A common elements approach to service provision for children and families

Discussion paper prepared for the South Australian Department of Human Services

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Contents

1. A preface about terminology

This preface provides a rationale for the terms used in this report. A glossary is provided in Table 1.

This report uses the term ***evidence-informed practice,*** rather than ***evidence-based practice*** throughout. Since the introduction of the term ***evidence-based practice*** in the 1990s (Guyatt, 1991), it has become clear that this term is not as accurate as it could be as it implies the use of evidence in practice is exact, and decision-making is rigid or robotic in response to new empirical evidence. ***Evidence-informed practice*** is a more fitting term for describing the complexity of how evidence can and should be used in practice. ***Evidence-informed practice*** is the integration of the best research evidence with practice expertise and client values. As such, it is a process that draws on different sources of input, and optimally weights these sources of input for clinical decision-making.

It is common for the term ***evidence-based program*** to be used to describe a structured package of prescribed content put together in a series of steps or sessions, that is supported by empirical research evidence. However, this term is problematic, as the strength of the evidence available varies program to program, and it does not reflect the nuance of what works for whom, and under which conditions. Many of these programs are implemented and adopted in settings that they have not been tested in, and with populations that they have not been tested with. Thus, it is questionable whether implementation of programs in this context is in fact "evidence-based".

In this report, the term ***manualised program*** is used to refer to a structured package of prescribed content put together in a series of (usually linear) steps or sessions, and ***empirically-supported intervention*** is used to indicate that an intervention, such as a manualised program, that has empirical support. In this way, there is a differentiation between the description of the intervention *style* (manualised) and the intervention *evidence*, rather than conflating the two as is the case with the term ***evidence-based program***.

This report uses the term ***common element*** as an umbrella term to refer to:

- practice elements (therapeutic strategies or techniques associated with effective intervention) *and*
- common factors (client, practitioner and relationship factors associated with effective service delivery).

For the purposes of this report, a common element is understood to be an evidence-informed, discrete technique or strategy found in various approaches and interventions (thus 'common') of demonstrated effectiveness.

There is additional discussion in the literature about the differences between ***kernels*** (the most granular of practice approaches), ***common elements***, and ***modules***. It is generally understood that a common element is made up of several kernels, while common elements can be combined to form modules, and modules combined to form programs. However, it is not always clear how a particular practice should best be categorised, as there can be difficulty in distinguishing between kernels and common elements, and common elements and modules. This report refers specifically to common elements, but does mention the modularised approach to intervention design and service delivery.

Table 1. Glossary of terms

Term	Definition
Evidence-informed practice	The integration of the best research evidence with practice expertise and client values
Empirically-supported intervention	Interventions that have been shown to be effective in empirical research.
Manualised program	A structured package of prescribed content put together in a series of (usually linear) steps or sessions.
Module	A module is made up of a combination of common elements. Multiple modules can be combined to form a program.
Common element	Evidence-informed, discrete techniques or strategies found in various approaches and interventions (thus 'common') of demonstrated effectiveness. Multiple elements can be combined to form a module. The common element example attached to this document is 'partnership relationship'.
Kernel	The most granular of practice approaches that cannot be subdivided further. Multiple kernels can be combined to form a common element. One kernel within the 'partnership relationship' common element is 'provide a rationale for working in partnership'.

2. Introduction

2.1. Purpose and scope

The South Australian government has developed a proposal to create a cohesive Child and Family Intensive Support System (CFISS) which will bring together all in-scope government and non-government delivered services to create a connected, evidence-informed service system for vulnerable, medium- and high-risk children and families. One of the approaches that is under consideration as a potential building block for the new service system is the common elements approach.

This purpose of this discussion paper is to resource both the government and the sector in their ongoing discussions and deliberations about service design, particularly as it applies to using the common elements approach to practice. It provides an introductory overview of what common elements are, how they can be understood and used in practice, and suggestions for how to use the existing evidence base to identify and define a selection of common elements associated with positive outcomes for children and families, and how to implement them in child and family services.

2.2. The service context: Meeting the needs of children and families

2.2.1. Vulnerability of children and families in South Australia

Families, in the main, function well and provide supportive and nurturing environments for their children to grow up in. However, some may experience events and stressors that may cause circumstances to deteriorate making them more vulnerable to child abuse and neglect. In South Australia, one in four children are notified to the Department for Child Protection by age 10. There are also high rates of repeat notifications of children and families intergenerationally over many years. Reducing the prevalence of child abuse and neglect – and the subsequent need for children to enter out-of-home care – is a key challenge facing the service system.

The need for support among South Australian families with child protection concerns is far more complex than previously understood. Many have “complex needs”, understood to the child protection concerns plus multiple other service needs including family violence, drug and alcohol abuse, mental and physical health, disability, homelessness, criminal activity and/or legal disputes. This is often coupled with intergenerational trauma histories within families. Many children begin life with these complex needs on account of being born into families who are facing these multi-faceted challenges.

