

About Empirically-supported Practices

Empirically-supported *practices* are also referred to as evidence-based and science-based practices. The terms refer to any intervention that has been identified as having research data generated using methods that meet scientific standards and demonstrate a level of efficacy deemed worthy of application and evaluation of effectiveness on a large scale.

A subgroup of such practices, referred to as evidence-based *treatments*, focuses on differentially diagnosed illnesses and disorders. According to the American Psychological Association, the designation of evidence-based treatment should be reserved for those interventions that have been tested in more than one scientifically rigorous study (either multiple case studies or randomized control trials) and have consistently been found to work better than a placebo or no treatment. Most evidence-based treatments are applied using a manual and are time-limited.

An *empirically-supported* practice may or may not be a *best* practice. A best practice is one that decision makers view as sufficiently productive in achieving desired results. Determination of a best practice may or may not be informed by formal research. When there has been no formal research, the empirical support usually stems from the experience of professional practitioners who implement the practice.

Another Intervention – Where and How Does it Fit?

Most evidence-based practices are discrete interventions designed to meet specified needs. A few are complex sets of interventions intended to meet multifaceted needs, and these usually are referred to as programs.

Viewed in isolation, empirically-supported interventions all can be seen as advancing practice. From a systemic and public health perspective, however, their introduction into an

organization can add to the widespread problems of fragmented and marginalized approaches and counterproductive competition for resources. Questions arise about where every newly proposed practice fits and how best to weave it into a comprehensive continuum of interventions (See sample of references at end of this document.).

For example, with respect to children and adolescents, most communities and schools offer a range of programs and services oriented to youngsters' needs and problems. Some are provided by schools, some by community agencies, and some agencies co-locate at or link to targeted schools. The interventions may be for all youngsters and their families, for those identified as "at risk," and/or for those who have been formally diagnosed.

Looked at as a whole, a considerable amount of activity is taking place and substantial resources are being expended. However, it is widely recognized that the whole enterprise is marginalized in policy and practice.

As a result, a major policy and practice consideration across the country is how to braid community and school resources together to develop a comprehensive, multifaceted, and cohesive systemic approach (see Figure 1). Such a continuum encompasses efforts to address emotional, behavior, and learning problems and enable social, emotional, academic, and physical development. As noted, most communities and schools have some programs and services that fit along the entire continuum. However, the tendency to focus mostly on the most severe problems has skewed things so that too little is done to prevent and intervene early after the onset of a problem. As a result, the whole enterprise has been characterized as a "waiting for failure" approach.

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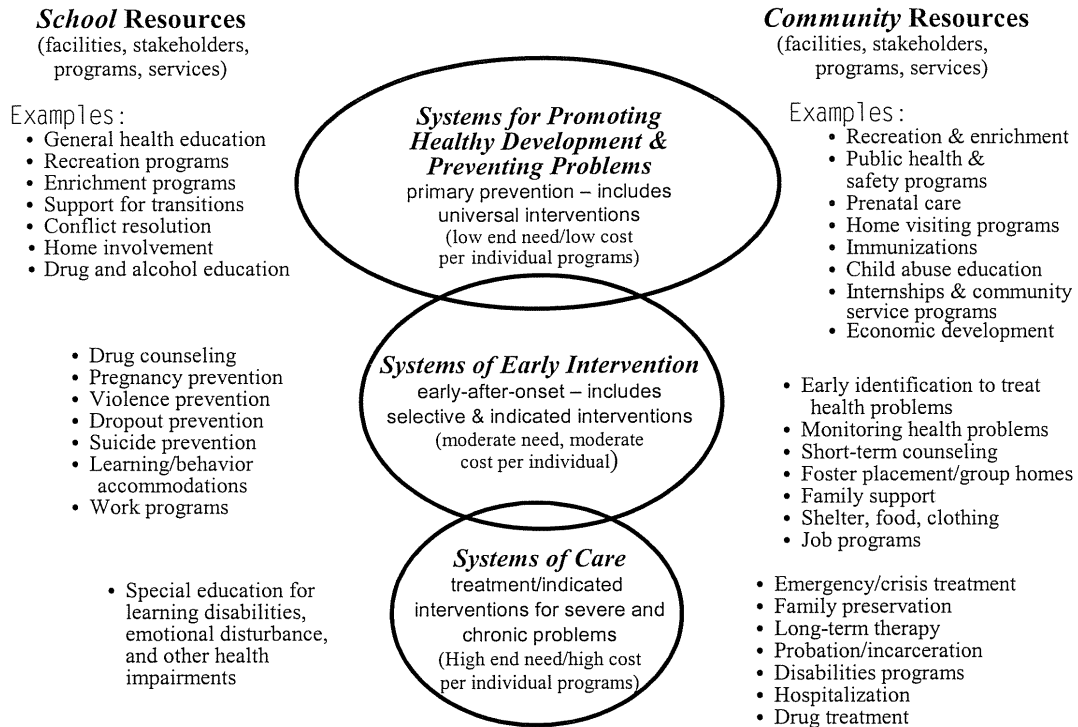
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Figure 1. **Interconnected Systems for Meeting the Needs of All Students**

