Evidence-Based Practice at a Crossroads: The Timely Emergence of Common Elements and Common Factors

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Abstract
Social work is increasingly embracing evidence-based practice (EBP) as a decision-making process that incorporates the best available evidence about effective treatments given client values and preferences, in addition to social worker expertise. Yet, social work practitioners have typically encountered challenges with the application of manualized evidence-supported treatments. For social work, the path to implementing the delivery of science-informed practice remains at a crossroads. This article describes two emergent strategies that offer a plausible means by which many social workers can integrate an EBP model into their service delivery—common factors and common elements. Each strategy will be presented, and related evidence provided. Tools to implement a common elements approach and to incorporate client feedback consistent with a common factors perspective will also be described. These strategies will be placed in the broader context of the EBP framework to suggest possible advances in social work practice and research.

Keywords
child welfare, evidence-based practice, mental health

As the profession of social work moves deeper into its second century of mental health practice, the challenge of improving the quality of usual care remains a key task. Thyer and Myers (2011) issued a charge to infuse social work with evidence-based practice (EBP) in order to better establish social work as an applied science. An examination of the historical trends of social work teaching reveals the relatively slow infusion of EBP (see reviews by Rubin, 2011; Thyer & Myers, 2011). Although the slow uptake might be bemoaned by some, the delayed adoption of EBP and manualized treatments provides a prime opportunity for the field to thoughtfully consider a paradigm shift in the way EBP is conceptualized. Rather than simply emulating early efforts in clinical psychology by embracing manualized treatments wholeheartedly, social work has the opportunity to blaze a new trail toward effective treatment delivery through the adoption of cutting edge clinical practices that reflect the core values of the profession. The purpose of this manuscript is to propose an integrated approach to social work that includes common elements, common factors, and a data-informed practice framework.

Historical Context of EBP in Social Work
A brief overview of how social work has historically engaged with evidence sets the stage for the current context (for a more complete history see Thyer & Myers, 2011). Over time and much like its professional counterparts in psychology and psychiatry, social work has moved from a pervasively psychodynamic perspective in the delivery of mental health services to one that is better characterized as eclectic (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010). Yet, many who identify their practice as eclectic cannot identify the theories or methods that they practice (Baumann, Kolko, Collins, & Herschell, 2006). The continued pursuit of effectiveness has led social workers to gradually expand their engagement with science-informed practices. This effort has, in part, emphasized strategies to help social workers evaluate their own practice and use that information to shape effective treatment (e.g., Bloom, 1982; Bloom, Fischer, & Orme, 2009).

The leading approach in social work education is the five-step EBP decision-making process initially developed in medicine and

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sometimes known by its shorthand COPES: client-oriented practical evidence search (Gibbs, 2003; Straus, Richardson, Glasziou, & Haynes, 2005). This e COPES process involves (a) formulating a well-designed question; (b) identifying evidence-based resources that answer the question; (c) critically appraising the evidence to assess its value; (d) applying the evidence with guidance from client preferences, the clinical state, practitioner expertise; and (e) reevaluating the application of the evidence to modify future practices. An underlying assumption of this approach is that the treatment with the best available evidence in support of its efficacy will be identified, and the practitioner will be able to competently implement it or find other resources to do so. Some (but not all) of the effective treatments would certainly include use of manualized evidence-supported treatments—the kinds that have recently become identified in a range of clearinghouses (e.g., California Evidence-Based Clearinghouse for Child Welfare, SAMHSA’s National Registry of Evidence-based Programs and Practices), critiqued by the Campbell and Cochrane Collaboratives (Soydan, Mullen, Alexandra, Rehman, & Li, 2010), and, not uncommonly, the basis for decisions about what treatments are reimbursable (Bruns et al., 2008). Although we do not see manualized treatments as tantamount to EBPs, we also recognize that these concepts have become conflated. These terms may have become linked because manualized treatments provide a convenient shortcut for monitoring fidelity in implementation of EBP, which is less readily measured in other versions that rely on the traditional elements of EBP. By equating EBP to equal only manualized treatments, the knowledge base of what works is, no doubt, short-changed.

