Research Evidence in Practice: Evidence-Based Interventions in Service Delivery

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Katie Zanoni (KZ): Hello, and welcome. I'm so excited to be here today. My name is Katie Zanoni, and I am the Senior Learning and Evidence Officer with the International Rescue Committee. I'm honored to facilitate today's session on Research Evidence in Practice: Evidence-Based Interventions in Service Delivery. Today, I'm delighted to introduce our speakers and panelists today. Sarah Diner holds an MA in Public Anthropology and an MPH in Community and Behavioral Health and is the Program Officer for Research at Switchboard. With a background in direct refugee resettlement services, she brings a deep understanding of frontline work and community health.

Sarah uses her research and writing skills to support providers in delivering high-quality services by producing Switchboard's evidence summaries and managing the evidence database. Myja Maki is a Licensed Clinical Social Worker and is a trauma-informed clinical supervisor and Program Manager at the IRC in Boise, Idaho. She integrates somatic and relational approaches to trauma recovery in her work. With experiences across individual, family, and group care, Myja focuses on culturally responsive, evidence-informed interventions to support forcibly displaced communities.

KZ: Next, we have Miriam Potocky, who holds an MSW and a PhD in Social Welfare and is a researcher with Switchboard. Dr. Potocky is a former child refugee from Czechoslovakia and is an internationally recognized researcher on U.S. refugee resettlement. She has authored nearly 100 publications, including *Best Practices for Social Work with Refugees and Immigrants,* and has previously served as a tenured professor of social work for over 25 years. Monica Indart holds a PsyD and is a Licensed Clinical Psychologist who used her extensive experience to develop IRC's Mental Health and Psychosocial Support Services Program in New Jersey and is currently acting as the Clinical Supervisor for the program.

Dr. Indart also maintains a private practice focused on trauma, grief, and disaster response and has provided pro bono care to torture survivors for over 15 years. Today, what we are working to deliver and our learning objectives for you are to describe evidence-based interventions and their relevance within service delivery for newcomers; identify appropriate evidence-based practices based on population needs, service context, and organizational capacity; and develop an evidence-based service delivery plan that integrates research evidence, client characteristics and preferences, and practitioner expertise. Now it's my pleasure to pass to Sarah to share more about evidence-based practice.

1. Evidence-Based Practice: The Relevance of Evidence-Based Interventions in Newcomer Service Provision

Sarah Diner (SD): Thanks, Katie. We're going to get started with our first learning objective, which is evidence-based practice and the relevance of evidence-based

interventions and newcomer service provision. We're going to start off with a Slido to get everyone participating. This is an open-ended question. You can join using the QR code scanning with your phone or going to slido.com, and using that number beneath on the slide to join in the question. What does evidence-based practice mean to you? Give a little bit for everyone to get it all set up. No idea. That's okay. We're going to be talking about it today.

SD: Hopefully, at the end of the webinar, you'll have a better idea. Grounded in research, accurate data, mental health interventions. Not sure. Again, totally fine. Someone has gone before and proved it works. Being shown most effective… based on research. Research, which proves is effective. These are all great answers. Some people, not sure. Great, you're in the right place. Some people have some ideas about it using research to see what has worked before with other people. Great. Thank you all for participating. Go ahead and move into our definition.

This is the definition that Switchboard uses for evidence-based practice. Evidence-based practice is a decision-making process that integrates the best research evidence available; information on client characteristics, culture, and preferences; and practitioner expertise to guide and inform the delivery of interventions. We wanted to go through some additional terminology that's often related and used sometimes in the field, but is slightly different. If you go ahead and click through those. Evidence-based interventions. These are specific actions or strategies designed to produce measurable improvements and targeted outcomes and are supported by empirical research.

SD: These interventions are often components of broader programs and are selected based on their demonstrated effectiveness with a particular population, such as newcomers in a specific context. Next, we have evidence-based practice, which we already just talked about. The decision-making process that incorporates research evidence, client needs and preferences, and practitioner expertise. Then we also have evidence-based programming. This is a cohesive set of evidence-based practices that are systematically organized and implemented together to achieve specific outcomes.

These programs are validated through research, showing that the combined implementation of the practices leads to positive, replicable results in real-world settings. Evidence-based programming is sometimes misunderstood as what could be considered data-driven programming, but to be evidence-based programming, it has to be more than just an M&E plan that is data-driven, [but] not necessarily evidence-based. It's also grounded in theory and has a clear logic model. It's monitored and evaluated. It's repeatable with statistically significant positive outcomes. It's implemented with fidelity, and it's rooted in research evidence.