In the service system, targeted intervention services that were originally designed for families with moderate risk are now actually providing services to families with high level, complex needs. This is driven by changing needs of the population over time (increasing levels of complexity and need within individual families) and funding threshold changes (with families needing to present with increasingly complex needs in order to be eligible for available services).

Families who use children and family services across South Australia bring with them a wide range of experiences, values, beliefs, strengths, and often complex needs. It is the role of child and family services to provide services that meet the specific needs of their particular clients. When service design results in multi-level, coordinated care that is user-centred and evidence-informed, better outcomes can be achieved (Lyon & Koerner, 2016; Ungar, Liebenberg, & Ikeda, 2012). Depending on the service and nature of the intervention these outcomes may include enhanced parenting skills, improved family functioning, enhanced community connections, improved mental health and wellbeing outcomes (for parents/carers and children/youth) and improved educational engagement and achievement.

2.2.2. Policy response

There is a clear rationale to intervene in a timely manner with targeted, evidence-informed services as part of a coherent system. The South Australia government has developed a proposal to create a cohesive Child and Family Intensive Support System (CFISS) which will bring together all in-scope government and non-government delivered services to create a connected, evidence-informed service system for vulnerable, medium- and high-risk children and families. While South Australia currently has a collection of services aimed at preventing and reducing child abuse and neglect, they are not organised as a relational system. If implemented well, CFISS may have the potential to deliver significant benefits by delivering a re-designed service system that is data- and evidence-informed.

The aim of CFISS is to facilitate immediate and strong intervention to disrupt the growing intergenerational problem of child abuse and neglect in South Australia. It will involve:

- Consolidating services and commissioning into a single Department of Human Services unit;
- Investing in better services (evidence-informed, best practice);
- Building a connected system;
- Supporting priority populations;
- Applying cultural considerations;
- Strengthening the workforce;
- Linking to other service systems;
- Focusing on outcomes.

The South Australian government is currently undertaking a co-design process with the child and family services sector to inform the design and delivery of CFISS. One approach that is under consideration and has the potential to be a building block of practice for the new service system is the common elements approach.

Common elements are discrete techniques of strategies used to engage clients or facilitate changes in client attitudes and behaviours. They are evidence-informed (found across programs/interventions known to be effective, and/or supported by evidence from multiple sources) and designed to be used flexibly in response to client need.

3. The evolution of a common elements approach

Over the past four decades there has been a strong emphasis on providing services to children and families that are demonstrably effective. For the most part, efforts have focused on empirically supported interventions, which have often (though not always) taken the form of manualised programs that are supported by randomised controlled trial evidence (Chorpita, Becker, Daleiden, & Hamilton, 2007; Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008).

These empirically supported interventions instigated an important shift toward more evidence-informed service delivery (Chambless & Hollon, 1998). Presently, however, there is an increased recognition of the implementation challenges that often accompany these interventions, meaning their full potential is often unrealised in real-world settings (Chorpita et al., 2007; Chorpita, Daleiden, & Weisz, 2005a; Ghate, 2018; Greenhalgh, Howick, & Maskrey, 2014; Lee et al., 2014).

Perhaps the most obvious barrier to widespread system implementation of empirically supported interventions is cost. Such manualised programs can be prohibitively expensive to acquire and implement with fidelity, especially for small service delivery agencies. In addition, the transportability of such programs from one context to another is not a given. Programs may be implemented in settings and with populations that differ markedly from the context within which the program was originally developed and tested. The implication is that children and families are participating in programs in the absence of robust evidence that they will work for them. This is a pertinent issue in Australia, where there is an absence of evidence regarding if and how these programs are effective for Aboriginal and Torres Strait Islander families.

Further, for interventions to be implemented in a culturally sensitive manner, it can be helpful to adapt content, and modes and methods of program delivery (Ortiz & Del Vecchio, 2013). However, adaptations are not always permitted by program developers, and this can result in a lack of alignment between the program and participants from diverse backgrounds.

Other implementation challenges that have been described in the literature (Bernstein, Chorpita, Daleiden, Ebesutani, & Rosenblatt, 2015; Chorpita et al., 2007; Chorpita et al., 2005a; Ghate, 2018; Lee et al., 2014) include the appropriateness of programs to meet the presenting needs (e.g. some child and family needs do not require lengthy or complex interventions), feasibility of program delivery (e.g. unavailability of the necessary workforce, or low referral numbers), and barriers to innovation and evidence-building regarding the effectiveness of adaptations when the unit of analysis for evaluation is the program as a whole. In addition to these challenges and limitations, many empirically supported interventions have content and techniques in common and thus are not as distinct as is sometimes implied.