Despite the increasing number of manualized treatments, the dissemination and implementation of manualized evidence-supported treatments (MESTs) remains strikingly limited in practice settings (e.g., Barth, 2008; Zima et al., 2005). In the real world of practice with complex populations, practitioners have identified many barriers to implementing manualized evidence-supported interventions (Addis, Wade & Hatgis, 1999; Franklin & Hopson, 2007), including access to training and managing the fit between various treatment models and the clients’ needs (Baker-Ericzen, Hurlburt, Brookman-Frazee, Jenkins, & Hough, 2010; Chorpita, Bernstein, & Daleiden, 2011) or duration of treatment (Powers, Bowen, & Bowen, 2010). Further, social work scholars have expressed concern about whether evidence for EBPs is adequately attuned to the service needs and preferences of ethnically and culturally diverse populations (McBeath, Briggs, & Aisenberg, 2010). McBeath et al. (2010) conclude that due to the difficulties in implementing MESTs, other approaches that are both evidence-based and consumer-centered are needed. This article tackles this vexing issue of how to shape an EBP approach that is suitable for professional social work values and practices.

**Reconceptualization of EBP**

Given that the number of evidence-based manualized treatments is in the hundreds and continues to grow (Chorpita & Daleiden, 2009), and that the drawbacks of MESTs have limited their widespread adoption, this is a critical time for reconsidering our field’s approach. Although the argument has been made that conceptualizing manualized treatments as necessary to the delivery of EBP is a detriment to our goal of promoting the application of science within social work practice (Thyer & Myers, 2011), powerful forces converge to place MESTs in the forefront of the EBP movement. The greatest of these is that the use of these interventions—at least with clients who have been assessed as in need of these services—has demonstrated outcomes better than treatment as usual (e.g., Cohen & Mannarino, 1996). This cannot be so readily concluded about employing the process of EBP. As another alternative, we propose an expanded view of EBP that involves two concepts from psychology—common elements and common factors. These concepts show promise in being effective for clients and being accessible to practitioners.

A **common elements** framework (Chorpita, Daleiden, & Weisz, 2005; Chorpita, Becker, & Daleiden, 2007) conceptualizes clinical practice in terms of generic components that cut across many distinct treatment protocols, and focuses heavily on identifying specific clinical procedures common to EBPs (cf. Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008). The **common factors** framework (Duncan, Miller, Wampold, & Hubble, 2010; Sparks & Muro, 2009) asserts that the personal and interpersonal components (e.g., alliance, client motivation, therapist factors) common to all therapeutic interventions are responsible for treatment outcomes to a greater extent than specific model ingredients. These two frameworks and their potential contributions have generally not been discussed along with other EBPs in the social work literature. What a common elements approach and strategies based on common factors have in common is that they are both emerging as a complement to the predominant social work discussions of EBP (i.e., via the COPES process) and MESTs. Common elements and common factors may thus be additional avenues to promote the quality and effectiveness of services clients receive. The next section will provide a brief overview of the common elements approach followed by a similar introduction to common factors.

**Common Elements**

Over the past 15–20 years, methods for summarizing the evidence base of psychosocial interventions have focused on the treatment manual as the unit of analysis (cf. Chambless & Hollon, 1998; Silverman & Hinshaw, 2008). This approach has promoted evidence-based treatments by providing a framework to evaluate the strength of evidence of manualized interventions. With the proliferation of manualized treatments, however, the utility of such an approach has diminished over time as clinicians who endeavor to use evidence-based treatments are left with the daunting task of selecting the right ones among many choices with little guidance (Kazdin, Bass, Ayers, & Rodgers, 1990). Or, practitioners may attempt to find a way to use the best features of many manualized evidence-supported treatments in a single treatment plan (e.g., Weisz...
The common elements framework has emerged as a complementary method for summarizing the evidence base. Common elements refer to the individual treatment practices such as psychoeducation, exposure, and rewards that comprise an intervention (Chorpita et al., 2005). This component level of analysis emerged out of the distillation and matching model for aggregating research findings across distinct protocols and laboratories (Chorpita et al., 2005), with the “distillation” piece of the model requiring the identification of overlapping treatment components across effective interventions and “matching” to client characteristics. Although the distillation and matching model was not designed as a formal treatment development framework, its common elements level of analysis has implications for treatment design that represent a departure from the commonly held notion of discrete, intact protocols. Unlike many treatment manuals (which are tools often given to practitioners during training), modular approaches to practice guided by a common elements framework can offer a high level of flexibility in regards to topic, pace, pairing, and sequence (Weisz & Chorpita, in press).

