

Framework for a menu of evidence-informed practices and programs

Menu Framework Report

Department of Health and Human Services

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# Glossary

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| Term | Definition |
| Cost Benefit Analysis | An economic efficiency analysis that measures net changes or levels in social welfare associated with an intervention |
| Dissemination readiness | Availability and quality of implementation materials for a specific practice or program. |
| Implementation | Methods or techniques used to support the adoption, implementation, and sustainment of an intervention. |
| Implementability | Set of characteristics that predict ease of (and obstacles to) implementation. |
| Logic model or program logic | A diagram that depicts how a practice or program is assumed to achieve outcomes for its end-users. It shows the interrelationships between activities and their outcomes, using arrows to indicate which sets of activities are believed to contribute to specific outcomes. |
| Manualised Program | A clearly structured package of practice elements, or modules, that have been combined into a clearly defined program. |
| Menu and/or repository | A platform, menu, clearinghouse or repository that contains information regarding evidence-informed practices and programs. |
| The Menu | The menu of evidence-informed practices and programs for Victorian child and family services, currently under development. |
| Practice element | Practice elements, or individual treatment practices, are discrete, identifiable techniques used to deliver a service to end-users. Practice elements represent the most granular of practice approaches and cannot be subdivided further. |
| Program module | Program modules are made up of combination of practice elements. Multiple modules can be combined to form a program. |
| Randomised Control Trial | A study design, which aims to reduce bias when testing a new intervention. RCTs reduce selection bias as participants are allocated at random. |
| Strength of evidence | Degree to which an approach has been shown, through rigorous testing, to be effective. |
| Systematic review | A systematic review summarises the results of available carefully designed studies (controlled trials) and provides a high level of evidence on the effectiveness of clinical practices and programs used in social services. |
| Meta-analysis | A statistical technique that summarises the results of several studies into a single estimate of their combined result |

# Executive summary

Background:

The *Roadmap for Reform: Strong Families, Safe Children* (Roadmap for Reform) highlights the pressures and challenges faced by the Victorian children and families service system and sets out the directions and first steps for reform[[1]](#footnote-1). A critical enabler for this reform is for the sector to become a learning system, where outcomes are measured and services are continually re-evaluated, refined and improved.

To support this process, the Roadmap for Reform includes a commitment to develop and publish ‘an evidence-based and promising practice menu for child and family services’. The Victorian Government intends to develop a menu to support its long-term vision of delivering policies and services that have been proven to work, while avoiding those that have proven to be ineffective.

This project – A framework for a menu of evidence-informed practices and programs

The Department of Health and Human Services (DHHS) commissioned the Centre for Evidence and Implementation (CEI) to develop a framework (the Framework) for a menu of evidence-informed practices and programs (the Menu), including:

* A standard definition of evidence-informed practice
* How practices and programs will be:
* Identified or submitted for review
* Rated and reviewed, including inclusion criteria and rating scales.

In addition, DHHS has commissioned CEI to provide general guidance on implementing the Menu in the Victorian service system (Implementation Report).

Recommendations in this report are based on:

* A review of existing menus in Australia and overseas (see Appendix A for a list of menus and resources examined as part of this project and the separate Synthesis Report)
* Insights from consultations with, and input from Victorian Government and service sector stakeholders (see Appendix B for additional acknowledgements).

Recommendations:

This Report presents recommendations for the design of, and supporting processes associated with, the Menu. Recommendations in this report are based on:

* A review of existing menus in Australia and overseas (see Appendix A for a list of menus and resources examined as part of this project and the separate Synthesis Report for more details)
* Insights from consultations with, and input from Victorian Government and service sector stakeholders (see Appendix B for acknowledgements).

These recommendations are summarised below.