SD: You may be thinking, "What are the benefits of using evidence-based practice when working with newcomers?" These include things such as supporting responsibility to clients. They can save time and increase confidence in decision-making. They meet requirements of many different funders. They can optimize use of resources, mitigate risk, and avoid harm for clients and staff. They can increase project success. I'm going to move a little bit into how to identify appropriate evidence-based practices. Another Slido question, a poll for you all. Do you currently incorporate evidence-based practice into your program design?

2. Identifying Appropriate Evidence-Based Practices

SD: Yes, we use evidence-based interventions grounded in research, staff expertise, and community or client input. No, we primarily rely on other factors, such as client feedback, monitoring data, and funder requirements, or not sure. We may be using elements of evidence-based practice, but haven't formally identified them and need to learn more. Jumping around a little bit, but it looks like most people so far are not quite sure. About half not sure. Then split the rest between yes, you're for sure using them, or no, we're for sure not using them. Now we're going to go through a suggested list of steps you can use when trying to incorporate more evidence-based practice into your organization. This is a quick intro to the five steps, and then we will go through each one in more detail.

Step 1: Set priorities. What are you hoping to achieve? Step 2: Assess readiness. Is your organization ready to make changes? Step 3: Examine research. What evidence-based practice are you going to use? Step 4: Adapt. Can you make a current program more evidence-based? Step 5: Adopt. What resources do you need to start new programming? This section is going to focus on those first three suggested steps: set priorities, assess readiness, and examine research. Then we'll go into more of the adapt and adopt in the next section. Our first step is setting priorities. This should be the guiding step that then informs everything else coming up.

SD: This is where you take a look at what you're currently doing and identify potential gaps. It's also important to know what client outcomes you want to improve or change and in what ways. You can also review your logic model or theory of change and revise those as needed to meet your new goals. To evaluate your current programming, a key question you can ask yourself is, what does your data and client feedback tell you about areas for improvement? A key question for identifying client outcomes could be, what are the most important needs of the population you serve, and how do those shape your anticipated outcomes?

For reviewing and revising your logic model or your theory of change, you can ask yourself, given your service context and organizational capacity, what inputs or resources are available to update your programming to improve client outcomes? While we aim to improve client outcomes through evidence-based programming, we must also navigate external pressures that influence our decisions. For example, it is important to reflect on how funder expectations, budget constraints, and timelines shape our priorities. We're going to discuss this more in a moment. We're into setting priorities.

It can feel overwhelming to start the process of developing more evidence-based practices. These are some examples of questions you can ask yourself to help guide you on what to look for, in addition to some of those other key questions I just mentioned. What specific needs has your organization identified in the community that you serve? Are there specific problems that clients are coming to you with? Is there something going on in the community or on a larger scale that you want to make sure your clients are prepared for? Are there parts of your programming that are not achieving desired outcomes based on data or feedback?

SD: Things like low attendance or a lack of improvement on assessments, or clients saying they're not satisfied. Asking yourself these questions can help you decide on what types of interventions you're looking for and what search terms to use when looking for them. Step 2: Assess readiness. This is where you take a look at your organization and determine what barriers and facilitators you are facing. These are some examples of questions you can ask yourself at this stage. Do you have buy-in from key stakeholders? Do staff have the bandwidth and resources to implement changes? Are funding or other resources available?

You may find that there are other barriers that you need to tackle before you can move through the next steps. These are some examples of barriers and facilitators to implementing evidence-based practices. These are the things that are either going to support the introduction of evidence-based practice or will be things to overcome or find workarounds for. There are three levels to look at: the system level, the staff level, and the intervention level. The system level includes things like context, so space, staff turnover, workflow; culture, like attitude to change, champions, motivation, communication processes; and external requirements, like reporting standards and guidelines.

SD: At the staff level, staff commitment and attitudes, understanding and awareness, identification of individual roles, skills, ability, workload, and confidence. At the intervention level, you have ease of integration. Complexity, costs, required resources of a program, validity of the evidence-based of a program, and then safety, legal, ethical concerns, and supportive components. Do people need education, training, marketing, or awareness of it? Our next step is where you get into the nitty-gritty of identifying sources to guide your programming. A great place to start are the evidence summaries available on Switchboard's website.

The goal of evidence summaries is to look for high-quality evidence on the efficacy of interventions on a given topic among refugees and other newcomer communities and present it in an easily understandable way. They are published on the website, and the topics range from working with unaccompanied refugee minors, mental health, women's employment, English language learning, a bunch of different things. You can also search through the evidence database, which includes all of the studies mentioned across all the evidence summaries. If you don't see an evidence summary that covers the topic you were looking for, please feel free to submit a technical assistance request, and we will be happy to help you out.

