

EBP Definition

Office of Mental Health and Addiction Services Proposed Operational Definition for Evidence-Based Practices

The Oregon Office of Mental Health and Addiction Services (OMHAS) proposes that programs incorporating practices derived from generally accepted scientific research be considered evidence-based. Such programs document efforts to assure fidelity to a practice and measure the impact of a practice on the program clients/participants/communities.

Clinical and prevention practices and their relation to research can be placed on an evidence continuum ranging from multiple studies using randomized assignment of patients in clinical settings to no evidence that supports the efficacy or efficiency of the practice. The following describes the levels of evidence that can be considered benchmarks along such a continuum. Each level defines the degree of evidence that a practice needs to be placed on the continuum.

OMHAS is proposing the first **three** levels (I-III) of evidence describe practices meeting the necessary scientific rigor to be defined as an evidence-based practice.

Evidence Continuum

Evidence-Based Practice Levels:

- I.** A prevention or treatment practice, regimen, or service that is grounded in consistent scientific evidence showing that it improves client/participant outcomes in both scientifically controlled and routine care settings. The practice is sufficiently documented through research to permit the assessment of fidelity. This means elements of the practice are standardized, replicable, and effective within a given setting and for particular populations. As a result, the degree of successful implementation of the service can be measured by the use of a fidelity tool that operationally defines the essential elements of the practice.

Key points:

- Supported by scientifically sound randomized controlled studies that have shown consistently positive outcomes.
- Positive outcomes have been achieved in scientifically controlled and in routine care settings.

II. A treatment or prevention service that is sufficiently documented through research studies (randomized controlled studies or rigorously conducted and designed evaluations). Research has only been conducted in a controlled setting or a routine care setting—not both. The elements of the practice can be standardized and have been demonstrated to be replicable and effective within given settings and for particular populations. As a result, the degree of successful implementation of the service can be measured by the use of a fidelity tool that operationally defines the essential elements of the practice, however such a tool may not have been formally developed or fully tested.

Key points:

- Supported by scientifically sound experimental studies that have demonstrated consistently positive outcomes.
- Positive outcomes have been achieved in scientifically controlled settings or routine care settings—not both.

III. A treatment or prevention service based on elements derived from Level I or II practices. The practice has been modified or adapted for a population or setting that is different from the one in which it was formally developed and documented. The modification's effect on outcomes is measured and documented. Based on the results of the outcomes, elements of the service are continually adapted or modified to achieve outcomes similar to those derived from the original practice. Practice is sufficiently documented to provide a framework for replication of practice and outcomes in a similarly modified setting. Fidelity tools developed for the original practice may be used to assess implementation, but high fidelity may not be possible due to changes in the original treatment practice or regimen. Low fidelity would indicate that modifications are too great to remain an evidence-based practice. In those cases where a fidelity tool does not exist, the relationship to the original practice must be clearly defined, and an explanation describing how the original practice is being modified should be documented for review.

Key point: Modified from Level I or II practice and applied in a setting or for a population that differs from the original practice.

Non Evidence-Based Practice Levels:

IV. A treatment or prevention service or practice not yet sufficiently documented and/or replicated through scientifically sound research procedures. However, the practice is building evidence through documentation of procedures and outcomes, and it fills a gap in the service system. The practice is not yet sufficiently researched for the development of a fidelity tool.

Key point: Intended to fill a gap in the service system and supported through sound research, documentation of service procedures, and consistently measured outcomes.

V. A treatment or prevention service based solely on clinical opinion and/or non-controlled studies without comparison groups. Such a service has not produced a standardized set of procedures or elements that allow for replication of the service. The service has not produced consistently positive measured outcomes.

Key point Practice is currently not research-based or replicable.

VI. A treatment or prevention service which research evidence points to having demonstrable and consistently poor outcomes for a particular population.

Key point: Practice produces poor outcomes.

Operationalization of Evidence Levels

In order to place any particular practice on the evidence continuum, each level must be operationalized in terms of attributes the practice must possess to be placed at a certain level. The table below operationalizes each level of the continuum based on the presence of the following six attributes:

- *Transparency:* Both the criteria (e.g., how to find evidence, what qualifies as evidence, how to judge quality of evidence) and the process (e.g., who reviews the evidence) of review should be open for observation by public description.
- *Research:* This will represent accumulated scientific evidence based on randomized controlled trials, quasi-experimental studies, and in some cases less rigorously controlled studies. Research should be published in appropriate peer reviewed journals and available for review. Limited

exceptions may be granted for non-published research, if it is of sufficient quality, documented, and available for review.

- *Standardization*: An intervention must be standardized in some way so that it can be replicated elsewhere by others. Standardization typically involves a description that clearly defines the practice and some measure to assess if the intervention is being accurately practiced.
- *Replication*: Replication of research findings means that more than one study finds similar positive effects when consumers receive the service.
- *Presence of a Fidelity Scale*: A fidelity scale is used to verify that an intervention is being implemented in a manner consistent with the treatment model – or the research that produced the practice.
- *Meaningful Outcomes*: Effective interventions must show that they can help consumers to achieve important goals or outcomes related to impairments and/or risk factors.

Operational Matrix for Levels of Evidence:

	Level	Transparency	Research	Standardization	Replication	Fidelity Scale	Meaningful Outcomes
Evidence-Based	I	yes	>=3 studies in peer reviewed journal	yes	yes	yes	yes
Practices	II	yes	>=3 studies in peer reviewed journal	yes	yes	Yes or in Development	yes
	III	yes	Based on published research	yes	no	Yes or in Development	yes
Non Evidence-Based Practices	IV	yes	None	no	no	no	yes
	V	no	None	no	no	no	no
	VI	no	Yes	yes	yes	no	no