Providing a *CONTINUUM OF SCHOOL-COMMUNITY PROGRAMS & SERVICES*

Ensuring use of the *LEAST INTERVENTION NEEDED*



Systemic collaboration is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among *systems for promoting healthy development and preventing problems, systems of early intervention, and systems of care.*

Such collaboration involves horizontal and vertical restructuring of programs and services

- within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools)
- between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies

(From various public domain documents authored by H. S. Adelman and L. Taylor and circulated through the Center for Mental Health in Schools at UCLA. Adapted by permission.)

By viewing programs, services, projects, and initiatives along the full continuum, communities and schools are more likely to provide the right interventions for the right individuals at the right time. Such a continuum encompasses efforts to positively affect a wide spectrum of social-emotional, behavioral, learning, and physical problems in every community and school by

- promoting healthy development and preventing problems
- intervening as early after the onset of problems as is feasible
- providing special assistance for severe and chronic problems.

As illustrated in Figure 1, note the emphasis on *systemic* design. That is, at each level effectiveness is seen as depending on development of a system – not just offering a service or program. Moreover, all levels need to be interconnected systemically.

This, then, illustrates the policy and practice context into which every newly proposed practice must be fitted.

Other Concerns and Controversies

The ways in which “science-based” practices are reshaping public policy have raised a range of concerns and controversies. Few argue against the value of integrating the best available research with professional expertise – with due appreciation for consumer differences stemming from individual characteristics, culture, preferences, and so forth.

Concerns arise when decision makers use criteria that those with appropriate experience and expertise see as inadequate and inappropriate. A major concern is that the science-base for many practices has been developed under laboratory conditions, and this is no guarantee that it will produce the same outcomes when applied widely.

In effect, until researchers demonstrate that a prototype is effective under “real world” conditions, it is a promising not a proven practice. And, even then it must be determined whether it is a best practice.

Findings from laboratory studies are referred to as data on *efficacy*; findings from studies conducted under common conditions of daily practice are

designated as data on *effectiveness*. In both instances, concern about generalizability arises when studies have not included samples representing major subgroups with whom the practice is to be used. Another major concern is that certain interventions increasingly are officially prescribed and others are proscribed by policy makers and funders, and only those practitioners who adhere to official lists are sanctioned and rewarded. This is a particular concern in sectors where individual needs come into conflict with powerful social, political, and economic forces.

In response to the various concerns and controversies, some researchers have suggested that the heated reactions they encounter from some practitioners represent mindless resistance. They often interpret the difficulty of achieving prototype fidelity in clinics and schools as the result of practitioner’s undermining the advance of science. It’s a truism that not everyone is ready for major changes in their lives. At the same time, not all concerns raised about proposed changes are simply resistance.

For example, the following matters are often heard in clinics and schools when some evidence-based practices are introduced:

“I don’t believe their ‘evidence-based’ intervention is better than what I do; they need to do the research on what I do before they claim theirs is better.”

“That intervention is too narrow and specific to fit the problems I have to deal with.”

“We wanted to use the grant money to enhance the work we already are doing, but we’ve been told we have to use it to buy evidence-based programs that we think don’t really fit our needs.”

“How do we know that if we adopt this evidence-based program we will get the results they got in their research.”

“We have so many things we have to do now, when are we going to have time to learn these new practices?”

“They make it sound like I am doing bad things. Soon, they will be suggesting that we are incompetent and need to be fired.”

"I've heard that some of the highly touted science-based programs have been found not to work well when they are tried on a large-scale.

"I'm not taking the risk of giving up what I believe works until they prove their laboratory model does better than me out here in the real world."

Any or these statements may be motivated by a desire not to change or by a deep commitment to the best interests of an agency and the families and youngsters it serves.

Controversies and concerns about what practices are appropriate and viable almost always are major contextual variables. Their impact must be addressed in efforts to diffuse empirically-supported practices, especially in settings that have well-established institutional cultures and organizational and operational infrastructures. Researchers need to avoid the blame-game and appreciate the complexities of diffusing such innovations and making major systemic changes. From such a vantage point, the focus shifts from "I'm right and they're wrong" to "Is this practice the right one for use here at this time?" and if there is resistance, the question is "What haven't I done to promote readiness for change?"

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