SD: Additional resources available to look for research evidence would be Google Scholar and Elicit. Elicit is a research-focused AI platform that allows you to ask a question, and it collates and summarizes various available research papers. I've been using it for a little while, and I haven't noticed any AI hallucination yet, but it is important to double-check the sources that it returns. Elicit does have a statement available on their website that indicates they are aware of the issue of hallucinations and are taking multiple steps to mitigate them in their platform. Then connect with other organizations and colleagues implementing evidence-based practices.

You can reach out to other offices that may have similar programming that you do and see what programs they've been implementing and what has been working for them to give you a start on where to look. Then when you start searching for evidence, this hierarchy can help you determine which types of evidence to give

more weight to. Systematic reviews are larger-scale reviews that follow a designated protocol. They collect evidence from multiple articles and compare the results. Randomized control trials have two groups of participants, the intervention and the control that individuals are randomly assigned to.

SD: This helps make sure that the characteristics of the two groups are relatively evenly distributed and can make it easier to compare outcomes. Suggested evidence are studies that include pre- and post-tests for the same group, don't have randomization, case studies, or qualitative data. Non-peer-reviewed research includes things like theses or dissertations, organizational and many-year evaluation data, or interviews and focus groups conducted with the community or other organizations. This doesn't mean that you shouldn't use that information to inform your programming, but if you are able to find research evidence from the categories towards the top of the pyramid, it can provide a stronger research evidence base for your programming.

We're going to look at a case study with Cecilia. Cecilia is the director of her organization's adult English Language Learning Program. They offer in-person group classes and one-on-one tutoring for clients interested in learning English. She has noticed recently that attendance has been dropping off, especially after a client secures a job. She has also heard that moms with young children at home have a hard time making it to class. Cecilia wonders if there are evidence-based practices that could help her clients. Step 1 for Cecilia is set priorities. Her goal, Cecilia's main goal, is to improve attendance in her adult English Language Learning, or ELL, classes.

SD: She has identified the gap of no virtual or supplemental options available for their clients. The action she's going to take is she's going to revisit her program's logic model to reflect on the need for more flexible and accessible learning formats, such as hybrid or virtual options. To guide her next steps, Cecilia formulates an evidence-based practice question: For adult English learners with limited availability, what evidence-based interventions improve attendance and engagement through virtual or hybrid learning formats? This question helps her focus her research on interventions that are both relevant to her population and feasible in her service context.

Then, Step 2: Assess readiness. Cecilia conducts an assessment of her organization to identify what resources could be available and what challenges she may need to work through. [The] organization does have a paid account for a video conferencing app that would allow classes or tutoring to be held virtually. They also receive some funding specifically to enhance their ELL programming. Cecilia has noticed, however, that some of their volunteer tutors are hesitant about moving to virtual platforms. Her next step is to talk with fellow staff members to assess their willingness to support the transition.

SD: Step 3: Examine research. Cecilia has been guided by the evidence-based programming question she developed before to look for research evidence on whether virtual ELL programs are as effective and what specific elements may help foster that efficacy. She looked at Switchboard's evidence summaries and found one titled "What Strategies Are Effective for English Language Acquisition in Newcomer Populations?" She noticed some key findings, including that many programs offered

through digital instruction had comparable or more favorable outcomes. She also saw that participants had high levels of satisfaction, enjoyment, and engagement.

SD: Her next step is to take this research and see if there's any knowledge or skills within her team that could be used in the implementation process. Time for another Slido question. Which of the following factors in Cecilia's service context could influence the implementation of a hybrid or virtual learning model? The availability of a paid video conferencing account, volunteer tutor's hesitation to use virtual platforms, funding available to enhance ELL program, or all of the above?

[pause]

SD: So far, people are saying all of the above. Pretty good.

[pause]

SD: All of the above. Looks like most people are saying all of the above. Great job, guys. Now we're going to be moving into developing a plan for evidence-based practice, the implementation part of it. We're going to look back at our definition a little bit that we had talked about earlier, that Switchboard uses for what evidence-based practice is. Newcomers often face complex intersecting challenges such as trauma, language barriers, cultural adjustment. Evidence-based practice ensures services are not only effective but also culturally responsive and individualized. This is a refresher of our definition in a little more detail.

