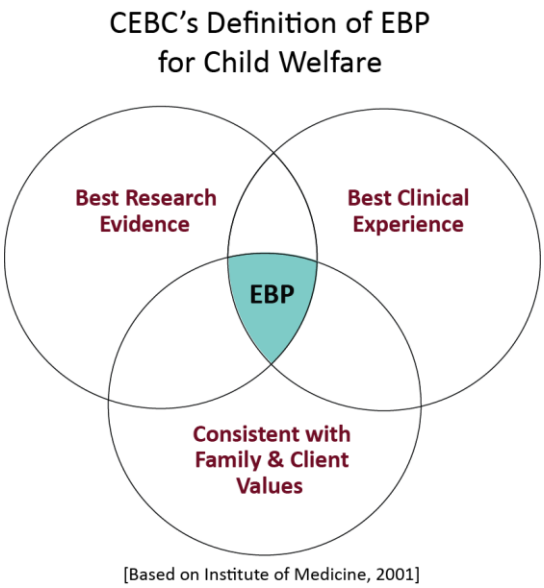
Understanding Evidence-Based Practices

Definition of Evidence-Based Practices



The Institute of Medicine defines *evidence-based practice (EBP)* as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values (IOM, 2001). These factors are also relevant for child welfare. The CEBC has adopted the Institute of Medicine's definition for evidence-based practice with a slight variation that incorporates child welfare language:

- Best Research Evidence
- Best Clinical Experience
- Consistent with Family/Client Values

This definition builds on a foundation of scientific research while honoring the experience of child welfare practitioners and being fully cognizant of the values of the families they serve. In contrast, *practice-based evidence (PBE)* is evidence of effectiveness from the practitioners and workers in the field, as well as a match with the needs and values of the local community. Click here to learn more about PBE vs. EBP.

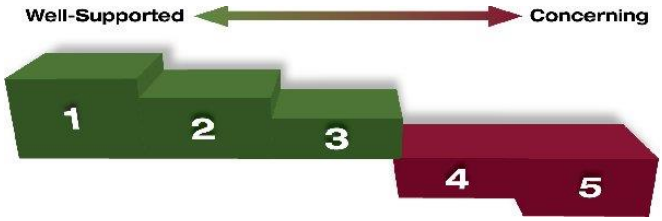
Brief History of EBPs

The seminal landmark for EBPs occurred in the early 1990s when the medical field founded *evidence-based medicine*, which is defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about individual patient care" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). Shortly after, the United States Congress passed the Alcohol, Drug Abuse and Mental Health Reorganization Act of 1992, which helped create the Substance Abuse and Mental Health Services Administration (SAMHSA; Williams-Taylor, 2007). The role of SAMHSA is to disseminate research and effective treatments for substance abuse and mental health issues. Since the founding of SAMHSA, many professional organizations, such as the American Psychological Association and the National Association of Social Workers, have adopted the EBP philosophy and promote ethical guidelines for practitioners to utilize intervention and/or prevention practices with supporting research evidence (National Association of Social Workers, 2013; American Psychological Association, 2006). Today, EBPs have been adopted in diverse service fields, such as criminal justice, education, mental health, public health, and social work.

What Makes a Program Evidence-Based?

As one-third of the above definition of EBP indicates, an EBP must have the "Best research evidence." Research on effective programs for children, youth, and parents is growing. There are some areas within child welfare that have been heavily

researched; yet in many areas, little research has been conducted. It is the goal of the CEBC to allow users to easily understand the level and quality of research evidence (defined on the CEBC website as "research study outcomes that have been published in a peer-reviewed journal") for each listed program in the CEBC registry.

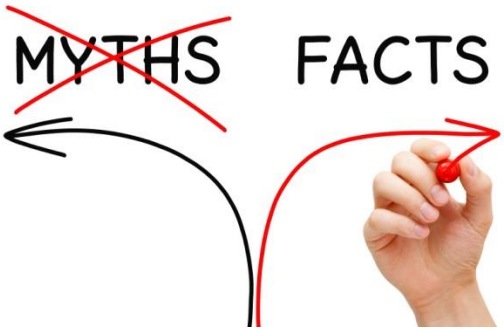


The CEBC does not label a program as *evidence-based* or *not evidence-based*, but uses a Scientific Rating Scale that details varying levels of supporting research evidence. The scale ranges from *1 - Well-Supported Research Evidence* to *5 - Concerning Practice*. There are also programs highlighted on the CEBC that are categorized as *NR - Not able to be Rated on the CEBC Scientific Rating Scale*. In fact, over 40% of the practices listed on the CEBC do not have adequate research evidence to be rated on the Scientific Rating Scale. The rationale for highlighting practices both with and without research is to provide unbiased and reliable information about marketed and/or widely used programs. Click here to access the CEBC Scientific Rating Scale.