The common elements approach developed as a means by which to advance the use of evidence-supported treatments within Hawaii’s Department of Child and Adolescent Mental Health Division (Chorpita et al., 2002). The most comprehensive examination of common elements to date has emerged from a systematic study of 322 randomized controlled trials (RCTs) testing treatments targeting common child mental health problem areas, including depression, anxiety, and disruptive behaviors. These studies were conducted over a span of 40 years, representing over a half billion dollars of treatment research and more than 30,000 youth participants cumulatively included in the study samples. Coding of the 615 treatment protocols tested in these studies yielded 41 practice elements common across the interventions that showed the best outcomes across the entire set of studies (Chorpita & Daleiden, 2009). Parallel efforts to identify common elements in children’s mental health (Garland et al., 2008) and other fields (e.g., HIV prevention programs: Swendeman, Ingram, & Rotheram-Borus, 2009) are emerging, as are pilot initiatives to train primary care providers in this approach (e.g., Stephan, Wissow, & Pichler, 2010; Wissow et al., 2008).

Incorporating a modular approach to treatment using a common elements framework offers possible advantages over traditional manualized interventions in isolation. For example, treatment manuals are often geared toward specific disorders, but some clients will have multiple issues to address, prodromal symptoms, or need services that do not match the length or intensity specified in a treatment manual (Chorpita et al., 2005, 2007) or for which no evidence-based treatment exists (Schiffman, Becker, & Daleiden, 2006). For practitioners, learning the common elements rather than a diverse collection of treatment manuals may promote mastery and confidence in delivering effective services (Chorpita et al., 2005, 2007). For agency administrators, the initial investment required to develop a workforce with expertise in multiple evidence-supported interventions may be prohibitive, and coordinating multiple manualized treatments within a single agency can create a complicated infrastructure of different forms, fidelity efforts, contracting, and monitoring tasks (Chorpita et al., 2007).

Yet, the common elements approach is not simply about the elements. Because the whole may be greater than the sum of its parts, applying the common elements in the absence of a practice framework may not yield the same results as a manualized treatment (Chorpita et al., 2007). Accordingly, the common elements framework includes a well-specified quality assurance model that includes structured treatment sessions, ongoing progress monitoring and reporting, and evidence-informed clinical decision-making that engages clients, clinicians, and other mental health stakeholders in the processes of treatment planning and delivery (Chorpita, Bernstein, Daleiden, & the Research Network on Youth Mental Health, 2008; Daleiden & Chorpita, 2005; Daleiden, Chorpita, Donkervoet, Arensdorf, & Brogan, 2006; Nakamura, Higa-McMillan, & Chorpita, in press).

Despite these possible advantages, the common elements approach is not conceptualized as a model to replace evidence-based treatments entirely, and as an approach it, too, encounters particular limitations. For example, the literature typically does not allow determination of the effect size of each common element on its own; rather, evidence for the common elements is based only on their frequency of inclusion in interventions that have demonstrated efficacy (Chorpita et al., 2007). Similarly, although common elements are identified through empirical research conducted with diverse samples of youth, few studies conducted adequate subgroup analysis to understand whether some youth in the research sample benefited more than others. Third, although the common elements approach allows for a high level of flexibility when there is a high degree of complexity or interference, following a treatment manual as prescribed may still be the best option when appropriate or available (Chorpita et al., 2007). Direct tests comparing manualized evidence-based treatments with modular, common-elements based approaches have shown that a modular approach improves provider attitudes toward EBP (Borntrager, Chorpita, Higa, & Weisz, 2009), but studies assessing the effects on client outcomes are still underway (Weisz et al., 2011).

Resources for Implementing Common Elements

The present discussion will focus on three tools that contribute to the implementation of a common elements approach—drawing on tools available at http://www.practicewise.com, as an exemplar: (a) PracticeWise Evidence-Based Services (PWES) database, (b) practitioner guides, and (c) clinical dashboard. Implementation of the common elements approach to treatment is informed by the PWES database that allows users to specify client (e.g., target problem, age, gender, ethnicity) and treatment (e.g., setting, format) characteristics, among other search criteria, to identify the practice elements...
that comprise the interventions that have demonstrated positive outcomes in studies that have included youth with those specified characteristics. For example, a search for elements appropriate for a 15-year-old male exhibiting disruptive behavior problems yields goal setting, praise, problem solving, and social skills training as the top four most frequent practice elements.