3. Developing a Plan for Evidence-Based Practice

SD: We're going to be getting more into the bottom two circles of the diagram in this section. Best research evidence use[s] interventions supported by rigorous studies, things such as trauma-informed care and culturally adapted cognitive behavioral therapy. This also means staying current with emerging research on migration, resettlement, integration. Client characteristics, culture, and preferences—this would involve understanding the unique backgrounds of newcomers, such as country of origin, migration journey, family structure. It can also incorporate cultural values, language needs, and personal goals into service planning.

SD: Then, practitioner expertise means leveraging your own professional judgment, experience, and contextual knowledge, and also reflecting on what has worked or hasn't in similar cases and adapting accordingly. Then here is a reminder of the steps we laid out earlier. We already covered those first three steps in the previous section. Now we're going to dedicate time to the final two steps, adapt and adopt. Adapt. There are two main things to think about when it comes to adapting. The first is whether you can adapt an existing program you're already running. There may be elements that could be adapted or updated to make the program more evidence-based.

The other main option is to incorporate an entirely new program. However, this could mean adapting certain elements based on your client's characteristics or preferences and practitioner expertise. That could mean having to translate materials or changing the format to better fit how your clients feel about classes, if it's going to be one-on-

one or class-based, things like that. Then our fifth step, adopt. This is our final step. This is where you're either updating your existing program or implementing your new intervention. This is a checklist you can use before and while implementing changes to make sure you, your organization, and clients are ready.

SD: Acceptability. Is the evidence-based program welcomed by clients and staff? This may require having feedback sessions with clients and staff about different aspects of the program. Appropriateness and feasibility. Does it fit the program's goals and resources? Would you be able to run a small pilot of the program to see how it goes before making widespread changes?

Uptake strategies. What supports are needed to encourage use? This could mean implementing any necessary training or securing various materials or software that are necessary. Fidelity, which means staying true to intentions of the intervention. Are staff delivering the evidence-based program as intended? This could mean conducting M&E at various points to ask for additional feedback on if there are other barriers to implementation that you hadn't originally anticipated. Then client-centered fit. Does the evidence-based programming reflect client preferences, cultural norms, and learning styles?

SD: You can also use M&E here to collect feedback from clients on how satisfied they are with the changes and if there's anything that doesn't feel comfortable or make sense to them. Cecilia, we're going back to her in our case study. As a reminder, Cecilia is the director of adult education at her organization. She noticed some gaps in their programming and wanted to implement more evidence-based practices. We've already gone through the first three steps with her. Set priorities. She wants to improve attendance. There's a lack of virtual options in her organization. Assess readiness. They have software and funding available, but the volunteers are a little bit hesitant about the shift.

Then examine research. She found an available evidence summary on the Switchboard website. Step 4: Adapt. Cecilia has decided on two courses of action that will each require their own forms of adaptation. The first is adapting their current program. Cecilia's organization is going to adapt their tutoring in class formats to have some virtual sessions. She has also decided to implement a new element to their programming. The research indicated that digital gamification can have positive outcomes, so she wants to find online gaming platforms that can be adapted for specific cultural contexts that clients can use either between classes or as supplements if they have to miss a class.

SD: Then Step 5: Adopt. Cecilia develops an implementation plan that includes offering training to volunteers and clients on how to successfully use the new virtual tools. She's also going to develop or curate a list of appropriate educational games and offer them to their students. Cecilia is also going to keep the checklist for adoption in mind as they move through the steps to implement these programs. Again, acceptability, appropriateness, uptake strategies, fidelity, and client-centered fit. Then we have one more discussion question for you all. What challenges and successes would you expect if you were Cecilia implementing the adapt and adopt steps?

[pause]

SD: Learning curve, you have people trying to learn the new platforms or programs.

[pause]

SD: Lack of computer literacy or tech literacy could be an issue. Running a focus group. That's a great option for those steps in adopt. To see if one hybrid or one ongoing class could be more…or expanding. That fits in with our appropriateness and feasibility step checklist. Consistency of classes. Staff unsure. Potential loss of students because tech is too hard. It might require more intensive training of clients to help make sure that everyone's feeling comfortable with the platform. Peer learning from those who are more experienced. Yes, that'd be a great option for uptake strategies.

[pause]

SD: More computer training. Great. These are all great answers, guys. Thank you. I'm going to pass it back over to Katie, who is going to kick off our Q&A section.

KZ: Thank you so much, Sarah, for the wonderful presentation. We'd like to invite you to drop any questions. Down below, you have a question and answer panel that you can click on and go ahead and ask those questions. While you're doing that, I am pleased to invite our panelists, Myja, Miriam, and Monica, along with Sarah, to answer some questions that we received from you all as you submitted your attendance and registration. Also, just based on some frequently asked questions. I'd like to invite our panelists now to-- you can turn your cameras on and join us.

