



Comparing rating paradigms for evidence-based program registers in behavioral health: Evidentiary criteria and implications for assessing programs



Stephanie N. Means, Stephen Magura, Jason T. Burkhardt*, Daniela C. Schröter, Chris L.S. Coryn

The Evaluation Center at Western Michigan University, 1903 West Michigan Avenue, Kalamazoo, MI 49007, United States

ARTICLE INFO

Article history:

Available online 6 October 2014

Keywords:

Evidence-based programs
Evidence-based practices
Best practices
Evidence-based program registers
Standards of evidence
Hierarchies of evidence
Treatment effectiveness
Behavioral health

ABSTRACT

Decision makers need timely and credible information about the effectiveness of behavioral health interventions. Online evidence-based program registers (EBPRs) have been developed to address this need. However, the methods by which these registers determine programs and practices as being “evidence-based” has not been investigated in detail. This paper examines the evidentiary criteria EBPRs use to rate programs and the implications for how different registers rate the same programs. Although the registers tend to employ a standard Campbellian hierarchy of evidence to assess evaluation results, there is also considerable disagreement among the registers about what constitutes an adequate research design and sufficient data for designating a program as evidence-based. Additionally, differences exist in how registers report findings of “no effect,” which may deprive users of important information. Of all programs on the 15 registers that rate individual programs, 79% appear on only one register. Among a random sample of 100 programs rated by more than one register, 42% were inconsistently rated by the multiple registers to some degree.

© 2014 Elsevier Ltd. All rights reserved.

1. Introduction

Since the 1960s, professional evaluation has aimed to apply scientific research methods to develop evidence-based practices or programs (EBPs). The term “evidence-based” gained traction in a number of primary disciplines ranging from healthcare to education to law enforcement. Most recently, federal, state, and local governments have begun to increase their mandates for the use of EBPs (Hawai'i State Center for Nursing, 2013; Minnesota Department of Corrections, 2011; Office of the President of the United States, 2014a, 2014b; Reickmann, Kovas, Cassidy, & McCarty, 2011; United States Office of Management and Budget, 2013). Such mandates may require recipients of funding to spend a stated portion of their funds on EBPs (Office of Adolescent Health/Mathematica Policy Research, 2014). A policy memorandum from

the United States Office of Management and Budget (OMB) directs federal agencies to use credible evidence in the formulation of budget proposals and performance plans. OMB further encourages funding of programs that are backed by strong evidence of effectiveness (United States Office of Management and Budget, 2013). However, exactly what constitutes credible evidence continues to be debated (Donaldson, Christie, & Mark, 2009; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996).

Discussions surrounding credible evidence have largely focused on the philosophical and ideological disagreements concerning taxonomies and hierarchies of methodological quality and rigor. Relatively well established hierarchies describing standards of evidence do exist, ranging from highly rigorous systematic reviews to randomized controlled trials to single-case designs. The preferred designs in those hierarchies are those that are likely to yield evidence that is subject to the least amount of bias (Rossi, Lipsey, & Freeman, 2004; Shadish, Cook, & Campbell, 2002). However, evidence that is derived outside of the sphere of experiments is often accepted as credible as well (Donaldson et al., 2009). Furthermore, Gambrill (2006) points out that what constitutes a program as being evidence-based must not be limited to quality of evidence (i.e. what method was used), but

* Corresponding author. Tel.: +1 269 387 5913.

E-mail addresses: stephanie.means@wmich.edu (S.N. Means), stephen.magura@wmich.edu (S. Magura), jason.t.burkhardt@wmich.edu (J.T. Burkhardt), daniela.schroeter@wmich.edu (D.C. Schröter), chris.coryn@wmich.edu (Chris L.S. Coryn).

must also include factors such as ethics and impartiality. The evaluation field has come to recognize that the context of evidence is also important. Information beyond manifest outcomes must be considered when making decisions about program implementation (Donaldson et al., 2009; Scriven, 2014; Shadish, Cook, & Leviton, 1991). Although considering multiple forms and sources of information of credible evidence sounds ideal in theory, it may cause problems for decision makers who need concrete and unambiguous rules to identify EBPs.

It is a daunting process for individuals and even organizations to access, review, and synthesize the large and rapidly growing body of research literature in many of the primary disciplines (Bastian, Glasziou, & Chalmers, 2010; Jette et al., 2003; Shadish et al., 1991). Policymakers, administrators, clinicians, and practitioners need assistance in efficiently collecting, aggregating, and interpreting what constitutes valid evidence of a program's effectiveness. Consumers need resources that will help them filter information in order to make sound decisions for program participation. Evidence-based program registers (EBPRs) are a relatively recent mechanism for assisting this in this process in the behavioral health field (United States Government Accountability Office, 2009). These registers were established to assess applied research and evaluation studies of programs/interventions according to evidentiary (evidence-based) standards, in order to help potential users decide which programs/interventions to support or select for implementation.