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| Reference | Recommendations |
| *What is evidence-informed practice?* | |
| Recommendation 1 | A contemporary definition of evidence-informed practice is included in the Menu. |
| Recommendation 2 | The Menu adopts the following definition of evidence-informed practice: The integration of best research evidence with practice expertise and client values. |
| Recommendation 3 | A range of evidence-informed approaches are considered in the Menu, including manualised programs, program modules and practice elements. |
| Recommendation 4 | All approaches (programs, modules and elements) are assessed in a standard and consistent manner. |
| *How will practices and programs be identified and submitted?* | |
| Recommendation 5 | Transparent and systematic procedures for searching and screening programs, practices and studies are developed, implemented and published. |
| Recommendation 6 | Regular (biannual) searching and screening for practices and programs occurs, based on pre-defined outcomes of interest to the Menu. |
| Recommendation 7 | Results from the screening and review activities are published. |
| Recommendation 8 | An Advisory Group is established to prioritise topic areas. |
| Recommendation 9 | Time-limited and topic-specific calls for submission are issued. |
| Recommendation 10 | A standard submission template is developed, which is aligned to the Menu’s inclusion criteria. |
| *How will decisions be made on what is included in the Menu?* | |
| Recommendation 11 | An initial assessment of identified or submitted practices and programs is undertaken by qualified staff members. |
| Recommendation 12 | An Expert Review Panel and review process is established that includes method and subject matter experts. |
| Recommendation 13 | Recently approved/re-rated programs and practice are given a provisional rating for a period of 60 days. |
| Recommendation 14 | Practices and programs already included on the Menu are re-rated when new research evidence becomes available (new research evidence identified through submissions and a bi-annual screening process by menu staff). |
| *What information will be included in the Menu?* | |
| Recommendation 15 | The following information categories are included in the Menu: overview of the practice or program, and ratings for the strength of evidence, implementability and cost. |
| Recommendation 16 | The overview of the practice or program includes the following fields: name and brief description, program goals and target outcome domains, target cohort, delivery model and setting, duration of intervention, origin of intervention, link to further details (e.g. external website), date of inclusion in the Menu and last update. |
| Recommendation 17 | A seven-point strength of evidence rating scale is adopted, including ‘logic-informed’, ‘well supported by research evidence’ and ‘concerning practice’ categories. |
| Recommendation 18 | Minimum requirements / standards for each point on the evidence rating scale are developed and published. |
| Recommendation 19 | Additional cultural and geographic markers and commentary are included to indicate whether the practice or program has been tested in Australia, with an Indigenous population (in Australia or overseas) and with a culturally and linguistically diverse population (in Australia or overseas). |
| Recommendation 20 | The Menu:   * Includes a Dissemination Rating Scale to assess the availability and quality of implementation materials, training and support resources and quality assurance procedures for included programs, modules and practices. * Lists the implementation and dissemination materials available for included programs, modules and practices * Lists mandatory program purveyor requirements, where applicable. |
| Recommendation 21 | An additional marker is included to indicate whether the practice or program is currently available in Australia. |
| Recommendation 22 | A financial cost rating scale is adopted, which should be defined following a review of the likely cost range associated with common programs and practice. |

# Introduction

This chapter presents an overview of the following:

* Victorian policy context
* This project
* Purpose of the Menu.

## Victorian policy context

The *Roadmap for Reform: Strong Families, Safe Children* (Roadmap for Reform) highlights the pressures and challenges faced by the Victorian children and families service system and sets out the directions and first steps for reform[[2]](#footnote-2). A critical enabler for this reform is for the sector to become a learning system, where outcomes are measured and services are continually re-evaluated, refined and improved.

To support this process, the Roadmap for Reform includes a commitment to develop and publish ‘an evidence-based and promising practice menu for child and family services’. The Victorian Government intends to develop a menu to support its long-term vision of delivering policies and services that have been proven to work, while avoiding those that have proven to be ineffective.

## Purpose and scope of the Victorian Menu

The Menu will cover the full continuum of child and family services in Victoria, including early intervention, child protection, out of home care and leaving care.

In the short to medium term, the Menu will:

* Support decision-making by presenting essential information in simple straightforward formats
* Communicate and disseminate this information to a broad range of stakeholders.

As the Menu is tested and refined over time, the longer-term vision for the Menu is that it will support DHHS’ service delivery and funding decisions.

## This project

The Department of Health and Human Services (DHHS) commissioned the Centre for Evidence and Implementation (CEI) to develop a framework (the Framework) for a menu of evidence-informed practices and programs (the Menu), including:

* A standard definition of evidence-informed practice
* How practices and programs will be:
* Identified or submitted for review
* Rated and reviewed, including inclusion criteria and rating scales.

In addition, DHHS has commissioned CEI to provide general guidance on implementing the Menu in the Victorian service system (Implementation Report).

Recommendations in this report are based on:

* A review of existing menus in Australia and overseas (see Appendix A for a list of menus and resources examined as part of this project and the separate Synthesis Report)
* Insights from consultations with, and input from Victorian Government and service sector stakeholders (see Appendix B for acknowledgements).

This project builds on a first draft of the Menu, which was published in December 2016[[3]](#footnote-3), along with a statement of intent that outlined the need for further development of the menu.

DHHS’s commitment to develop the Menu is consistent with approaches adopted by other agencies in Australia and globally. See Box 1 for summary of common benefits and concerns associated with menus.

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| **Box 1 – Benefits and concerns associated with existing menus in Australia and globally**  The increasing use of menus has a range of benefits, including:   * Enhancing the uptake of evidence by: * Making research evidence more accessible to a variety of users, including users who do not have access to scientific journal articles * Translating and disseminating this research to support evidence-informed decision-making * Supporting policy makers to make more targeted funding decisions.   Despite these benefits, some concerns are emerging globally about the focus, and use of, menus, including that most existing menus:   * Focus almost exclusively on manualised programs, without considering the component parts (i.e. practice elements) that are common across many of these programs (see Chapter 2 for discussion). A growing body of research suggests that: * By focussing only on manualised programs and equating evidence-informed practice to only manualised programs, the broader knowledge base of what works is ‘short-changed’ (Barth et. al., 2012) * Difficulties associated with implementing these programs with high integrity and adapting them to local contexts, may prevent their large-scale application in broader service areas (Barth et al., 2012; Chorpita et al., 2005 & 2007). * Require varying degrees of rigour for an evidence-based program designation, which often does not align to the strength of evidence generally required before the effectiveness of a program, module or practice can be clearly stated * Lack transparency associated with their review, inclusion and rating process. This has led to concerns about potential conflicts of interest (e.g. Gorman, 2017) * Focus on the strength of evidence alone, without due consideration for additional information required for informed decision-making (e.g. cost and implementability) * Do not adequately recognise the needs and preferences of families from culturally diverse backgrounds. |