In response to these issues, there has been increased interest in alternative approaches that might complement the use of manualised programs, without compromising the need to be evidence-informed when working with vulnerable children and families. An emerging approach involves the identification of ‘common elements’ of effective practice, with the goal of determining which elements reliably relate to positive outcomes for service recipients under different conditions (e.g. different circumstances and needs).

4. Understanding common elements

Common elements are evidence-informed, discrete practice techniques or strategies found in various approaches and interventions (thus 'common') of demonstrated effectiveness. There are common elements of effective service delivery, and common elements of effective intervention. This roughly translates to common elements for ***how*** practitioners work with children and families, and common elements for ***what*** practitioners do with children and families, respectively. Common elements are defined by their content, not by duration or timing of delivery (Chorpita et al., 2005a).

The common elements approach to child and family service delivery is flexible and responsive to the specific circumstances, problems, and needs of the clients being served. Common elements can be used when multiple issues need to be addressed, and when the intensity or magnitude of the presenting problem is not well-matched to existing manualised programs (Barth et al., 2012; Mitchell, 2012). Training practitioners in the common elements rather than in a diverse collection of manualised programs may facilitate increased mastery and confidence to deliver effective services, is likely to be a more streamlined and lower-cost approach for agencies and funders (Chorpita et al., 2007; Mitchell, 2012), and enables efficiencies if practitioners move between agencies as they will already have the applicable training.

Common elements associated with effective service delivery (the 'how') lay the foundation for a positive and productive relationship between the practitioner and the client, which is a necessary, though not sufficient, condition for change to occur. The relationship is the medium through which practitioners can support families take action to address problems and build capabilities. The importance of building this foundational relationship (or alliance, as it is sometimes called) is underscored by the findings of numerous meta-analyses and systematic reviews, which have found moderate but consistent and direct associations between the practitioner-client relationship and intervention outcome (Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). In other words, the outcomes achieved through intervention are influenced by the practitioner-client relationship. This indicates that the success of an intervention is determined not only by what is delivered, but also by the way in which it is delivered (Dunst & Trivette, 2009; Greenhalgh et al., 2014). Some examples of common elements associated with effective service delivery include **seeking feedback** from clients (the process of continually checking how parents, carers and families have experienced the service and whether the practitioner is delivering the service in line with best practice), **strength-building** (focusing on the strengths of parents, carers and families, seeking to identify and openly acknowledge what families do well or are able to do for themselves), and developing a **partnership relationship** with clients (explicitly seeking a collaborative partnership relationship with parents, carers and families based on mutual sharing of information, decision-making, and responsibilities; see Appendix A for an example practice guide for 'partnership relationship').

Using common elements associated with effective intervention (the 'what') hinges on accurate identification of the presenting problems and needs, and responding to these with well-matched common elements that have been shown to be effective in bringing about the desired outcome. If the problem is not correctly identified, the wrong intervention strategy is likely to be selected. It is analogous to making a medical misdiagnosis and consequently prescribing a drug for a condition that the person does not have. Conversely, if the selected intervention strategy is not well-matched to the identified problem, the intervention will be ineffective because it has been designed to address a different problem. This is analogous to prescribing the wrong drug for a diagnosed illness. Thus, evidence-informed decision-making is a core activity for practitioners (Chorpita, Bernstein, Daleiden, & Research Network on Youth Mental Health, 2008). Examples of common elements for effective intervention include **goal setting** (how to facilitate identification and development of realistic goals that help motivate and guide behaviour change), **psychoeducation** (provision of tailored and information and support about their emotional and mental challenges), and **responding to change talk** (noticing, elaborating, affirming and reflecting back statements that express a desire or wish for change).

Evidence-informed practice (including decision-making at its core) is the integration of best research evidence with practice expertise and client values. (APA Presidential Task Force on Evidence-Based Practice, 2006;

Buysse & Wesley, 2006; Moore, 2016; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). Thus, selecting an effective intervention strategy is not simply a matter of choosing a common element from a list of evidence-supported options. Instead, a practitioner must consider a range of contributing factors including the presenting problems and needs, the desired outcome, and client circumstances, preferences and values (Greenhalgh et al., 2014). It is clear then that the decision-making process inherent to effective use of common elements in practice is no simple matter. Decision-making guides, practice frameworks, and ongoing implementation support may all be useful in supporting practitioners to engage in good evidence-informed decision-making when using the common elements approach (Greenhalgh, 2017; Moore, 2016).