Several recent reviews of EBPRs, primarily focused on federally sponsored registers – such as the National Register of Evidence-Based Programs and Practices, the What Works Clearinghouse, and Social Programs that Work – found needs for more transparency in how such registers assess program effectiveness, in their use of evidence-based standards, and in how information is disseminated to the public (Hennessy & Green-Hennessy, 2011; United States Government Accountability Office, 2009, 2010).

At the inception of the present study, it was unknown whether these problems were remedied. The authors' preliminary examination of relevant EBPRs found many different paradigms for rating programs. In particular, some registers listed programs as "evidence-based" (or not) with no further gradation in ratings, while others employed graded levels ("tiers") of evidence in support of a program. Among the latter type of register, it appeared that the top two tiers of evidence were indicative of what the field has termed "evidence-based," although the distinctions between the top two tiers varied among registers. In general there seemed to be many and often not obvious differences among registers in designating programs as evidence-based.

The purpose of this study is to describe the similarities and differences in evidentiary criteria of effectiveness and program rating schemes for EBPRs in behavioral health, with special attention to variation in evidentiary criteria between the top two tiers for registers with multiple rating tiers. This study also attempts to determine the extent to which such differences in evidentiary criteria affect ratings of the same program appearing in more than one register.

2. Methods

The present study was phase 2 of a sequential mixed methods study. In phase 1, the authors identified 20 active evidence-based practice registers that included interventions pertinent to behavior health. This was followed by analysis of the websites of those registers to identify their scope, purpose, key structural elements, funding sources, marketing and dissemination strategies, and challenges associated with maintaining them. Interviews with the register managers were also conducted in order to confirm the interpretation of documents and to provide the opportunity for the

register managers to provide additional information (Burkhardt, Schröter, Magura, Means, & Coryn, 2014, in this issue). The present second paper focuses on the variations in evidentiary criteria used by the registers, the ways in which those criteria are applied, and the implications of applying different criteria to rating the same programs.

2.1. Sample

The population of interest for the study was EBPRs in behavioral health. Behavioral health is defined as being "An umbrella term for care that addresses behavioral problems bearing on health, including patient activation and health behaviors, mental health conditions and substance use, and other behaviors that bear on health" (Peek, 2013).

Evidence-based behavioral health interventions are interventions whose effectiveness and appropriateness for implementation are supported by empirical data derived from systematic scientific inquiry (Agency for Healthcare Research and Quality, 2013; APA Presidential Task Force, 2006; Chambless & Hollon, 1998; Council for Training in Evidence-Based Behavioral Practice, 2008; Mattox & Kilburn, 2013; National Institute of Health – US Department of Health and Human Services, 2011; Southam-Gerow & Prinstein, 2014). EBPRs for behavioral health were defined in this study as: (1) online and actively managed for updates, (2) including behavioral health interventions, (3) including documentable criteria for including and excluding programs or interventions, and (4) presenting evaluative information that could support decision making. Online actively-managed registers were chosen for investigation because the authors believe that print listings or printed articles of evaluation results or syntheses no longer constitute the kind of timely information needed by decision makers, and that decision makers would likely primarily access web-based resources in preference to printed materials, which quickly become out of date. We did find several examples of printed evidence-based program lists that had been placed on-line, but these were not being updated or otherwise actively managed, and were thus excluded from study eligibility (U.S. Department of Education, 2001).

The authors began with a set of reports, resource lists, linking sites, practice manuals, and evidence-based program registers as defined by this study, conducted a current search of the web, and developed a final pool of 129 candidate EBPRs. The study inclusion/exclusion criteria listed above were applied, reducing the list to the final candidates. EBPRs that focused exclusively on medical treatment, physical health or general education programming (e.g., the Best Evidence Encyclopedia, Johns Hopkins University Center for Data Driven Reforms in Education, 2013) were then removed from the study, as were registers that solely relied on another register for their content. One example of the latter is FindYouthInfo.gov, which states that it uses a common database with Crimesolutions.gov. Another example is the OJJDP Model Programs Guide, which now shares a common dataset with Crimesolutions.gov. Additionally, although the large majority of the interventions reviewed by the Cochrane Collaboration are medically-related, many do address behavioral health, and given the Cochrane Collaboration's position in the evidence-based practice discussion, the Cochrane Collaboration was included in the study. The authors believe that the present study includes all existing EBPRs which include behavioral health interventions within their scope.

2.2. Document review

The registers included in the study were reviewed and coded according to a scheme that was iteratively developed. The major

Download English Version:

<https://daneshyari.com/en/article/6793343>

Download Persian Version:

<https://daneshyari.com/article/6793343>

[Daneshyari.com](https://daneshyari.com)