After developing a treatment plan that has been partly informed by the PWEBS search, clinicians may use the practitioner guides, a set of clinical guidelines for how to implement the practice elements. Each two-page practitioner guide reflects a synthesis of the literature regarding the standard content related to the element and provides step-by-step instructions to facilitate implementation (e.g., communication skills includes creation of communication hierarchy, discussion of speaker and listener skills, and turn-taking as the speaker). The practitioner guides can be used flexibly with fidelity, such that a clinician who is unfamiliar with a particular element may choose to adhere closely to the steps outlined in the guide. A clinician with significant experience with a particular element may choose to review the guide for additional ideas or may adhere more closely to the guide if the practice element as delivered by the clinician previously has not been effective.

After the treatment plan has been developed and the clinician begins implementing the practice elements, the clinical dashboard provides a way to monitor treatment progress (Chorpita et al., 2008). The dashboard is a graphic representation of clinical progress and practice elements over the course of treatment. The progress graphic diagram plots scores on outcome measures indicated by the clinician. Clinicians are encouraged to use standardized measures (e.g., Child Behavior Checklist, Youth Self-Report, Children’s Depression Inventory) as well as idiographic measures that reflect the treatment goals of the individual client and can be regularly monitored by the youth and/or adults in the environment (e.g., frequency of school attendance, number of prosocial peer interactions, subjective mood rating). The practices checklist marks the practice elements covered at each treatment session. Using the clinical dashboard, clinicians, supervisors, and clients have access to historical progress and treatment data at a glance. Regular collection of data provides a means of monitoring progress and the graphical presentation of progress and treatment data together allows for inferences to be drawn regarding the effectiveness of selected practice elements. For a more detailed case example of the implementation of the common elements in Hawaii, readers are referred to other sources (see Daleiden & Chorpita, 2005; Daleiden et al., 2006; Nakamura et al., in press).

**Common Factors**

The earliest mention that different psychotherapeutic approaches contained common unrecognized factors critical to positive treatment outcomes was made by Rosenzweig (1936). Although also written about by social workers (e.g., Cameron & Keenan, 2010; Drisko, 2004), the concepts have not yet been embraced by the profession and the fit of this perspective with the movement toward EBP has not been much discussed. The name “common” or “nonspecific” factors was originally given to features of the psychotherapeutic exchange that were universal to the therapy experience, not related to the specific therapy model or approach, and highly determinant of the outcomes. For example, the therapist’s personal qualities, therapeutic alliance, and the client’s hopes and expectations are considered common factors, and have been shown to be associated with therapeutic outcomes regardless of the intervention techniques employed. These nonspecific factors are considered by common factors advocates to be critical in manualized interventions, not simply as preludes to procedures but essential to outcomes. Part of the empirical evidence supporting the common factors has been assembled through meta-analyses (Duncan et al., 2010; Wampold, 2001). In comparing results across diverse psychotherapeutic models, outcomes show little variation by unique model, suggesting that the bulk of therapeutic change is due to therapist effects, the therapeutic alliance, and client hope about recovery that are common across all generally accepted approaches. In assessing meta-analytic findings, advocates of the common factors perspective have suggested that the effect size of treatment differences is 0.20, a small effect in the social sciences, indicating that only 1% of the variance in outcomes is due to the treatment (Wampold et al., 1997). Results from a meta-analysis of 27 component studies (where a complete treatment was compared to a treatment without a theoretically important component) found the exclusion of a component did not significantly impact outcomes (Ahn & Wampold, 2001). Some cognitive-behavior therapists have long recognized that a well-trained clinician who has exceptional skills in engaging clients and creating a therapeutic alliance and in the use of an evidence-based intervention would have the best chance of a positive outcome (e.g., Raue & Goldfried, 1994). Common factors proponents similarly value the therapist’s relational skills along with a mutually acceptable treatment technique that engages the client in pursuasive collaboration (Hatcher & Barends, 2006).