# What is evidence-informed practice?

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| --- | --- |
| Reference | Recommendation description |
| Recommendation 1 | A contemporary definition of evidence-informed practice is included in the Menu. |
| Recommendation 2 | The Menu adopts the following definition of evidence-informed practice: The integration of best research evidence with practice expertise and client values. |
| Recommendation 3 | A range of evidence-informed approaches are considered in the Menu, including manualised programs, program modules and practice elements. |
| Recommendation 4 | All approaches (programs, modules and elements) are assessed in a standard and consistent manner. |

The inclusion of a contemporary definition of evidence-informed practice (EIP) in the Menu will inform what can be added to the menu (Chapter 3), how practices and programs are assessed (Chapter 4) and how the Menu will be implemented in Victorian service system (which will be covered in the Implementation Report).

Definitions of EIP applied to the human services sector have evolved from the evidence-based medicine movement, which began in the 1990s. Multiple definitions of EIP have emerged overtime. However, we recommend the following definition, which is adapted from the Institute of Medicine (2001): ‘The integration of best research evidence with practice expertise and client values.’ This definition suggests that EIP should draw on multiple sources of evidence, including the acknowledgement that EIP should:

* Be based on the best available research evidence (see Chapter 5.2)
* Be selected and delivered with practice expertise
* Align to the values and preferences of clients.

EIP comes in a range of approaches, including:

* Manualised programs - A clearly structured package of practice elements, or modules, that have been combined into a clearly defined program (e.g. Multisystem Therapy (MST) or Functional Family Therapy (FFT))
* Practice elements – Practice elements, or individual treatment practices, are discrete, identifiable techniques (e.g. verbal praise)
* Program modules – Practice modules are made up of a combination of practice elements. Multiple modules can be combined to form a program (e.g. Motivational Interviewing).

The extent to which a practice element approach, module or program is evidence informed (or not), depends on how well it meets pre-defined strength of evidence standards. The determination of whether an approach is evidence-informed therefore varies based on the standards it is assessed against.

By adopting this definition of EIP, the Menu will facilitate evidence-informed decision making by Victorian stakeholders (i.e. by presenting, and clearly categorising, a broader spectrum of approaches that could potentially be implemented in Victoria). To allow for meaningful comparison, all approaches should be assessed in a standard and consistent manner (e.g. see recommended evidence rating scale in Table 3, which will be applied to all approaches).

# How will practices and programs be identified and submitted?

This chapter presents recommendations on processes DHHS should adopt to identify practices and programs for review through:

* Regular searching and screening for practices and programs
* A complementary process that allows for external stakeholders to submit practices and programs for review.

## Searching and screening

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| --- | --- |
| Reference | Recommendation |
| Recommendation 5 | Transparent and systematic procedures for searching and screening programs, practices and studies are developed, implemented and published. |
| Recommendation 6 | Regular (biannual) searching and screening for practices and programs occurs, based on pre-defined outcomes of interest to the Menu. |
| Recommendation 7 | Results from the screening and review activities are published. |

To be credible, the Menu should adopt strategies and approaches that are transparent, systematic and rigorous. A transparent and systematic approach to retrieving and utilising literature for the Menu implies the following steps:

* Defining a clear scope for literature searches based on precisely defined target populations, and the outcomes to be achieved for these target populations
* Developing clearly described search strategies, including the search terms to be applied, electronic databases and other literature sources to be searched
* Screening literature based on clear inclusion / exclusion criteria (e.g. criteria that are based on target populations and outcomes of interest) that help to identify relevant studies
* Extracting data from included studies, based on procedures that can ensure reliability
* Analysing data based on current best practice for narrative and statistical synthesis of study findings, such as best practice for systematic reviews and meta-analysis
* Synthesising findings in simple report formats that can be accessed and used by internal and external stakeholders.

The above steps should be described in publicly accessible protocols that describe how often literature is searched, analysed and synthesised in the above way. The reports that emerge from literature searches should be published to enable experts, researchers and others with a strong interest in the science behind the Menu to understand the methodologies used.

This will ensure that the rationale behind the content of the Menu is fully understood and potentially replicated. By ensuring transparency and replicability, the Menu will gain credibility as a source of the best evidence and information available on practices and programs in child and family welfare, increasing the likelihood that the Menu will be used by service agencies, practitioners and experts in the field.

