To Whom It May Concern:

Re: Application to be Deemed Evidence-Based

From: The Evidence-Based Practices Workgroup, a subcommittee of the Prevention Advisory Council-Workgroup of the Governor's Council on Behavioral Health

Thank you for your interest in having your program evaluated as an evidence-based practice by the Rhode Island Evidence-Based Practices Workgroup (RI EBPW). The goal of the RI EBPW is to provide guidance to the Prevention Advisory Committee of the Governor's Council on Behavioral Healthcare on the use of evidence-based practice in the delivery of behavioral healthcare services within the state.

An evidence-based practice (EBP) is one that is based in research and shows effectiveness under a particular set of circumstances. The term "practice" is synonymous with "program, intervention or strategy" in this context. The type of evidence and the relative strength of the evidence may differ based on the fidelity to the practice, culture, context and population targeted. Even though a proposed practice has been implemented in another setting or with a different population, it should not be assumed to be evidence based in all contexts.

Please fill out the enclosed application and submit your completed application via email to bhddh.ebpw@bhddh.ri.gov.

Your submitted application will be reviewed by a staff member for completeness. You may be contacted if formatting revisions or clarifications are necessary. Completed applications will then be reviewed by a panel of three experts. You may expect a decision regarding your application approximately 8-10 weeks after submission. At that time, applicants will be advised of acceptance or any requested revisions.

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Sandra DelSesto,
Chair, Evidence Based Practices Workgroup

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Corinna Roy, Director of Behavioral Health,
Department of Behavioral Healthcare,
Developmental Disabilities and Hospitals

Applying to Become an Evidence-Based Practice for Behavioral Health in Rhode Island

Overview

An evidence-based practice (EBP) is one that is based in research and shows evidence of effectiveness under a particular set of circumstances. The term "practice" is synonymous with "program, intervention or strategy" in this context. The goal of seeking recognition as an evidence-based practice for behavioral health is to create and sustain outcomes attributed to a practice. Many funders promote use of evidence-based practice(s) (EBPs) because it is believed that their effects are known and can be replicated. In addition, they may want to preserve scarce resources which might otherwise be directed towards developing practices which are untested and for which outcomes are less certain. The type of evidence and the relative strength of the evidence may differ based on the fidelity to the practice, culture, context and population targeted. Even though a proposed practice has been implemented in another setting or with a different population, it should not be assumed to be evidence-based in all contexts.

EBPs can be found on a registry or on lists of approved programs published by a federal agency or research group; reported in peer reviewed literature; or determined by a consensus of experts who review other types of documentation of effectiveness. There is no one path to a designation of evidence-based practice but rather a continuum of approaches. The decision to seek designation as an evidence-based practice should be weighed carefully based on potential benefits and challenges and a clear level of evidence.

Why Do It?

There are many potential benefits to being recognized as evidence-based:

- It can give credibility to program innovations or emerging practices developed by communities or agencies.
- It provides a concrete set of guidelines and structures to describe a level of evidence associated with a practice, strategy, program or intervention.
- It helps to define where a practice, strategy, program or intervention falls along a continuum of evidence.
- Funding or resources may be linked to an evidence-based designation. However, please note that the results of review do not guarantee funding.
- Research and evaluation consultation may enhance or increase program implementation capacity
- Service recipients may receive better outcomes as a result of the use of prescribed evidence-based practices
- Evidence based, culturally competent services for underserved populations may be increased

There are also some challenges with efforts to be recognized as evidence-based by this process

- There is not necessarily a universal standard of evidence or effectiveness that can be applied to every behavioral health condition across the continuum of care.
- For emerging problems or populations there may be insufficient research or theory to support the application. Therefore, other types of evidence to support the practice may need to be demonstrated
- The underlying research or theory base may later turn out to be flawed especially if it has not been tested extensively with the population targeted.
- Resources devoted to research and evaluation consultation may be required to complete this application process.
- The time and resources to complete the application may feel like a burden.
- The time required for the application review may be more than the organization believes it can afford before implementing the practice.