Research exploring the effectiveness of the common elements approach in practice is in its infancy. A small number of randomised trials have demonstrated that utilising a flexible and modular common elements approach: is more effective in bringing about target outcomes than manualised programs (Weisz et al., 2012); has more sustained positive outcomes than standard treatment designs (Chorpita et al., 2013); results in faster improvement on outcomes relative to usual care (Chorpita et al., 2017); elicits more positive responses from practitioners relative to approaches that do not permit adaptation (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009), and can be delivered with fidelity and effectively by non-specialist therapists/practitioners (Bolton et al., 2014; Murray et al., 2018; Weiss et al., 2015).

This emerging evidence provides a positive foundation upon which to expand the evidence base and inform and support the translation of a common elements approach into practice and policy in a way that has a clear focus on meeting the needs of children and families in a flexible but evidence-informed way.

5. Identifying and choosing common elements

Multiple approaches exist for identifying common elements, though most of the work that has been done to date has been based on, or builds on, the *Distillation and Matching Model* (DMM) proposed by Chorpita, Daleiden, and Weisz (2005b). The DMM provides a framework for aggregating information from the existing empirical literature and involves three steps: 1) identifying effective interventions; 2) distilling effective interventions into common elements by separating out discrete techniques and strategies identified in the treatment manuals; and 3) matching the common elements child and family needs and characteristics (e.g., presenting problem, age, gender, ethnicity, service setting).

The first scholarly attempt to identify and organise common elements focused on distillation of nonpharmacological treatment program manuals for youth with psychological disorders (Chorpita & Daleiden, 2009). Manualised programs that were supported by randomised controlled trial evidence were selected for inclusion in the study, and the program manuals were distilled into their common elements by two independent raters. This process resulted in identification of 41 common elements for clinical intervention. This seminal work has formed the basis for the development of a repository of common elements, designed to support the social services sectors worldwide in their delivery of effective services. This repository – called *PracticeWise*[1] – contains 58 common elements extracted from youth mental health treatment programs. These 58 common elements are listed and described in *PracticeWise*.

These and other (see Becker et al. (2015); Lindsey et al. (2014)) distillation attempts have used only randomised controlled trial studies to identify manualised programs, and have focused particularly on youth with a psychological disorder as the target population (and therefore on youth mental health as the broad outcome of interest).

Another relevant piece of work is the distillation and meta-analytic study of manualised programs for the prevention of out of home care for children and young people (Lee et al., 2014). The analysis included 20 randomised controlled trials plus 17 studies with other research designs (nine quasi-experimental, seven single-group pre/post-test, one single-group post-test), including 64,750 children and young people with notable diversity in the samples (e.g. ethnicity, presenting problems) and service settings (e.g. child welfare, juvenile justice, child mental health). Each of these studies was coded for common elements by two independent raters, and the elements were categorised according to whether they were youth-directed, caregiver-directed, or family-directed. The common elements were ranked according to frequency, with those of lower frequency excluded from the list (i.e. those appearing in effective programs less than 70% of the time, and those appearing in less than 25% of the effective programs). Median effect sizes were calculated for the resulting common elements to indicate the magnitude of the effect of each common element on each outcome category of interest (out of home placement, hospitalisation, incarceration). The process described above resulted in the identification of 27 common elements in total: 11 youth directed, 11 caregiver directed, and 5 family directed.

More recently, similar work has been undertaken in relation to community- and home-based interventions for improving academic achievement for vulnerable children (Engell, Hagen, Hammerstrøm, & Kornør, 2016). Thirty-one effective interventions were distilled into their common elements, and the four most frequent common elements for intervention was selected as the core components of an enhanced academic support intervention delivered within the context of child welfare services (Engell, Follestad, Andersen, & Hagen, 2018). A randomised controlled trial testing this intervention relative to usual care is currently underway in Norway.

All distillation efforts are based on the assumptions that different manualised programs share elements in common, that these common elements can be explicitly defined, and their presence within manualised programs can be reliably coded from the treatment manuals. If particular elements of the program are not

[1] https://www.practicewise.com/

well operationalised or described in treatment manuals, they may be missed using the distillation approach. In particular, it has been argued that this approach favours identification of common elements associated with effective interventions ('what' practitioners do with families), and often overlooks common elements associated with effective service delivery ('how' practitioners work with families). Indeed, the original authors of the DMM are explicit in their focus on techniques for clinical intervention rather than processes of engagement and rapport building (Chorpita et al., 2005a).

To address this, the distillation of common elements from programs can be supplemented by the *convergent evidence* approach, which reviews evidence from multiple sources (including evidence from different settings, sectors and research fields, and practice synthesis) to identify elements that are common to effective practice in different forms of human services. The convergent evidence from a variety of different fields and service sectors points to the interpersonal factors and therapeutic processes that have been shown to be associated with effective service delivery[2]. As already noted, these tend not to be as frequently or as easily identified using the distillation approach. These common elements describe the 'how' of service delivery, rather than the 'what'.