## Submissions by stakeholders

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| Reference | Recommendation |
| Recommendation 8 | An Advisory Group is established to prioritise topic areas. |
| Recommendation 9 | Time-limited and topic-specific calls for submission are issued. |
| Recommendation 10 | A standard submission template is developed, which is aligned to the Menu’s inclusion criteria. |

Submissions of practices and programs by external stakeholders could be facilitated by one, or a mix of, the following:

* Open calls for submissions – Suggestions for practices and programs are received through open calls that provide opportunities for service agencies and program developers to respond, which could include:
* Ongoing or continuously open call
* Time-limited, where submissions can only be made during predefined times
* Topic-specific calls for submissions – Staff responsible for maintaining the Menu, possibly in collaboration with external experts, define topics of interest on a regular basis.

The table below presents an overview of the nomination processes adopted by three existing menus. These examples are representative of the general approaches adopted by the menus reviewed, based on available information. The process adopted by these menus for assessing submissions is presented in Chapter 4.

**Table 1: Submission processes adopted by other menus**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Early Intervention Foundation Guidebook (EIF) | Blueprints for Healthy Youth Development (BHYD) | California Evidence-Based Clearinghouse for Child Welfare (CEBC) |
| Time limited | Yes | Yes | No |
| Topic | Topic specific – Process for defining priorities is not stated but programs need to ‘fit within the scope of the review.’ | Open | Topic specific – Annual consultation of an Advisory Committee to identify topic areas. |
| Eligibility | Open | Open | Restricted / invited - Topic expert generates a list of potential programs for each topic area. |
| Form of submission | Standard questionnaire completed by nominee. | Not stated, however, following a submission, write-ups are completed by staff. | Questionnaire is sent to the program representative. |

Based on the above, we recommend that:

* An Advisory Group is established to prioritise topic areas
* Time-limited and topic-specific calls for submission are issued
* A standard submission template is developed, which is aligned to the Menu’s inclusion criteria.

By adopting these recommendations:

* Submitted practices and programs are more likely to align to government priorities
* External stakeholders are clear on what information needs to be provided
* There is a reduced risk that external stakeholders will invest time in nominating programs that are unlikely to be considered
* The administrator of the Menu can efficiently allocated resources and staff, based on predefined timelines.

# How will decisions be made on what is included in the Menu?

This chapter presents recommendations on the decision-making structures and processes that should adopted to:

* Assess the inclusion of, and ratings applied to, practices and programs
* Review information already included in the Menu.

## Assessment

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| Reference | Recommendation |
| Recommendation 11 | An initial assessment of identified or submitted practices and programs is undertaken by qualified staff members. |
| Recommendation 12 | An Expert Review Panel and review process is established that includes method and subject matter experts. |
| Recommendation 13 | Recently approved/re-rated programs and practice are given a provisional rating for a period of 60 days. |

Once a practice or program has been identified or submitted (see Chapter 3), a clearly defined and transparent decision-making structure needs to be established.

The table below presents an overview of the decision-making and assessment processes adopted by the same menus discussed in Chapter 3.2. These examples are representative of the general approaches adopted by the menus reviewed, based on available information.

**Table 2: Decision-making and assessment processes adopted by other menus**

|  |  |  |  |
| --- | --- | --- | --- |
| Phase | Early Intervention Foundation Guidebook | Blueprints for Healthy Youth Development | California Evidence-Based Clearinghouse for Child Welfare |
| Initial search and assessment by staff | Staff conduct web-based search to identify other potentially relevant evaluations and studies. | Monthly search of the literature on outcomes of interest. | Staff conducts a literature search on each program to obtain any published, peer reviewed research. |
| Staff conduct an initial assessment (against 33 criteria) on the quality and rigour of the identified evaluations. | Write-ups (see Table 1) are reviewed and edited by two senior staff.  Decision is made as to whether a program might qualify as model or promising and should be submitted for expert review. | Staff review and edit the program outline.  Edited program outline is finalised by adding the Scientific Rating and other relevant information. |
| Expert reviews | Initial assessment is reviewed by a panel of experts (e.g. experts in the specific subject area, evaluation and statistical analysis). | Promising programs reviewed by the Advisory Board twice a year.  In some cases, the Advisory Board may ask the program designer/evaluator for additional information or analysis that will help make the case for acceptance. | Program outline is sent for review by a topic expert.  A Scientific Panel also provides guidance on the scientific integrity of the program outline. |
| Content experts and staff also review each assessment and agree on a provisional evidence rating. |
| Finalise | Provisional ratings are shared with providers.  A final moderation meeting is held with all members of the sub-panel to ensure consistency of rating. | Letter of notification sent to program designer with the final decision and reasons for decision. | Approved/rated programs are added to the website.  The rating for all new programs added onto the website is considered provisional for 60 days to allow comment from users. |

Based on the above, we recommend that:

* An initial assessment of identified or submitted practices and programs is undertaken by qualified staff members
* An Expert Review Panel and review process is established that includes method and subject matter experts
* Recently approved or re-rated programs and practice are given a provisional rating for a period of 60 days, which is consistent with the approach adopted by CEBC, to allow time for external stakeholders to provide feedback for consideration by menu staff
* Minimum standards, that must be met for a practice or program to be included in the ‘logic-informed’ category, are developed and published (see Chapter 5.2).