The first one I'm going to ask is for all of you. I will go ahead and start with Myja. How do you use research evidence to strengthen your programming, Myja?

Myja Maki (MM): Thanks, Katie. Hi, everyone. Happy to be here. Happy to share space with this panel. To answer your question, how do I use evidence-based and research evidence in my practice? I largely look at it as building a strategic foundation for the programs that I manage in terms of how I design those programs, how I will implement staff training around that, and how I'll look for outcome evaluations. What I'm saying is research evidence helps me identify which interventions may be the most successful for the program or for the community that I'm working with. For me, because of the populations that I work with, I prioritize those practices for those that have a really strong evidence base in trauma-exposed populations. Again, I use this as a foundation, not as a ceiling. I build on that foundation, then with the client insight, and I take that and I see if the research that has been done can be adapted to the realities of humanitarian work, because it's a tricky time right now.

Can that research adapt to limited resources? Can that research adapt to cultural diversity in the context that I'm working in? Long answer short, yes, research evidence does give me and my programming the direction that I want to move towards, but it's been my responsibility to make sure that that direction is actually responsive to the population that I'm serving.

KZ: Thank you so much, Myja. Such important points about the context and how that's always shifting. I'd like to pass to Miriam to also answer, how do you use research evidence to strengthen your programming?

Miriam Potocky (MP): Thanks, Katie. Hi, everyone. I use research evidence in a couple of ways. One is in grant writing. Grant reviewers love to see citations of data and research that has been done. This significantly supports what you are proposing in your grant. That's one way. Another way that I use research is to identify instruments and tools for monitoring and evaluation, so ways to measure outcomes. Sometimes it can be difficult to think of a way to measure something.

The first thing I always do is run to the literature, and usually, you can find someone who's done it somehow, and you can either adopt the tool that they have already verified, validated, or you can develop your own based on what the research is saying. That way, your own tool is much stronger as well. Those are my suggestions. Thank you, Katie.

KZ: Thank you, Miriam. Now I'll pass to Monica to share.

Monica Indart (MI): Thanks, Katie. I really appreciated both Myja and Miriam's responses. Myja, the idea of building a foundation, it really makes so much sense to me. Miriam, the first place to look is who's done what already, and what's the existing base that we have. I appreciate both of those. From a broad perspective, I tend to look at common factors and core principles. I use a lot of common factors. Common factors in psychotherapy research tells us what are some cross-cutting factors that lead to positive outcomes in psychotherapy. Some of the common factors that I use in choosing interventions and basing these decisions are decreasing distress, developing skills.

I admit I have a particular propensity for somatic approaches, somatic psychotherapy, which I'm trained in, so I tend to focus a lot on those. Increasing knowledge through psychoeducation, so some core common factors that cut across what's effective in most psychotherapies. Then, adding to that, what I think of as core principles, dignity being an absolutely essential core principle, particularly for our population, the people we serve and work with, and particularly during this time.

MI: Dignity is so critical to uphold. Choice. Again, many of our clients are feeling like they have increasingly limited choices, so wherever possible to give people choice. I'm a big believer in the power of lived experience. When I was in academia for a couple of decades, I focused a lot on qualitative research because I believed in the power of collecting stories and lived experience. That's another aspect. Then lastly, trauma-focused. Although not everyone will be receiving trauma-focused treatment for post-traumatic stress disorder, so many, if not most, of our clients have experienced various traumas. Some approaches that are grounded in trauma-focused principles. That's about it. Thanks, Katie.

KZ: Thank you so much. Now that we know a little bit about how you're applying this in your work, one question that came through, and I'll pass this to you initially, Miriam, is what role do clients and communities play in shaping your use of evidence-based practices, and how do you balance fidelity to evidence-based models with the need of cultural adaptation?

MP: As to the first question, how do we engage clients? It's absolutely critical. As we saw when Sarah was presenting the evidence-based practice Venn diagram, it consists not only of those evidence-based interventions, but it has the client values and preferences, and then, of course, the external context. It's just absolutely critical to get client input, and a very simple way to do that is to present them [with] an intervention that you may have identified in the literature and describe it to them, and ask them what they think. Is that something they would like to try?

That's one way to start. Now, the second question was how do we balance fidelity with cultural adaptation? Let's define these first a little bit. Fidelity means you are implementing that intervention the way it's intended. You are staying true or faithful to the principles or core activities of that intervention, as Monica was describing earlier. Cultural adaptation is, of course, the changes you have to make to make that intervention acceptable and applicable, and feasible within a given context and given culture.

