theories pertinent to their population of interest. This course should be organized around helping students understand how to apply theoretical models to create interventions in the absence of empirical guidance, and to form questions to guide information seeking. Carefully selected readings, combined with application of theories to practice problems through small group activities and written assignments, can support development of theoretical application skills—particularly if learning activities focus on problem formulation and theoretically-based care planning. Because the application of theoretical models in practice settings must be emphasized, this course needs to be rooted in case-based or problem-based pedagogy that supports skill development by applying course content to clinical, organizational, community, or consumer-related problems (Gambrill, 2012, 2015).

The practice and theory courses will complete student mastery of CSWE competencies four, and seven through nine by equipping students with knowledge and skill in using evidence-informed tools for assessment, intervention, and evaluation of practice specific to each program concentration. The practice
and theory courses for management, policy, and administration-focused students supports student growth in competencies four and five by enhancing students’ knowledge and skill development in supporting organizational and community-level evidence-informed practice and practice-based research.

**Strengths, Limits, and Implications of the EISW Teaching Model**

Much attention has been given to the confusion between the EBP process and ESTs, and the superiority of one over the other, but little has been paid to how ESTs can and should exist in tandem with the EBP process. The strength of the proposed Evidence-Informed Social Work teaching model rests in demonstrating the congruent relationship that can exist between the common elements, behavioral vaccines, Common Factors, ESTs, and the five-step process of EBP. This model distills and combines multiple perspectives about evidence-informed practice into a clear, holistic skillset that accounts for the uncontrolled environments of community-based practice settings, the complexities and variation of the vulnerable populations being served, the limitations of real-world resources, and the constraints of local, state and federal policy. As Bertram and colleagues (2014) point out, most social work students do not enter graduate education intent on discovering how research can inform their work; most students enter social work programs with an interest in providing direct services and are thus concerned primarily with obtaining the skills needed to do so. While other models for EBP education focus on incorporating the process and conceptual framework for EBP across all courses in both micro and macro practice curriculums (Mullen, Bellamy, Bledsoe, & Francois, 2007; Shlonsky & Stern, 2007), the EISW educational model is focused specifically on equipping students with tools they need to engage in high quality practice, with an emphasis on developing skills that can be utilized across a variety of complex settings with diverse populations.

While the EISW model is comprehensive yet agile enough for real-world practice settings, adjusting graduate programs to prepare students to engage in EISW at the Master’s level, may be challenging for some schools of social work. Ensuring there is a theory and empirically-supported
EVIDENCE INFORMED SOCIAL WORK: A TEACHING FRAMEWORK

intervention course offered for each concentration in the social work program, with each course tailored to the specific settings within each specialization track, may strain programmatic resources in developing and delivering the needed assortment of courses. It is likely that much content is currently being delivered in smaller slices across a variety of currently existing classes. Moving to a curriculum that supports the development of Evidence-Informed Social Workers will require a survey of the current course offerings and a realignment of content and resources to support delivery of such curricula; however, investing time and energy in this effort would support maintaining program accreditation, as these courses directly fulfill the expectations set forth by the CSWE for competency development.

The EISW model leaves unanswered practical questions on the execution of Evidence-Informed Social Work in the fast-paced, budget constrained, emotionally charged world of community-based social work, such as: how do I find the time to do the required research? How will my organization afford the resources needed to implement an empirically supported intervention? What if organizational, local, state or federal policy constrains my use of an intervention that is indicated by best evidence and client preference? Though addressing these questions is critical to bridging the gap between research and practice, many solutions rest at the organizational or policy level and are thus beyond the scope of this teaching model. Some concerns can be addressed by continuing to create new inter-organizational relationships at the university level; enhancing collaboration between professional organizations, schools of social work, and the practice community will help to eliminate or reduce barriers to accessing and applying research (Bellamy, Bledsoe, Fang, Manuel, & Mullen, 2012). The lack of access to quality, peer-reviewed research for most practitioners (Bowen, Mattaini, & Groote, 2013) might be solved through restructured agreements between social work training programs and graduates or field education partners: schools could extend a certain level of continued access to key academic databases to their graduates as they enter the field, and university social work programs might offer database access to community social work practitioners or organizations who participate in field instruction for their
students. Further, practitioners could work collaboratively with scholars to develop evidence-based methods that can be accessible and applicable without the need for expensive research databases or costly manual-based interventions. To this end, research efforts should focus on the broader identification and dissemination of common elements, kernels, or behavioral vaccines relevant to populations served in community-based settings.