Common Misconceptions and Facts about Evidence-Based Practices

Based on the work of Bernstein et al. (2015) and Bertram et al. (2015), six misconceptions about EBPs and the facts that rebut them are highlighted below. Please note: Although the CEBC will not label a practice as evidence-based, the social services field has taken to categorizing practices with higher levels of research as EBPs and that is how the term is used in the text below.

Misconception 1: "EBPs are a cookbook approach that disregards practitioner expertise."



EBPs are meant to enhance practitioner expertise, not replace it. Two-thirds of the definition of EBP is having the "best clinical experience" and "consistent with family/client values," this starts with the practitioner deciding the applicability of available EBPs based on their client's needs and values. EBPs commonly feature a manual or book to ensure that providers implement the vital intervention components that are known to be effective. Some manuals include flexible guidelines and practitioner actions ultimately depend on their own judgment and skills. In some cases, EBP components can be modified to meet unique needs; however, practitioners should consult the EBP developer prior to making any changes to ensure they are not jeopardizing the program's effectiveness.

Misconception 2: "The push for agencies to adopt EBPs is just a fad that will eventually pass."

Social service organizations commonly experience grant changes, funding reductions, high staff turnover, and an increase in accountability. Due to their effectiveness, EBPs are promoted by government agencies, funders, and boards to ensure allocated resources achieve maximum impact for children, youth, and families. Many organizations and systems have successfully adopted EBPs, integrated them into their continuum of services, and consider their EBPs *business as usual* once they've reported positive outcomes.

Misconception 3: "If a program is labeled as *evidence-based,* then it has achieved a high standard of research support."

Unfortunately, the term *evidence-based* is commonly used as a buzzword by program developers to market their program when there is not sufficient research evidence to justify the use of the term. When applicable, the CEBC provides a program in the registry with a rating that is based on the published peer-reviewed

research available for it. The rating is intended to educate those in the field and guide their decision on adopting a specific program. See the above "What Makes a Program Evidence-Based?" section for more information.

Misconception 4: "EBPs fail to account for client diversity."

Research testing EBP effectiveness on diverse populations is limited but growing. Cultural adaptations are available for some EBPs and many developers will work with a provider on making cultural modifications to their EBP. The CEBC provides cultural resources, including a recorded webinar and numerous articles, on issues related to cultural adaptation, effectiveness of EBPs in cultural minority groups, and the engagement and retention of cultural minority groups in EBPs.

Misconception 5: "There are too many challenges to starting and sustaining an EBP."

Implementing an EBP can present challenges for those in the field, however, that should not dissuade a provider from adopting one. It is important to consider the ethical implications of not utilizing an EBP in situations where clients may potentially benefit from one. Many social work and mental health professional groups provide ethical guidelines stating that providers should offer their clients services that are known to be effective and safe. EBPs are tested to be safe and are found to be generally effective for a specific population (it is important to keep in mind that no treatment exists that is effective for everyone). The CEBC has created the *Selecting and Implementing Evidence-Based Practices: A Guide for Child and Family Serving Systems* and provides additional guidance and resources to support the implementation of EBPs in child welfare and community-based settings.

Misconception 6: "It's too time consuming to keep up with current research to determine what's effective."

That's why the California Evidence-Based Clearinghouse for Child Welfare (CEBC) was created! The CEBC features a searchable registry of programs with varying degrees of supporting research evidence. The research evidence for each rated program in the registry is reviewed and updated on a regular basis. The CEBC provides every applicable program with a rating. Please note that not all programs listed on the CEBC have research evidence conducted on their effectiveness or research evidence that can be rated on the CEBC Scientific Rating Scale. See the above topic, "What Makes a Program Evidence-Based?", for the rationale on including programs that are not evidence-based in the registry.

Note: Misconceptions content adapted from Bernstein et al. (2015) and Bertram et al. (2015).

Rady Children's San Diego | Chadwick Center for Children & Families

CDSS

The CEBC is one of the California Department of Social Services' (CDSS) targeted efforts to improve the lives of children and families served within the child welfare system. The CDSS contracted with Rady Children's Hospital's Chadwick Center for Children & Families, located in San Diego, to create the CEBC.

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