It is important to note that, as described in chapter 4 of this report, the common elements approach is designed to be used flexibly in response to presenting problems and needs of clients, and the matching of elements to presenting problems is influenced by the circumstances and service setting. It is because of these considerations that we urge against the pre-selection of a shortlist of common elements for use by the sector. Doing so is not in keeping with the 'spirit' of the common elements approach to practice, which emphasises responsiveness to client need. The suggested, alternative method for selection of common elements is to:

1. First identify a broad outcome category to focus on (e.g. preventing out-of-home care, educational achievement, youth mental health) based on what you know (from data, needs analysis, etc) about the current challenges and unmet needs in the sector.
2. Either draw upon relevant program distillation work that has already been completed and published, or if this is not available, undertake the distillation work to identify the common elements within programs that have been proven to effectively impact on this broad outcome category.
3. Review and draw from learnings from the convergent evidence about how these practices should be delivered.
4. Work collaboratively with services (including their executives, managers, team leaders, practitioners) to understand a) the specific unmet needs of their clients and b) the outcomes they are aiming to achieve in their work with clients.
5. Use a practice framework (or other decision aid) to match the common elements identified in steps 2 and 3 to the target population and outcomes specified in step 4, and/or use co-design methods with the sector/service representatives to develop a modular intervention consisting of common elements that can be combined flexibly to achieve the specified, intended outcomes.

[2] While elsewhere (e.g. Barth et al., 2012) these have been described as common factors that underpin intervention, for simplicity we refer to these here also as common elements.

6. Implementing the common elements

6.1. The case for an implementation focus

Implementation is the active process of integrating evidence-informed programs and practices in the real world (Rabin & Brownson, 2017). Evidence-informed programs and practices are incorporated into 'business as usual' at very different speeds and there is often a gap between what we know works and what is being done in practice. There are many reasons for this, including the research evidence being difficult to access and translate into a real-world environment, the program or practice not being a good fit for the local context, lack of interest in and commitment to change, or external funding or policy restrictions. Active, high-quality implementation efforts can help in identifying and overcoming these (and other) barriers, thus closing the research-practice gap.

Implementation of the common elements approach into the child and family service system in South Australia is no exception. When the implementation of an evidence-informed practice is high-quality, the children and families receiving the intervention are more likely to benefit. Having an effective program or practice is necessary for good client outcomes – but not sufficient. Two common pitfalls contributing to their potential not being realised include:

- only focusing on 'what' program or practice to use, and ignoring 'how' the program or practice will be implemented
- failing to consider influencing factors (such as barriers and enablers) that impact an organisation's or system's ability to initiate and sustain the program or practice.

All of these factors – the 'what', the 'how' and the influencing factors – must be taken into consideration to achieve the best outcomes for children and families, as illustrated in Figure 1. These factors should be considered at both the local-level (agencies and sites) and the system-level.

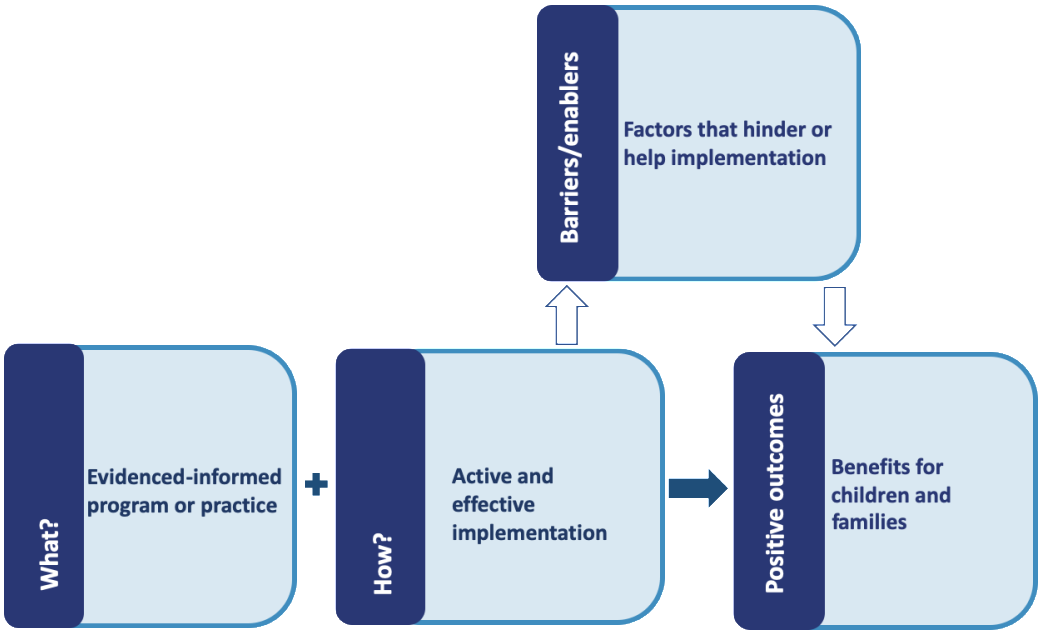

Figure 1. Factors to consider for improving outcomes for children and families

6.2. Core components of a common elements implementation framework

Implementation always occurs in stages. It is a process, and not a single event. Different implementation strategies are relevant in different stages (e.g. during planning versus during service delivery), and the barriers and enablers that influence implementation are likely to change as the implementation process unfolds.