Critics (e.g., Siev, Huppert, & Chambless, 2009) have taken issue with the results of these meta-analyses that downplay the value of unique factors from specific treatment models for a variety of reasons. Specifically, critics have challenged the meta-analytic strategy of aggregating data across treatments, disorders, and measures, possibly masking real treatment differences. Moreover, the analysis of the impact of common factors is entangled with the treatment methods used—obscuring the relative importance of specific ingredients. Because the quality and dose of a therapist’s service delivery of a treatment model may vary, studies reporting and comparing actual practices within treatment models would more precisely capture differences within and between therapy models (Sexton, Ridley, & Kleiner, 2004). Nevertheless, empirical evidence for the impact of common factors has the most robust support in the areas of therapist effects and the working alliance. For example, research on the power of the alliance reflects over 1,000 findings (Orlinsky, Rønnestad, & Willutzki, 2004) and alliance is consistently a strong predictor of outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011).
In sum, the meta-analytic work that arguably demonstrates the greater impact of certain common factors such as the alliance and therapist effects over specific evidence based treatments has set off a volley of analyses and counteranalyses by treatment researchers. It is possible that specific treatment techniques must be combined with the power of other common factors to create a necessary condition for change (Anderson, Lunnen, & Ogles, 2010). From our perspective, common factors and MESTs are complementary. The effective delivery of an approach that is consistent with client preferences and culture and that engenders hope and engagement is essential to the reciprocal and evolving psychotherapeutic process.

Instead of simply offering a generalist argument for focusing on the therapeutic alliance, common factors proponents have developed tools that help the therapist monitor the therapeutic alliance and progress. Based on the pioneering work of Lambert (see, e.g., Lambert et al., 2001), Duncan, Miller, and Sparks (2004) have endeavored to elevate the use of common factors and “practice-based evidence” Barkham et al. (2001) to a higher level of impact by structuring a real-time feedback system called “client-directed and outcome-informed” (CDOI). A central element of the CDOI approach, is an effort to continuously measure the therapeutic alliance and the level of client progress throughout the course of therapy. Repeated and systematic use of fairly simple tools (described later) are designed to significantly enhance the therapist’s attunement to client needs, preventing premature dropout. The use of CDOI measurement tools (or other valid feedback instruments) provides a consistent way to assess alliance and progress so clinicians can modify their approach to better fit client preferences. This system has now been studied in randomized clinical trials and found to enhance therapeutic gains, above clinical treatment without these assessments (e.g., Anker, Duncan, & Sparks, 2009; Lambert, 2010; Lambert & Shimokawa, 2011; Reese, Norsworthy, & Rowlands, 2009; Reese, Toland, Slone, & Norsworthy, 2010).

The common factors are “intertwined” (Duncan et al., 2010, p. 67) and often measured collectively. They function in collaboration with each other in a dynamic way, making it impossible to assess the potential impact of a deficit in one common factor. For example, if there is no agreement between a provider and client on treatment goals, treatment alliance and expectations are likely to be compromised. Therefore, the routine collection of client feedback regarding the therapeutic alliance and treatment progress are recommended by many common factors proponents.

Common factors have been endorsed as the “heart and soul of change” (Duncan et al., 2010), but other researchers are less certain how central these factors are to change. Sexton et al. (2004) have noted that factors like hope and alliance are more likely outcomes of the therapeutic process rather than purely mechanisms for change. If hope is a mechanism for change, can therapists really be trained to activate hope? Anker, Owen, Duncan, and Sparks (2010) have recently shown that the alliance significantly predicted outcomes over and above early change, suggesting that the alliance does make an independent impact on the outcome. Finally, Sparks, Kisler, Adams, and Blumen (in press) argue that the best way to train and supervise therapists to improve the alliance and generate hope is through the routine collection of client feedback and using it to guide the selection of next steps in treatment.

Resources for Implementing Common Factors

To implement the CDOI approach, simple measurement tools that incorporate client feedback were created. The Outcome Rating Scale (ORS) and Session Rating Scale (SRS) are each only four items, allowing quick and easy implementation. Both measures are available in full online (http://www.heartandsoulofchange.com). The ORS asks the client about his current level of functioning personally, in close relationships, in life outside the home, and overall. The ORS is completed at the beginning of each session, as the responses should guide the topics and content of the therapeutic interaction. At the end of the session, the client can complete the SRS. The SRS collects feedback about the therapeutic alliance, specifically the extent to which the client felt heard and understood, worked on issues he wanted to work on, appreciated the therapist’s approach, and an overall session rating. For both the SRS and the ORS, clients rate each item from 1 to 10, with higher scores indicating higher functioning or satisfaction. An additional measure, the Child Outcome Rating Scale (CORS) allows children aged 6–12 to have a voice in their treatment. Adolescents aged 13–17 can use the adult ORS. Psychometric properties have been assessed for the ORS, CORS, and SRS. The CORS was found to have high internal consistency, high test–retest reliability, and adequate concurrent validity with another outcome measure (Duncan, 2010).