By adopting these recommendations:

* The review process will align to common review processes adopted by respected menus globally and deliver the rigour required for stakeholders to have confidence in the Menu
* External stakeholders will have the opportunity to challenge the rating assigned to a practice or program for up to 60 days from inclusion in the Menu.

## Review of practices and programs already included on the Menu

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| Reference | Recommendation |
| Recommendation 14 | Practices and programs already included on the Menu are re-rated when new research evidence becomes available (new research evidence identified through submissions and a bi-annual screening process by menu staff). |

To ensure the Menu continues to be informed by the latest available research and remains credible, we recommend the regular and systematic review of practices and programs already included on the Menu (i.e. new research evidence identified through submissions and a bi-annual screening process by menu staff).

This is consistent with the approach adopted by a range of existing menus. For example, the California Evidence-based Clearinghouse for Child Welfare (CEBC) undertakes a biannual literature review process of all programs.

# What information will be included in the Menu?

This chapter presents recommendations on the inclusion criteria and rating scales to be included in the Menu.

Within reason, the more information that is made easily accessible through the Menu, the more informed Victorian service providers will be in their decision-making process.

Most existing menus include:

* Overview of the practice or program, including general information such as program name, target population, target outcomes and delivery approach
* Strength of evidence supporting a particular practice or program.

While the above are important, more recent menus around the world (e.g. Early Intervention Foundation) are also increasingly including information relating to:

* Implementability
* Cost.

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| Reference | Recommendation |
| Recommendation 15 | The following information categories are included in the Menu: overview of the practice or program, and ratings for the strength of evidence, implementability and cost. |

As noted in Chapter 2, we recommend that all approaches (programs, modules and elements) are assessed in a standard and consistent manner. This chapter outlines how this should be applied in presenting:

* An overview of a practice or program (Chapter 5.1)
* The strength of the evidence behind a practice or program (Chapter 5.2)
* Programs’ or practices’ implementability (Chapter 5.3)
* Costs related to the use of practices and programs (Chapter 5.4).

## Overview of the practice or program

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| --- | --- |
| Reference | Recommendation |
| Recommendation 16 | The overview of the practice or program includes the following fields: name and brief description, program goals and target outcome domains, target cohort, delivery model and setting, duration of intervention, origin of intervention, link to further details (e.g. external website), date of inclusion in the Menu and last update. |

To be useful, the Menu will need to provide a high-level description of the practice or program. We recommend that the Menu includes the following fields:

* Name and brief description
* Program goals, and target outcome(s) and cohort(s)
* Delivery model, setting and modality (i.e. delivered individually, in a group or both)
* Duration and frequency of intervention
* Origin of intervention
* Link to further details (e.g. external website)
* Date of inclusion in the Menu and last update.

The information above will provide the basic level of information required to introduce the practice or program. This information will also be useful for filtering practices and programs in the Menu down to, for example, programs targeting a specific outcome.

## Strength of evidence

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| Reference | Recommendation |
| Recommendation 17 | A seven-point strength of evidence rating scale is adopted, including ‘logic-informed’, ‘well supported by research evidence’ and ‘concerning practice’ categories. |
| Recommendation 18 | Minimum requirements / standards for each point on the evidence rating scale are developed and published. |
| Recommendation 19 | Additional cultural and geographic markers and commentary are included to indicate whether the practice or program has been tested in Australia, with an Indigenous population (in Australia or overseas) and with a culturally and linguistically diverse population (in Australia or overseas). |

Strength of evidence relates to the degree to which an approach has been shown, through rigorous testing, to be effective. Hierarchies of evidence are a central concept in the field of EIP that provide a structure for appraising evidence (see Box 2).