Implementation efforts should always be tailored and responsive to the specific context within which an intervention is being implemented. However, drawing from the implementation science literature and our learnings in the Victorian context, CEI can recommend core components of a staged implementation framework to support the adoption and sustainment of the common elements approach in child and family service settings. CEI can also provide tailored implementation support to implementing sites to guide them through the process and provide technical assistance.

A suggested framework to support the implementation of the common elements approach I child and family service agencies is illustrated in Figure 2, with the various components further articulated in Table 1.

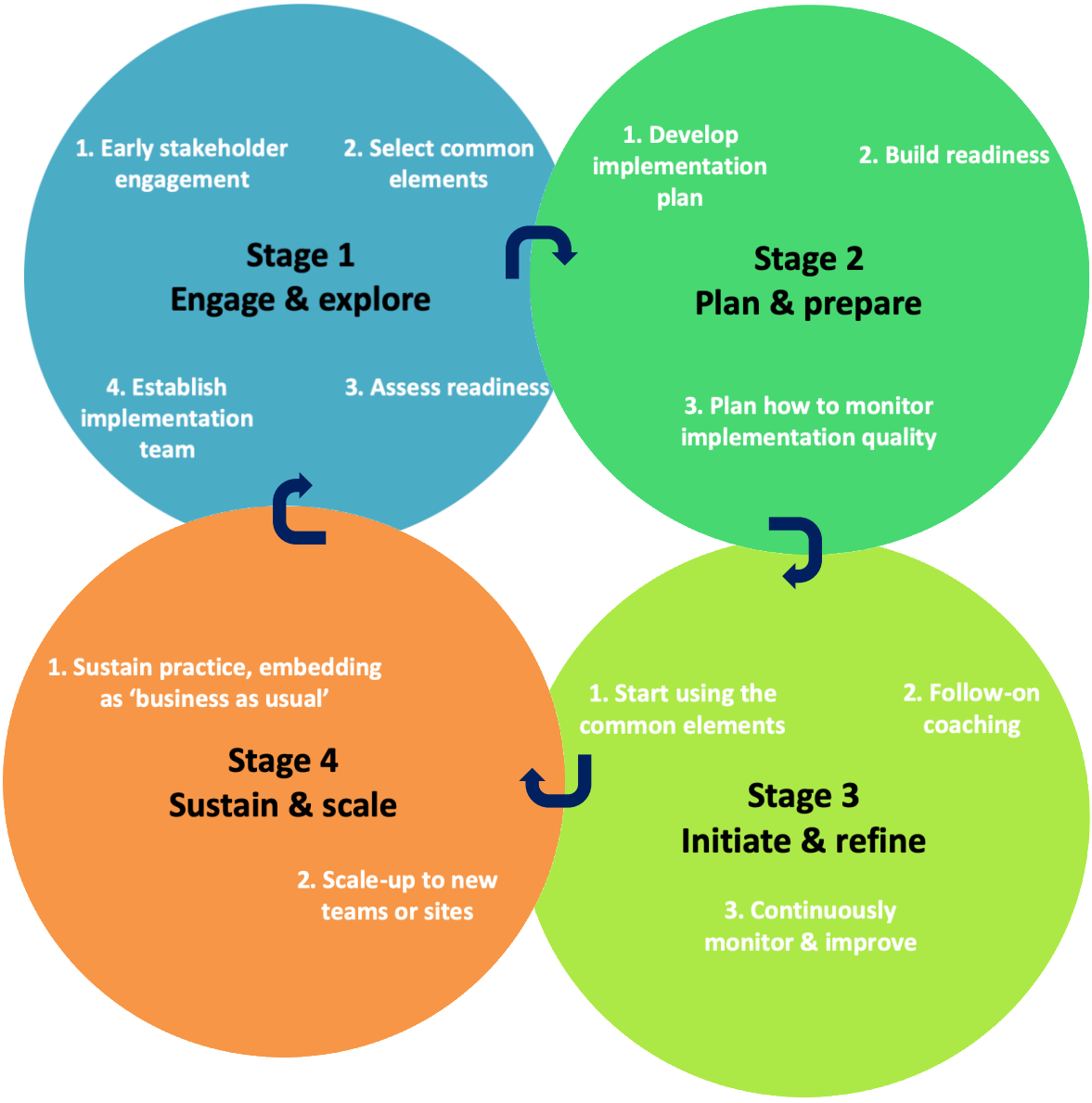

Figure 2. Proposed staged implementation framework for the common elements approach in child and family service agencies