The use of ORS and SRS measures was recently tested in a RCT on marital therapy and found to have a significant benefit for couples (Anker et al., 2009). In another study of over 6,000 clients, implementing the ORS and SRS and using the feedback to guide practice increased client retention and doubled the effect size of the intervention (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). The CORS for children under 13 and their caretakers and the ORS for adolescents and their caretakers have been validated and shown to be reliable as brief measures of global distress suitable for assessing treatment outcomes for these age groups (Duncan, Sparks, Miller, Bohanske, & Claud, 2006). There are two means to collect, store, and interpret CDOI data. One is an end-user software program (ASIST) and the other a web-based program (PCOMS). Both of these indicate each client’s unique expected trajectory of change based on the intake score. The SRS scores are also plotted. Graphic depiction of the alliance and progress are shared and discussed with clients at each meeting, giving clients a format for voicing their views about the direction of therapy and desired changes.

Common Ground Between Common Elements and Common Factors

The approach inspired by research on common factors and the common elements approach share some common features.
In addition to both approaches emerging as a response to the proliferation of individualized treatments, areas of agreement between the common factors and common elements are: (a) a “both/and” relationship with MESTs; (b) an emphasis on client involvement and practice-based evidence; and (c) “flexibility within fidelity” (Kendall et al., 2008). This section will first describe key areas of overlap and then review the distinguishing characteristics of each approach.

All three areas of agreement have value for practitioners. The common elements provide an option when there is no manualized EBP known to be effective with a specific client or problem area. When manualized interventions exist for a given clinical situation, the common elements approach is not intended as substitute practice (Chorpita et al., 2007). Rather, the decision-making framework requires clinicians to identify compelling evidence to deviate from evidence-based interventions (Chorpita et al., 2005, 2007). Within the common factors field, manualized interventions have been criticized as inflexible and disengaged from client input (Duncan & Miller, 2006; Sparks & Muro, 2009). However, manualized EBPs have also been recognized as complementary to common elements and common factors (Morgan & Sprenkle, 2007; Sexton et al., 2004; Sprenkle, Davis, & Lebow, 2009). Rather than expecting practitioners to choose either manualized practices or common factors/elements, a “both/and” perspective should be embraced.

The importance of client involvement and client input in monitoring progress toward outcomes are key facets of both the common factors and common elements frameworks. In the common elements approach, the clinical dashboard is a tool that a practitioner can use to track intervention components and client improvement (Chorpita et al., 2008). Within a common factors inspired approach, short instruments like the ORS (Miller, Duncan, Brown, Sparks, & Claud, 2003) and SRS (Duncan et al., 2003) and CORS (aged 6–12; Duncan et al., 2006) provide feedback to the practitioner about progress from the client’s perspective. The need to develop routine ways to monitor treatment and create feedback systems has been identified as critical to the improvement of mental health services (Bickman, 2008). Although it is not possible to identify the prevalence of providers who have implemented client feedback systems, there are over 30,000 CDOI users worldwide, including large community-based systems of care (see http://www.heartandsoulofchange.com) and promising evidence of increases in client-reported successful completion of treatment, reduced length of stay, and reduced clinician caseloads (Bohankse & Franczak, 2010).

Finally, the idea of flexibility within fidelity is relevant for both models (Kendall et al., 2008). For common elements, flexibility is inherent in the approach, in regards to the selection, sequence, and pacing of each practice element. However, each practice element has generally prescribed steps or tasks that should be covered to insure that it is delivered in a comprehensive way. Even so, the common elements approach does not necessarily require that prescribed steps be covered. If a clinician implements a common practice element the way she always does and the client data show progress, then the clinician does not need to implement the common practice element according to the practitioner guide.

But, if a practice element is new to a clinician or the clinician is not seeing progress, then it is suggested that the clinician check their fidelity to the guide.

Flexibility in engaging clients is central to an outcome-informed approach. Treatment should be adapted to meet a client’s characteristics and preferences, including the therapist’s own style or methods. Fidelity here means assessing the client’s perspective of the treatment to insure that the client’s goals are being met and, if not, changing course. In this way, fidelity does not mean staying true to a treatment manual, but staying true to the client’s goals in the treatment process.
Despite some overlap in the ideas and ideals of the common elements and common factors approaches, they have critical differences. Table 1 compares the common elements and common factors on a few key facets where differences are clear. Within approaches, individual advocates may take a perspective that differs from what is reported in the table.