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| **Box 2 – Hierarchies of evidence**  Hierarchies of evidence are a central concept in the field of evidence-informed practice. They provide a structure for appraising evidence and giving information about its quality and strength. A simplified version of such a hierarchy for effectiveness and prevention questions is provided below, indicating that systematic reviews rank highest[[4]](#footnote-4).   |  |  | | --- | --- | | Type | Description | | Systematic review | A high quality systematic review of the effectiveness of a program, policy, practice or service follows specific guidelines (see, for example, [www.cochrane.org](http://www.cochrane.org) or [www.campbellcollaboration.org](http://www.campbellcollaboration.org)) to synthesize the results of all available research evidence, carefully appraising the quality of each study and using rigorous methods to synthesize the results. In general, rigorous effectiveness studies (e.g., controlled trials) carry more weight than less informative studies because they are better at measuring effectiveness. The content of systematic reviews depends largely on available trials, their quality, and the outcomes that were measured. Then evidence is assessed for any benefits or harms from the practices and programs. Often, authors pool numerical data about effect size of the intervention (an effect size shows the magnitude of effectiveness of an intervention) through a process called meta-analysis. Because a meta-analysis uses the combined results of several studies, the result is more accurate than the results from individual studies (in this case, accuracy means external validity – the extent to which the same effects would be expected if the program was provided to similar populations). In this way, systematic reviews can summarise the existing clinical research on an intervention. | | Randomised Controlled Trial (RCT) | RCTs, including stepped-wedged, cluster and other randomised designs, test whether more people benefit from having received a ‘treatment’ (a program or service) than would have been the case if they had not received the treatment. RCTs are considered the gold standard in individual studies for determining whether people responded to a specific treatment as opposed to responding for some other reason. The main feature of an RCT is that participants are randomly allocated to receive the treatment or to receive one of several interventions, including a ‘control’ (no intervention), ‘treatment as usual or TAU’ (standard treatment), or a comparison treatment (testing one intervention versus another). For information of the growing prevalence of social work RCTs see, for example, Thyer (2015). | | Quasi-Experimental design (QES) | Quasi-experimental research shares similarities with the traditional experimental design or RCTs, but it specifically lacks the element of random assignment to treatment or control. Instead, quasi-experimental designs do their best to create similar groups of participants, one group receives the intervention and the other does not, using some criterion other than random assignment. The extent to which groups are considered similar is the extent to which the results are credible. Examples of these include case-control studies and propensity-score matching, difference in difference (Heckman) approaches, and other selection/matching designs. | | Other study designs | Other studies not included in the categories above are pre-post evaluations without real or statistical controls, cross-sectional studies, cohort studies without statistical controls, case reports and time series. |   In addition to the type of study conducted, consideration should also be given to the quality of each study, including consideration of the:   * Use of a clear conceptual / theoretical framework in studies * Consistency and accuracy (i.e., reliability and validity) of measures used in studies * Significance and magnitude of effect sizes achieved in studies * Sustainment of program effects over time * Size of the sample for intervention and control groups that are compared in studies. |

To varying degrees, the menus examined, consider and include:

* Study design, including minimum requirements, such as a logic model
* Other factors relating to the quality of studies (e.g. the consistency and accuracy of measures used in studies and the size of the sample for intervention and control groups)
* Cultural and geographic relevance, to varying degrees
* An assessment of the strength of evidence and associated evidence rating scale.

We recommend that:

* A seven-point strength of evidence rating scale is adopted (see Table 3), including ‘logic-informed, ‘well supported by research evidence’ and ‘concerning practice’ categories
* Minimum standards that must be met for a practice or program to be included in the ‘logic-informed’ category are developed and published (see Table 3)
* Additional cultural and geographic markers are included to indicate whether the practice or program has been tested in Australia, with an indigenous population (in Australia or overseas) and with culturally and linguistically diverse population (in Australia or overseas).

**Table 3: Recommended evidence rating scale for the Victorian menu**

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| Rating | Description |
| Well supported by research evidence | At least one high quality **systematic review** that statistically synthesises the outcomes (i.e., a systematic review that is inclusive of a meta-analysis) based on RCTs and/or quasi-experimental studies, and conducted in a range of usual care or practice settings, has found the practice or program to be **superior** to an appropriate comparison practice.  In this systematic review, the practice or program has been shown to have a **sustained effect** for at least one primary outcome lasting at least one year beyond the end of treatment, when compared to a control group. **No adverse effects** were identified for the practice or program. |
| Supported by research evidence | At least **two rigorous RCTs** conducted in a usual care or practice setting has found the practice or program to be **superior** to an appropriate comparison practice or program[[5]](#footnote-5).  In both studies, the practice or program has been shown to have a **sustained effect** lasting at least one year beyond the end of treatment, when compared to a control group. **No adverse effects** were identified for the practice or program. |
| Promising research evidence | At least **one rigorous RCT or quasi-experimental study** conducted in a usual care or practice setting has established the program’s or practice’s benefit over the control group or found it to be **superior** to an appropriate comparison practice. **No adverse effects** were identified for the practice or program. |
| Emerging research evidence | The practice or program meets the requirements of the logic-informed rating.  The practice or program has been tested using high-quality quasi-experimental or other study designs. Testing of impact is underway but evidence needed to meet the requirements of the ‘promising research evidence’ rating is not yet achieved. |
| Logic-informed | Key elements of the logic model / program logic for the practice or program are defined and verified in relation to the practice or program and the underpinning scientific evidence (adapted from Early Intervention Foundation, 2016). |
| Evidence fails to demonstrate effect | Two or more randomised, controlled outcome studies have found that the practice or program **has not resulted in improved outcomes**, when compared to usual care.  If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice or program. |
| Concerning practice | If multiple outcome studies have been conducted and one or more of the following applies:   * The overall weight of evidence suggests the practice or program has a **negative effect** upon clients served * There is **case data** suggesting a risk of harm that: a) was probably caused by the practice or program; and (b) the harm was severe and/or frequent * There is a **legal or empirical basis** suggesting that, compared to its likely benefits, the practice or program constitutes a risk of harm to those receiving it. |

By adopting these recommendations, the Menu will:

* Create sufficient room to accommodate a broad range of practices and programs in the Menu that, at a minimum, meet the requirements of the logic-informed rating, while also ensuring that categories remain meaningful and mutually exclusive
* Ensure that, at a minimum, items included in the Menu are underpinned by an evidence-informed logic
* Require that, for a practice or program to achieve the highest rating, a relatively high standard of evidence (i.e. high-quality systematic review that includes a meta-analysis) will be required. As noted in Box 2, a high quality systematic review statistically summarises the results of available carefully designed studies (controlled trials) and provides a relatively high level of confidence on the effectiveness, when compared to results from single studies
* Reduce the risks associated with items on the Menu being misrepresented or misunderstood through the clear and deliberate wording of each classification
* Increase the applicability of the Menu to families and communities from culturally and linguistically diverse backgrounds, including Aboriginal families and communities.