Table 1. Elaboration on proposed common elements implementation framework

Implementation stage	Implementation component/strategy	Explanation
Stage 1. Engage & explore	Early stakeholder engagement	Workshops, educational sessions and consensus discussions with service executives, managers, team leaders and practitioners who will be adopting and implementing the common elements approach.
	Select common elements	Use data or a needs analysis to identify unmet needs of clients, and articulate desired outcomes. Use this information to drive selection of common elements to adopt.
	Assess readiness	Systematically explore ways in which the organisation is ready and unready to start using the common elements that have been selected. This is not a 'pass/fail' assessment, but rather a way to identify what needs to be focused on in the next stage before practice can be initiated.
	Establish implementation team	Establish a local implementation team that consists of executive leaders, managers, team leaders and practitioners that will champion the implementation and take responsibility for driving the implementation of the common elements approach at a local site level. Note that additional 'layers' of implementation teams may be needed (e.g. central team that sits across multiple sites).
Stage 2. Plan & prepare	Develop implementation plan	The local implementation team develops a tailored implementation plan that outlines specific implementation strategies that will be used to progress the implementation and build readiness to initiate practice. These can be selected in response to known or anticipated barriers at the site level, or be selected based on what has been shown to work elsewhere/in the past.
	Build readiness	Begin to use the implementation strategies outlined in the implementation plan to build readiness to initiate practice, starting with the ones most relevant to the stage of implementation. A key implementation strategy to use at this stage is to deliver training in how to use the selected common elements in practice for practitioners and team leaders.

Implementation stage	Implementation component/strategy	Explanation
	Plan how to monitor implementation quality	The local implementation team will plan for how to monitor quality of implementation of the common elements (e.g. uptake, fidelity, acceptability, appropriateness, feasibility), and also for how to monitor impact and outcomes for clients.
Stage 3. Initiate & refine	Start using the common elements	Practice is initiated using the common elements.
	Follow-on coaching	Regular, follow-on coaching to practitioners and team leaders to support integration of what they learned about common elements in training into practice. Coaching focuses on skills-building and troubleshooting through modelling, rehearsal and feedback.
	Continuously monitor and improve	Puts the monitoring plan in place and regularly reviews and responds to data. In doing so, they will continuously identify barriers and enablers as they emerge, and will engage in data-driven decision-making about how to respond to these in order to progress and improve the implementation.
Stage 4. Sustain & scale	Sustain practice, embedding as 'business as usual'	When the practice is consistently being delivered with fidelity and has become part of 'business as usual', the initiative has reached sustainment.
	Scale-up to new teams or sites	Once sustainment has been reached for the initial implementation, the site may consider scaling-up the approach to new teams or sites. This begins a new implementation cycle.

7. Conclusion

The common elements approach to child and family service delivery is flexible and responsive to the specific circumstances, problems, and needs of the clients being served. The approach should not be considered an either/or alternative to structured, manualised programs but rather a complementary approach that sits up the more flexible end of the continuum of evidence-informed practice approaches.

While research exploring the effectiveness of the common elements approach in practice is in its infancy, the emerging evidence that is available offers a positive foundation to inform and support the translation of a common elements approach into practice and policy in a way that has a clear focus on meeting the needs of children and families in a flexible but evidence-informed way.

However, an effective program or practice is necessary but not sufficient to achieve the best possible outcomes for vulnerable children and families. Implementation of the common elements approach into the child and family service system in South Australia is no exception. When the implementation of an evidence-informed practice is high-quality, the children and families receiving the intervention are more likely to benefit. The adoption and roll-out of the common elements approach in South Australia must be supported by an implementation framework that draws on evidence and principles from the field of implementation science to increase the likelihood of implementation success.

The Department of Human Services will continue to work with the Centre for Evidence and Implementation who will support the exploration of the ways in which the common elements approach can be incorporated into service system re-design and implemented in service delivery settings.

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Appendix A Example common element practice guide *Partnership Relationship*

Brief Description

This practice guide focuses on how to build and maintain a partnership relationship, which means explicitly seeking a collaborative relationship and working together as equal partners in a mutually agreed upon way. A partnership involves shared information, being clear about our roles, sharing in decision-making, working collaboratively to identify actions that will work and having shared responsibilities in developing solutions.

Key Outcomes

- Carers/individuals remain productively engaged with services more consistently and for longer periods of time and are increasingly likely to seek support in the future if required.
- Carers/individuals experience a sense of empowerment and increased self-efficacy in their ability to work collaboratively with practitioners.
- Practitioners have increased ability to collaboratively identify, create and implement effective solutions to resolve challenges that the carer/individual is experiencing.