MP: These might be things like translating materials, interpreting materials, changing the pace of the materials, using culturally relevant examples, metaphors, stories, and so forth. How to balance this can be tricky, but you have to think about what are those core principles to the intervention. Again, going back to what Monica was saying, she presented some very key principles of pretty much all of the interventions that we carry out in the humanitarian space. We need to ensure that those are present.

A good way to do that is to use a checklist and to list all those mandatory activities or principles that make up a given intervention or approach, and then develop your adaptations. As you're delivering this intervention, check off that list. Check each day, each week, to ensure that you are staying true to those principles while adapting to the cultural context.

KZ: Thank you so much. I'd like to invite Monica if you'd like to come in and add anything, any thoughts there.

MI: Again, I just appreciate, Miriam, your thoughtfulness about this. I was taking in what you were saying and thinking how I wanted to use that too. It was just such a thoughtful and thorough overview. Again, I probably approach this more as a clinician and as somebody who's been a worker in the field, and look at it from that perspective. Once again, I borrow from two major fields of intervention. One is disaster mental health. Here, we use type of intervention, the timing of the intervention, and the target of the intervention to guide us.

That is one way, although very broad-based, to consider fidelity, that we're staying true to these three aspects of an intervention that is very field-based, which I think, again, we need to do with the clients that we're seeing. Then secondly, real quickly, I also identify as a community psychologist. Community psychologists live and breathe by a set of their own ethical principles in some ways that I think speaks to some of these questions. To always be able to take an ecological perspective, to understand the ecology, the lived experience of our clients.

MI: There's some tension I know with the fidelity to an intervention model with lived experience of clients. I'm just going to be honest, and Katie, this may not be the

answer you want me to give in this webinar, but I'm always going to defer to the dignity and the lived experience of the client. That's always going to be prominent for me. That's a huge principle. To build empowerment. To be questioning, “In staying faithful to this model, in adhering to fidelity, am I also empowering the client? Am I respecting their dignity and empowering them?" To focus on building a sense of community and social support. It's not about this particular intervention, but it is the longevity and the life of that intervention in a community that I'm interested in. Lastly, as I know Myja mentioned as well, to really engage a community of our clients to be part of this process. There is a lot of buy-in for fidelity to an intervention because they want to see, is this going to help us. Is this going to help my family? Is this going to help my community?

MI: In some ways, by engaging participatory research and engagement, we enhance the chances of fidelity while also building in cultural adaptation.

KZ: Wonderful. All of your experiences are informing how we're seeing this. All the ways in which you do this work are more than welcome. I do want to pull out a little bit, Monica, if you could provide an example, just maybe if folks aren't familiar with the example. Could you offer, when you're talking about the type, the timing, and the target of the intervention to guide us, what does that look like in your day-to-day work?

MI: Again, it borrows from disaster mental health, but I think it also has relevance for the settings that we're in. For example, for newly arriving refugees, an intervention like psychological first aid may be most beneficial, also has probably the most data about it in terms of field interventions that are helpful in the moment, because the initial phase of resettlement and adaptation is so stressful.

That would be both a type of intervention, psychological first aid, that again has a database behind it, and also the timing of it, because we would want to include things like that at the beginning of the resettlement cultural adaptation process. Then, be able to move into looking at targeted interventions for specific issues that specific clients may be struggling with. I don't know, Katie, if that makes sense.

KZ: Yes, I think that's great. Thank you so much, Monica. Myja, I'm going to invite you to address this next question and, of course, bridge any comments to the last. We're thinking about these evidence-based practices, and really, as Monica pointed out, too, we're very focused and centered within what's best for the client. Have you observed changes in client outcomes from using evidence-based practices?

MM: Oh, that's such a great question. Yes. My lens is both as a program manager who's overseeing extended [programming] and also as a clinician myself. Through that lens, which is right in between Miriam and Monica, I have seen evidence-based practice be successful. We've been talking now for this whole panel, especially when the evidence-based practice is delivered in a very culturally-grounded manner. Some concrete examples of that within my work would be the integration and pairing of mental health support with trauma-informed case management.

How can we help meet clients' needs both in a very day-to-day setting and also in a mental health setting? Another example would be my team and I have taken parental curriculum, like [the] Strengthening Families curriculum, that some of us might be

familiar with, or [the] Circle of Safety curriculum. We have adapted that in a culturally-informed manner to work with the families within our communities who are involved with child protective services. We've seen a really big improvement in reunification of families because of this model.