**Conclusion**

In preparing social work students to engage in evidence-informed practice, teaching efforts should focus on encouraging emerging practitioners to do what is possible, and continuously look for ways to reduce barriers to further integration of evidence in their practice. The EISW model provides many avenues for the infusion of evidence into home- and community-based work, but it is unrealistic to expect social work graduates to immediately incorporate research at every opportunity. In the EISW educational model, evidence-informed practice should be explained as a spectrum of professional development: at one end of the spectrum is a social worker who incorporates Common Factors into their regular professional interactions; at the other end of the spectrum is a practitioner who consistently utilizes Common Factors in their engagements with stakeholders, faithfully integrates common elements of effective interventions or relevant theory into client or stakeholder interactions and care planning, and regularly consults, evaluates, and applies high quality evidence to practice problems. To support the development of new social workers on this spectrum, the Evidence Informed Social Work teaching model suggests a curriculum that equips students with specific evidence-based resources and a conceptual framework that is practical, flexible, and applicable to home and community-based work with diverse populations and presenting problems.
References


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Table 1. EISW Course Work and Learning Objectives

<table>
<thead>
<tr>
<th>General Practice: BSW and 1st year MSW</th>
<th>CSWE EPAS Competency</th>
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<tbody>
<tr>
<td><strong>Learning Objective:</strong> Skill development in the common factors &amp; in executing a modified process of EBP</td>
<td></td>
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<tr>
<td><strong>Course Topic</strong></td>
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<tr>
<td><em>Engaging with Consumers:</em> Common factors skills development through readings and problem-based learning approaches in small groups, live role playing with class and instructor feedback, and use of video with self-critique</td>
<td>Competencies 6, 8, and 9</td>
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<tr>
<td><em>The Role of Evidence in Social Work Practice:</em> Basic skills in locating, assessing and applying research evidence; Understanding the EBP process, modified for community-based settings; explicit discussion of ways that EISW process aligns with NASW code of ethics, and all 9 CSWE competencies</td>
<td>Competency 1 through 9</td>
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<tr>
<th>Specialized Practice: 2nd year MSWs focused on Direct Practice</th>
<th>CSWE EPAS Competency</th>
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<tr>
<td><strong>Learning Objective:</strong> Training in a variety of evidence-related practice tools</td>
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<tr>
<td><strong>Course Topic</strong></td>
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<tr>
<td><em>Specialized Practice Course (Direct Practice):</em> 3 key ESTs, practice guidelines, and 5 to 8 Common Elements and Behavioral Vaccines for population and social problem within each practice specialization; knowledge and skill development through readings, live role play with feedback and reflection</td>
<td>Competency 7 through 9</td>
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<tr>
<td><em>Specialized Theory Course (Direct Practice):</em> Basic and practice theories focusing on population and social problem for each practice specialization, with explicit focus on applying theory to presenting problems and care planning; based in readings, problem-based learning in small groups, and written assessment and care planning assignments</td>
<td>Competency 7 &amp; 8</td>
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<tr>
<th>Specialized Practice: 2nd year MSWs focused on Management and Administration</th>
<th>CSWE EPAS Competency</th>
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<tbody>
<tr>
<td><strong>Learning Objective:</strong> Training in a variety of evidence-related practice tools</td>
<td></td>
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<tr>
<td><strong>Course Topic</strong></td>
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<tr>
<td><em>Specialized Theory Course (Management and Administration):</em> Knowledge and application of basic organizational theories, including knowledge transfer and implementation theories and frameworks; learning occurs through readings, and written real world organizational assessments and change management planning aimed using evidence in community and organizational practice</td>
<td>Competency 4 and 5</td>
</tr>
<tr>
<td><em>Specialized Practice Course (Management and Administration):</em> Key components of community assessment, service planning, and organizing; knowledge and skills developed through readings and written assessment and community plan developed through community-based group project</td>
<td>Competency 4 and 5</td>
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Figure 1. Council of Social Work Education (CSWE) Educational Policy and Accreditation Standards (EPAS)

| Competency 1: | Demonstrate Ethical and Professional Behavior |
| Competency 2: | Engage Diversity and Difference in Practice |
| Competency 3: | Advance Human Rights and Social, Economic, and Environmental Justice |
| Competency 4: | Engage In Practice-informed Research and Research-informed Practice |
| Competency 5: | Engage in Policy Practice |
| Competency 6: | Engage with Individuals, Families, Groups, Organizations, and Communities |
| Competency 7: | Assess Individuals, Families, Groups, Organizations, and Communities |
| Competency 8: | Intervene with Individuals, Families, Groups, Organizations, and Communities |
| Competency 9: | Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities |

Figure 2. An Integrated Model of Evidence-Informed Social Work (EISW)

Note: “Step 4 => tx plan” denotes that the decision-making process of step 4 will result in a plan for moving forward in treatment or services (i.e., a plan of care, or a treatment plan)