How-to guide	
Step	**Skills / Strategies**
1. Provide a rationale for working in partnership	• Explain that you will work collaboratively with the career/individual as equal partners, respecting their experience, values and preferences. • Explain your role and your program clearly. Check for understanding. • Use strength-focused language when talking about the carer's/individual's ability to contribute to the process. Highlight with empathy what they have already achieved. • Provide positive reframes (when they are genuinely applicable) and reinforce the collaborative relationship. • Explain that action/goals developed will be worked on together, allowing them to set a pace that suits. Also, that you believe they will have a lot to offer in finding the right solutions for themselves. • Provide reassurance that you will discuss with them serious issues that exist/emerge and get their views about what should happen. For example: *I need to talk with you about a serious issue that has come up. Would it be ok if we talked about this before we got into what we were planning on doing today?*
2. Prepare for and seek collaboration	• Working in partnership is about both the practitioner and the carer/individual having a shared voice to enable joint decision-making. • To achieve this, practitioners need to verbalise and respect carer/individual autonomy and what they know about their own circumstances and experiences. • Explicitly seek to understand as much as possible about the circumstances, experiences and resources of the carer/individual before sharing any of your own perspectives or expertise. • Always explicitly acknowledge the contributions of the carer/individual as valid and important, and incorporate these into whatever actions are planned. • Always check if there are other people who could provide helpful contributions.

How-to guide	
Step	**Skills / Strategies**
3. Work collaboratively	• Always begin discussions of goals or actions by asking permission. For example: *Is it OK if we talk about what you could do about this situation?* • Always invite the carer/individual to give their views first. For example: *Can you tell me what your experience has been?* • When sharing your own views, always seek the permission of the carer/individual to do so. For example: *Can I share with you what we have learned about ways in which this problem can be managed?* • When you have shared the information, ask what the carer/individual thinks and feels about the information, and what they might do. • Take every opportunity to encourage and openly acknowledge the contribution of the carer/individual and allow them enough time to respond and contribute further. • Always give the carer/individual meaningful choices – of what goals are being sought, what form of support works best for them, what role they play, which family members should be involved. • Always be clear if a particular behaviour or circumstance will not be seen as acceptable due to the risk it poses the child. For example: *You know we have talked about the dangers of leaving babies unattended. It's important we are all clear that Johnny cannot ever be left with Uncle Peter as he does not seem to understand that he needs to check on Kelly regularly.*
4. Get feedback on how the partnership is functioning	• Regularly check with carers/individuals regarding their experience of the partnership relationship.
5. Reflect upon the partnership	• Every now and then, set up a time to reflect upon what they have achieved and what role they have played in the partnership. • Begin the reflection by reminding them what the goals of the partnership were and inviting them to say what the experience has been like. • Take care to note their contributions and achievements and help them reflect on what this means for them. • This is a partnership exercise, so the recollection and reflections should involve the practitioner as well as the carer/individual. • See this exercise as an opportunity to highlight the gains the carer/individual has made to date. This can assist in sustaining the gains achieved.

Helpful Tips

- When meeting new practitioners or services, carers/individuals are likely to be unsure of their exact role. Practitioners need to introduce the idea of collaboration early – and then demonstrate partnership through the ways in which they interact.
- To be effective, both parties must build trust the other party. Practitioners need to lead by example and believe that every carer/individual has the capacity to be a meaningful participant in a partnership.
- Similarly, when deciding what actions will be implemented to resolve an issue or achieve a goal, ensure the action steps are realistic and achievable and not too onerous or stressful for the carer/individual.
- Carers/individuals benefit from the opportunity to reflect upon what they have achieved and what it means for them. This is part of the process of moving forward. Constructing a positive narrative about the carer/individual and their capabilities gives them a new perspective on what they may be able to achieve.
- Engaging with services can be intrusive and at times difficult for families. Thinking of ways to make things more positive helps with developing a partnership that carers/individuals want to invest in.

Our mission

We are dedicated to using the best evidence in practice and policy to improve the lives of children, families and communities facing adversity.

How we achieve this

We work with a diverse range of key stakeholders who want to achieve social impact for children and families facing adversity. We bring specialist skills in:

- Supporting sustained change in the behaviour of systems, organisations and individuals. We put a strong emphasis on supporting and strengthening the core components of effective program implementation.
- Providing knowledge translation to policymakers, and relevant stakeholders, so they can access – and use – research for evidence-informed decision-making.
- Program design – selecting and creating evidence-informed programs and services to achieve outcomes for children, family and communities.
- Conducting rigorous evaluations, and assessing the long-term effect of outcomes.

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