MM: Another example would be integrating movement into our treatment. Pairing trauma-informed yoga group therapy has shown really big improvements on emotional regulation within our clients, a reduction of somatic symptoms, and body pains that a lot of our clients will constantly bring up. That's something that they need assistance with. We've seen trauma symptoms reduction with that model as well. Again, taking those two things and pairing them together.

For the work that I focus on, just like Monica was saying, focusing on what the clients are identifying as the most helpful and the most healing, whether this is in casework, whether this is in a more therapeutic setting. Not that casework can't be therapeutic. What has the client identified as healing? What is the community wisdom saying that they're a part of? What is the historical context that they relate to? When we're looking at our program evaluations, holding space for both of those to be able to be results. I think a lot of our results are usually symptom reduction, but can we hold both?

KZ: Thank you so much. We know that holding that space is so important. Also, just protecting that space to do that work is really important, too. Miriam, I'd be curious if you'd like to join in and share any ways you've observed changes in client outcomes from evidence-based practices.

MP: Yes. I will speak from my past experience as a professor of social work. For 30 years, I taught a course on evidence-based practice twice a year. That's a lot of classes and a lot of students. You might think that I'd be over it by now, but this has always been my favorite class. I enjoy it so much. The reason is that students come in absolutely terrified. They have no idea what this evidence-based practice thing is all about, and they're fearful of it, as some of you might be at the moment.

Lo and behold, 12 weeks later, 15 weeks later, they're utterly happy, dancing out the door when class ends. The reason for that, there are several reasons, but one is, they usually see client improvement. More importantly, they see it in a measurable way because they have selected an instrument or tool to use to measure client progress, not just from beginning to end, but continuously throughout that period.

Thirdly, they can see the linkage between the intervention that they have so carefully selected because they go through this whole process that Sarah was describing of identifying appropriate evidence-based interventions. They can see the results of that. They've selected that intervention. They've adapted it to their client needs. They've implemented it. They've gotten feedback from the client, and in most cases, it's very positive, as I say. For those reasons, students have been very happy at the end of the course. That's my perspective. Thank you.

KZ: Thank you so much. We know that sometimes these fields, they grow, and we have to address any tensions with anything that we do to make sure that we're growing continually and learning. This next question, I'll ask you, Monica, to start

with, is what tensions have you experienced when applying evidence-based practice in your work?

MI: A core question that I think all of us struggle with regularly and try to balance. Again, in an overarching way, probably a general tension arises from trying to adhere to the fidelity of a model, how you're implementing a particular intervention for the purpose of collecting service-related data versus meeting the need of a particular client in a particular situation, at a particular moment in time. Sometimes there's a dynamic tension between those. I know we've felt that sometimes at IRC in Elizabeth, and trying to be able to balance that.

A couple of other things. I will just say some of the tensions arise from the fact, if I can—this is biased, so I'm going to own it. A lot of evidence-based practices and the literature on that comes from the Western world, European countries, the U.S., Australia, so largely, the Western world's approaches to it. They reflect Western world assumptions. An example is, in some ways, the predominance of cognition, of thought. CBT-based interventions in this country are the most researched and studied.

MI: It's no coincidence that so many evidence-based practices are CBT-based. That's what we're studying. Just a shout-out to all of us to broaden our lens and look at a range of different kinds of interventions, like the trauma-focused yoga Miriam was talking about. I would have loved to have actually been a student in Miriam's class. The last couple of things are that the staff bandwidth that Sarah relayed when she was giving her presentation, I think is something we always have to take into account.

It takes a lot of consistent effort and bandwidth to be able to develop, implement, [and] assess evidence-based interventions. The reality is, this moment in time, we're all stretched, and it's a particularly stressful moment in time. Then, lastly, this is maybe just an artifact of IRC in Elizabeth, though I doubt it, but regular attendance is a huge problem in the programs that we offer. People get a job, drop out, like the example with Cecilia. Regular attendance is a problem. That affects what we think of as the dose-response relationship to interventions, trying to see how much and how consistently people got a particular type of intervention, what the response was. It affects that.

That's, in some ways, a unique artifact of the settings that we're in that I want us to be able to think through how we're going to address that. That's about it, Katie. Thanks.

KZ: Thank you so much. CBT, just to clarify, is cognitive-based therapy? Okay, great. Miriam, did you have anything to add in terms of tensions?

MP: I think the major tension I've seen among practitioners is this misunderstanding of the difference between an evidence-based intervention and an evidence-based practice. We were making this distinction from the beginning. People often think that evidence-based practice means you have to apply that specific intervention the way it is structured and developed, and that you can't make any adaptations. I hope we have gotten that across, that, indeed, you can, and that that evidence-based intervention is a foundation, as Myja just said, and you build from there.