An Integrative Framework

In our view, both common elements and common factors make potentially important contributions to evidence-informed treatment as usual in social work practice. This section will propose an integrative framework for thinking about the role of the common factors, common elements, and evidence-supported manualized interventions, as well as other sources of knowledge within the field. As other social work practices evolve in the era of EBP, a model that organizes the varied approaches and concepts seems fitting. A recent survey of social workers found that a single understanding or definition of EBP has not been embraced (Rubin & Parrish, 2007), suggesting that an organizing framework that incorporates the diverse efforts towards evidence-informed practice may be a helpful contribution. Whereas the current analysis has focused primarily on common elements and common factors, we have also touched on the influence of the COPES approach (Gibbs, 2003) and the use of MESTs. We argue that each of these approaches has a role in decision-making about intervention approaches with clients seeking treatment. The integrative framework identifies these components and suggests an order in the hierarchy of evidence-informed social work practice (Figure 1).

Policy and value directives. Social work practice stands on the platform of policy and value directives that determine such core considerations as ethical conduct, communicating only with those who have a legally supported “need to know” (unless explicit permission is obtained to go beyond this group), legal and agency mandates, cultural competence, and so on. This is the foundation of the pyramid and must be applied with every client. This foundation does not have empirical evidence, in a traditional sense, but is a basis of social work as a profession (NASW, 1996/1999).

Practice principles. Many agencies have practice principles or specific models of care that serve as a next level to help select appropriate interventions. For example, child welfare agencies may require that interventions are “family-focused” or mental health agencies may operate within the framework of “systems of care.” These are not evidence-based interventions, per se, but are principles that contribute to the identification and conduct of best practices. Consideration of these principles is clearly part of the COPES process.

Common factors. The common factors framework is a more specific way to implement what can be considered common practice principles of engaging clients and attending to the achievement of progress. By focusing on the therapeutic relationship and the client’s assessment of progress toward goals, clinicians can remain responsive and flexible. The systematic collection of client feedback is critical to this approach. This relatively new refinement is now considered the tie that binds all the factors together allowing the common factors to engage the clients, heighten hope for improvement, fit client preferences, maximize therapist client fit, and accelerate client change (Duncan, 2010; Sparks & Duncan, 2010). The CDOI, a feedback protocol designed to enhance common factors, is currently listed as an EBP in Arizona and Colorado and is under review elsewhere for national evidence-based standing (http://www.heartandsoulofchange.com).

Common elements. Common elements may represent the next level of EBP precision. These are specific practice elements that have been identified, as described above, because they were present in successful treatments in RCTs involving at least one manualized intervention. Developers of the common elements perspective would certainly expect that intervening with any of the common elements would include attention to the therapeutic alliance but not as the sole focus. The common elements approach also prioritizes collecting data from clients about their outcomes—a hallmark of client feedback methods. Because of this overlap, the line between these approaches could be conceived by us as dotted. Early implementation of the common elements approach in Hawaii, Minnesota, and Maine focuses on achieving general practice improvement by children’s mental health clinicians. From this work has arisen a later version which is more testable as a specific intervention for specific outcomes.

Manualized evidence-supported treatments. The MESTs are treatments that have been identified as superior to a treatment...
as usual condition or a placebo condition in a RCT. There are several hundred of these in the published literature for mental health treatment for children alone (Chorpita et al., 2007) and more for adults. Manuals typically clarify the expected duration of the overall intervention and, most often, the order and expected duration of each of the treatment components. The manuals often include “techniques” that have never been tested outside the package but which are part of a theorized, and perhaps positive, combined effect.

Specific practice knowledge. At the top of the pyramid is a category that we call specific practice knowledge, which includes information that may be particularly germane to the culture, circumstances, and characteristics of clients. (We note that there is not a commonly accepted term for specific treatment knowledge as it seems inaccurate to refer to it as “practice wisdom,” and it is more than book knowledge of local culture or context.) This category may include sensitive topics in a subculture of care that arise because of a specific chronic condition (e.g., schizophrenia or cystic fibrosis), family circumstance (e.g., divorce or adoption), or cultural heritage (e.g., living in a family that is first or second generation in the United States). Mastery of this information may improve engagement of clients and promote treatment completion. We do not argue that this specific practice knowledge is essential to successful treatment but expect that it will contribute to practice effectiveness when used to properly inform the implementation of other science-informed treatments.