## Implementability

|  |  |
| --- | --- |
| Reference | Recommendation |
| Recommendation 20 | We recommend that the Menu:   * Includes a Dissemination Rating Scale to assess the availability and quality of implementation materials, training and support resources and quality assurance procedures for included programs, modules and practices * Lists the implementation and dissemination materials available for included programs, modules and practices * Lists mandatory program purveyor requirements, where applicable. |
| Recommendation 21 | An additional marker is included to indicate whether the practice or program is currently available in Australia. |

Implementation refers to methods or techniques used to support the adoption, implementation, and sustainability of an intervention. To enhance the likeliness of practices and programs creating their intended benefits, they should be implemented to a high quality. High quality implementation:

* Is concerned with increasing the likelihood that an intervention produces value for its intended recipients
* Requires practitioners and agencies to implement practices and programs as intended. This includes that clients are exposed to the right amount of the intervention, with the right intensity and based on the right therapeutic principles and techniques. To support practices and programs being implemented as intended, clear implementation materials (e.g. practice manuals and quality assurance procedures) are required.

Globally, there is increasing recognition that implementation matters in efforts to increase positive outcomes for children and families. For example, a review of over 500 child and adolescent mental health and wellbeing program evaluations found that the impact of programs on child and family outcomes was 2-3 times stronger when these were implemented well (Durlak & DuPre, 2008).

Dissemination readiness is an indicator of the implementability of a practice or program. Dissemination readiness refers to the availability and quality of implementation materials for a specific practice or program.

The Menu could present information dissemination readiness through one, or a mix, of the following options (listed from highest to lowest resource intensity):

* Rating scale - Individual assessment and rating of the implementability and/or dissemination readiness of the practice or program. For example, the National Registry of Evidence-Based Programs and practices (NREPP), developed by the U.S. Substance Abuse and Mental Health Administration, previously used a Dissemination Rating Scale. External reviewers independently evaluated the intervention's Readiness for Dissemination using three criteria: availability of implementation materials, availability of training and support resources, availability of quality assurance procedures. This may have included an assessment of the quality of materials provided, although no public information on quality assessment was found. Interestingly, NREPP no longer follows this approach, which could be a function of the resources required to update and maintain this rating
* List the types of materials available – Note the information, materials and support available to implement the practice or program, without providing an assessment of the quality of the materials provided
* General information only - Provision of general information (i.e. not program specific) about good implementation practice.

We recommend that the Menu:

* Includes a Dissemination Rating Scale to assess the availability and quality of implementation materials, training and support resources and quality assurance procedures for included programs, modules and practices. This would be relatively resource intensive to maintain but would provide an easily understandable rating to users. Prior to developing and implementing the Dissemination Rating Scale, DHHS should consider engaging with representative from NREPP to better understand the benefits and challenges associated with maintaining a Dissemination Rating Scale
* Lists the implementation and dissemination materials available, including: implementation materials, training and support resources, quality assurance procedures and any workforce or implementation requirements (such as minimum qualifications). This should be updated as new materials become available, which could be undertaken as part of the process for maintaining the Dissemination Rating Scale
* Lists mandatory program purveyor requirements, where applicable (e.g. pre-training requirements). Program purveyors specialise in supporting the dissemination and implementation of a single evidence-informed program. Often, the program purveyors are a commercial arm of the developer of a program and holds its licence. Examples of such purveyors are Triple P International Prt Ltd. (for the Positive Parenting Program), MST Services Inc. (for Multisystemic Therapy) and TFC-O Consultants Inc. (for Treatment Foster Care – Oregon).

The Menu should also indicate whether the practice or program is currently available for use in Australia.

The provision of general information, as a stand-alone strategy, is not recommended because it is unlikely to provide sufficient detail to inform the decision-making process.

## Cost

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| --- | --- |
| Reference | Recommendation |
| Recommendation 22 | A financial cost rating scale is adopted, which should be defined following a review of the likely cost range associated with common programs and practice. |

The purpose of this component is to provide guidance to the users of the Menu on the likely financial cost associated with implementing the practice or program in Victoria.

The Menu could present cost information through one, or a mix, of the following options (listed from highest to lowest resource intensity):

* Cost benefit analysis (CBA) – CBA is an economic efficiency analysis that measures net changes or levels in social welfare associated with an intervention, including consideration on market and non-market values (Watson at. Al. 2007). Importantly, for this to be relevant for Victoria, separate CBAs need to be undertaken for the Victorian context (i.e. existing international CBAs would not be relevant)
* Rating scale of financial costs – Under this option, programs would be rated, preferably based on standard cost per unit/person rating scale
* List estimated costs (total program and/or per client costs) – Under this option, a dollar value would be provided in this field(s), which could represent a total program cost or unit cost
* Report on whether cost information is available – Under this option, a yes/no response would be provided for this field.