MP: I also want to echo what Monica said. It's absolutely true that there's a dearth of evidence on interventions with marginalized populations, such as those we are working with. Yet, I don't think that clearly, and I'm sure Monica agrees, that this is no reason not to use evidence-based practices, but to expand our perspective and to work to contribute to the evidence base through our own innovations. Thank you.

KZ: Thank you so much. I'm going to open up this last question and fold it in with the question that's in the Q&A. In terms of the last question, Myja, I'll start with you just to hear your voice. What advice would you offer to others integrating evidence-based practice into their work? If you want to, you can also tailor this to this idea that sometimes there might be fear among refugee populations in accessing non-therapeutic services like case management and employment, or ESL. What evidence-based strategies might exist if you have any advice on that, too, to just encourage the buy-in of implementing these evidence-based practices?

MM: Yes. I'll start with the advice because that may just roll over. I would say start with humility, start with curiosity, learn the model that you want to implement deeply, learn that model, but then also understand whose worldview that model was initially created for, what voices may be missing from that model, and then be open to modifying that. Then, for the question about how do I maybe implement something if clients are unwilling or fearful or have some hesitancy in accessing service, number one would be hold and use supervision in peer consultation.

Get supervision from cultural knowledge-holders that can answer that question for you. If you're able to, compensate those cultural knowledge-holders for sharing that knowledge with you and use that then to implement that in the communities that you're hoping to address the need. I think a lot of us go into communities with really great intentions, and we want to help and we want to support, but we do it from our own worldview and our own mindset. The communities themselves are going to be able to tell us what they need, and they're going to be able to tell us how they want that to be implemented.

KZ: Thank you so much. Maybe just a quick round robin, Monica, and Miriam, a brief offer of advice.

MI: I'll just say quickly and then let Miriam conclude. Again, a general piece of advice would be, think about practice-based evidence. This is about evidence-based practice. Turn it around, practice-based evidence. Think about using each encounter that we have, group, individual, family, in the community, each encounter that we have to gain information, and information is evidence. Focus on not just quantitative data, but qualitative data, the stories of lived experience. That's data.

Then, be thinking how you can start organizing that practice-based evidence so that you can either tailor an existing evidence-based practice to your setting, or maybe, which I am really in favor of all of us doing, creating our own interventions for the communities that we work with that are really based on those communities.

KZ: Thank you so much. Miriam?

MP: Yes, I would suggest starting with one client. Think of a client that you're having a challenge with, or that you're struggling to find a way forward. Identify the issue,

the outcome that you want to work toward, and then go to our Switchboard evidence database that Sarah was talking about. It is chock-full of evidence summaries on all types of outcomes and interventions. It is likely that you can find your client issue and evidence-based interventions there.

MP: I would then select one of those evidence-based interventions and just start trying it with the client. Start adapting while staying faithful to the original intent, and keep it low-key, but just give it a try and see what happens. That's my advice.

KZ: Thank you so much. With that, I just want to thank all of you, all of our panelists, and our presenter, Sarah, for the wonderful presentation and discussion. We really hope that today you're walking away understanding a little bit more about evidence-based practice. Our objectives were to ensure that you're able to describe evidence-based interventions and their relevance within service delivery for newcomers; identify those appropriate evidence-based practices; and develop an evidence-based service delivery plan that integrates the research evidence, those client characteristics and preferences, as well as your own practitioner expertise.

I'd also like to encourage all of you to look for opportunities to share your results when you're applying evidence-based strategies, especially changes and insights from your program with relevant learning communities, including your clients. Your experiences can really inform and inspire others and grow this culture. Now, before we share our recommended resources, we'd like to take 30 seconds and see if you could scan this QR code. Maybe 60 seconds. There's five questions. If you can, please answer those.

It's really important to help improve our future trainings. We look forward to reading your responses.

[pause]

KZ: Please remember that you'll get a recording with these resources and also that we'd love to hear from you. If your work involves evidence-based practice or you still want to talk about this because you're still unsure of how to do this, drop us a technical assistance request. We'd love to talk to you at Switchboard. We have a team of researchers whom you've met here, some of them today, and implementation experts, and we would love to support your efforts. For more technical and training assistance, we hope that you stay connected.

Email us at Switchboard@Rescue.org, visit us at SwitchboardTA.org, and follow us on social media. On behalf of all of us at Switchboard, thank you so much for learning with us. We hope to see you again. Thank you again, Sarah and our panelists, Miriam, Myja, and Monica, and also our wonderful Switchboard hosts. Thank you so much. Have a great day.

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