Client-Oriented Practical Evidence Search. We think of the COPES process (Gibbs, 2003) as guiding the application of common factors, common elements, MESTs, and specific treatment knowledge. The COPES flows readily from the National Association of Social Workers (2010) definition of EBP as a process in which the practitioner combines well-researched interventions with clinical experience, ethics, client preferences, and culture to guide and inform the delivery of treatments and services. The COPES process identifies MESTs that are appropriate and available and, if not, point to a common elements strategy. The COPES process also identifies factors that would help the clinician and client select a starting point for treatment. By acknowledging the client values and preferences, the COPES process aligns with the common factors and client-driven approaches discussed here.

In all, this framework outlines how the varied efforts to infuse evidence into social work practice can be ordered. This model both acknowledges and identifies the many sources of influence that drive practice decision-making. Each of these approaches has a contribution to make in preparing social workers to serve clients. Practitioners should be well-prepared and adept at navigating each of these layers as they identify treatment and service delivery that will be most effective for each client. The longstanding presence of social work values, policy directives, and specific practice knowledge likely make these levels most familiar to social workers and most prevalent in social work education. Recently, social work practice and education have begun to integrate MESTs (Rubin, 2011), but the common factors and common elements approaches have largely been ignored by social work.

Conclusions and Implications for Social Work

One of the greatest challenges of social work practice is being competent to work effectively with the myriad of problems and issues faced by clients. Effective service delivery requires having a systematic approach to engaging with clients and an array of successful intervention tools. The MESTs alone are not likely to be sufficient for incorporating research-based findings into practice for all clients. Thus, social work practitioners should be skilled in common factors and common elements to broaden their skills in meeting client needs.

Both the common factors and common elements provide tools for quickly and easily monitoring client progress. Agencies are likely to have an increasing interest in outcomes management, in order to respond to growing pressures to achieve quality improvement, accreditation, and reimbursement (Bickman, 2008). On a practice level, social workers need to be skilled in consistently evaluating the impact of their services. Although this is mandated in the Code of Ethics, this is not uniformly practiced in a systematic way. Being responsive to clients’ preferences and tracking progress toward client goals could well increase the quality of care social workers provide.

A growing number of states and counties have implemented policies that encourage or incent the delivery of EBPs (Bruns et al., 2008). Some of these involve creating state strategies for rolling out the training of MESTs, others provide enhanced rate structures for agencies that employ MESTs. Littell and Shlonsky (2010) have argued that evidence-informed policies should increase our options rather than narrow them. Consistent with these ideas, Los Angeles County has recently adapted their approach to disseminating and supporting EBPs by including training in a “common elements” approach as an option.

Whereas this article argues that methods consistent with common elements and common factors frameworks are legitimate alternatives to treatment as usual, more research is needed to assess whether these approaches are as effective as manualized treatments. The RCTs evaluating the use of common elements and client feedback strategies based on common factors are emerging and indicate that these methods, alone, advantages over treatment as usual (e.g., Anker et al., 2009; Weisz et al., 2011).

In addition, social work research is needed to take the common factors and common elements beyond just traditional mental health care. Thus far, the common factors inspired approaches emphasizing client feedback have primarily developed in individual adult mental health treatment and more recently with marriage and family therapy and child and family behavioral health. The common elements approach originated
with child mental health. Social work researchers might employ the frameworks to identify and advance both common elements and common factors in child welfare, intimate partner violence, juvenile justice, geriatric psychosocial services, and other family work found in social work settings. Even though this article calls for increased attention to the common elements and common factors in improving usual care of social work practice, these are not without limitations. The greatest limitation is that the evidence of their effectiveness and long-term outcomes are not yet strong enough to definitely meet the most rigorous tests for EBPs. In addition, barriers to implementing these approaches to scale exist. Specifically, the common elements tools are available only to individuals with paid subscriptions to these resources. These fees, although nominal, may create hardship for implementation. Brief outcome and alliance instruments to implement CDOI are available to individual clinicians free of charge at http://www.heartandsoulofchange.com; the cost to agencies of these tools is not likely to be prohibitive. Finally, the flexibility inherent in these approaches may lead to forms of eclectic practice that may not significantly improve on current social work practices.

Nonetheless, we argue that the field is at a crossroads and we must make choices about how to invest our efforts to improve outcomes of social work practice in mental health and beyond. Continued reliance on the dissemination of MESTs as a primary transformational strategy will not achieve our goals. Refocusing on the training and integration of evidence-supported elements and factors with a practice framework that builds on social work values and client preferences will best advance our effectiveness.

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