We recommend that the Menu includes a financial costs rating scale, which should be defined following a review of the likely cost range associated with common programs and practice.

This option provides sufficient detail to inform decision-making, while avoiding the additional costs associated with commissioning separate CBAs.

The remaining options are not recommended because:

* CBA – Cost burden and methodological issues associated with commissioning CBAs for all programs
* List estimated costs (total program or per client costs), by project – The preferred approach takes the same information and presents it in a more usable form including allowing for the development of a combined overall rating
* Report on whether cost information is available – Does not provide sufficient detail to inform the decision-making process.

# Appendix A Menus examined

Fourteen online menus and two key reports (Superu, 2017; MCRI, 2016) were analysed for this project The following table presents the menus examined as part of this project (see Appendix C for additional reports and references).

|  |  |  |  |
| --- | --- | --- | --- |
| Acronym | Full name of resource | Link | Description |
| BHYD | Blueprints for Healthy Youth Development | www.blueprintsprograms.com | Online platform for evidence-based programs addressing the health and wellbeing of children and youth (U.S.) |
| CEBC | California Evidence-based Clearinghouse for Child Welfare | www.cebc4cw.org | Online platform for evidence-based practices and programs relevant to child welfare (U.S.) |
| CFCA | Child Family Community Australia - hosted by the Australian Institute for Family Studies | https://apps.aifs.gov.au/cfca/guidebook | Online platform for information exchange for professionals working with children, families and communities, including an evidence-based program guidebook (AUS) |
| DEECD | The Victorian Government’s Department of Education and Early Childhood Development Online Catalogue of Evidence-Based Strategies | http://www.education.vic.gov.au/about/ research/Pages/catalogue.aspx | Online platform for evidence-based strategies (AUS) |
| E4L | Evidence for Learning (E4L) Teaching and Learning Toolkit | http://evidenceforlearning.org.au/the-toolkit/ | Online platform for summary of educational research and its effectiveness (AUS). |
| EEF | Education Endowment Foundation – The Teaching and Learning Toolkit | https://educationendowmentfoundation.org.uk/  resources/teaching-learning-toolkit | Online platform for effective practices and strategies to improve school children’s learning (UK) |
| EIF | Early Intervention Foundation Guidebook | http://guidebook.eif.org.uk/ | Online platform for information about early intervention programmes that have been evaluated and shown to improve outcomes for children and young people (UK) |
| EPIC | European Platform for Investing in Children | http://ec.europa.eu/social/  main.jsp?catId=1246&langId=en | Online platform providing information about policies that can help children and their families face the challenges that exist in the current economic climate in Europe (EU) |
| NREPP | National Registry of Evidence-Based Programs and practices, developed by the U.S. Substance Abuse and Mental Health Administration | www.nrepp.samhsa.gov | Online platform for evidence-based programs and practices targeting mental health and substance abuse (U.S.) |
| OJJDP | The U.S. Office of Juvenile Justice and Delinquency Prevention | https://www.ojjdp.gov/mpg/ | Online platform for model programs in juvenile justice (U.S.) |
| PWB | Practice Wise Blue Menu | https://www.practicewise.com/ | Online platform for the common processes and practices of evidence-based treatments for clinicians and organisations aiming to improve the quality of health care for children and adolescents (U.S.) |
| WSIPP | Washington State Inventory of Evidence-based , Research-based and Promising Practices | http://www.wsipp.wa.gov/BenefitCost | Online platform for evidence-based programs with a focus on assessing their cost-effectiveness (U.S.) |
| WWC | The Institute of Education Science What Works Clearinghouse | www.whatworks.ed.gov | Online platform for research on programs, products, practices, and policies in education (U.S.) |
| WW4K | The Nest What Works for Children, created by the Australian Research Alliance for Children and Youth (ARACY) | http://whatworksforkids.org.au/ | Online platform for interventions aiming to improve the wellbeing of children and youth, aged 0–24 years (AUS) |

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3. Murdoch Childrens Research Institute (2016). Supporting the Roadmap for Reform: Evidence-Informed Practice – Version 0.2, Melbourne. Retrieved from: http://www.strongfamiliessafechildren.vic.gov.au/ [↑](#footnote-ref-3)
4. There exist more detailed tools for appraising evidence that can be used for agencies making decisions about which interventions they choose. One high-quality example is GRADE ( <http://www.gradeworkinggroup.org/>). [↑](#footnote-ref-4)
5. For a practice or program to be superior to an appropriate comparison practice or program, the observed difference between those who got the service and those who did not was both statistically significant (p<0.05) and had meaningful impact (i.e., the effect size was large enough to make a clinically meaningful difference in a child and/or family’s life) [↑](#footnote-ref-5)