How to Apply

An application process has been developed by the Governor's Council on Behavioral Health's Prevention Advisory Committee's Evidence-based Practices Workgroup (EBP-W). The EBP-W was convened to: (1) develop guidelines for ascertaining whether a given practice, policy or program meets existing standards for evidence-based practice in behavioral health; and (2) identify a process by which an innovative or locally developed behavioral health practice, policy or program can be designated as an evidence-based practice in RI.

This application packet contains the following items:

1. **Sources of Evidence-based Practice** describing various sources of evidence-based practices.
2. **Application to Be Recognized in RI as an Evidence-based Practice**
3. **Appendix of Resource Documents**

Completed applications are to be submitted electronically to bhddh.ebpw@bhddh.ri.gov. Once an application is received, it will be reviewed for completeness by a staff member of the EBP-W. It will be forwarded to the EBP-W to schedule review of the application by three expert reviewers with expertise in the behavioral health condition targeted by the practice, researchers as well as peers who have experience with implementing practices.

Once the review is completed, the expert reviewers will provide a recommendation to (1) recognize the practices at Level 1 – Evidence-based Practices from Federal Registry, Level 2 – Evidence-based Practices from Peer Reviewed Journals/Research Literature; or Level 3 – Evidence-based Practices/Other Evidence of Effectiveness/Innovation; (2) request further information to complete review; or (3) decline to recognize the practice as evidence-based at the current time. Written feedback will be provided from the expert reviewers selected by the

Evidence-Based Practices Workgroup to the applicant regardless of the recommendation. Projected timeline of full process is between 8 and 10 weeks.

Application to Become an Evidence-based Practice for Behavioral Health in Rhode Island

Please utilize this application to be recognized as an evidence-based practice addressing behavioral health in the state of Rhode Island if your strategy, practice or program is an innovation or locally developed and not currently on a federal registry of best practices. See page two for additional instructions.

Applicant Name and Contact Information (E-mail, Phone Number): Click here to enter text.

Name of Evidence-Based Practice: Click here to enter text. Date of Application: Click here to enter text.

Please answer the following questions for the panel considering this application to be recognized as an evidence-based practice in RI:

1. Describe the behavioral health condition or problem that the practice is designed to address and the target population for which it's being proposed.
   Click here to enter text.

2. Describe the specific and measurable positive behavioral outcomes you anticipate by implementing this practice or strategy.
   Click here to enter text.

3. Is your proposed practice innovative, and not found on any federal registry? If yes, please proceed to question 5.
   Click here to enter text.

4. If your proposed practice is on a federal registry, please check the appropriate boxes below, whether or not you plan any adaptations.

Components	**Same**	**Different**	**N/A***
Behavioral health problem (substance targeted, mental health diagnosis)			
Risk or protective factor(s) or intervening variable(s)			
Setting (e.g. geographic location, virtual/physical format, etc.)			
Age			
Gender			
Gender identity			
Sexual orientation			
Race			
Ethnicity			
Differently abled			
Length of intervention			
Other (please describe)			

*Does not apply to the intervention or strategy/ not mentioned

Explain each of the differences noted above. Attach any proof (e-mail, letter) that the developer of the original evidence-based practice has approved of these adaptations or your efforts to contact the developer.

Click here to enter text.

5. Are there research articles that support the use of this practice in the proposed target population? If yes, please include citations and briefly summarize the results of the research articles. *Please refer to these research articles as appropriate in your answers for questions 5 through 9.*
   Click here to enter text.

6. Describe the behavioral change theory (e.g. self-efficacy, stages of change, health beliefs model, theory of reasoned action, planned behavior, youth development, etc.) that supports the proposed practice or strategy. Please describe the relevant findings from the attached research to support your answer.
   Click here to enter text.

7. Explain how the behavioral change theory is incorporated into the strategies proposed in the application.
   Click here to enter text.

8. Describe the primary behavioral health factors, negative or positive, or intervening variable(s) that the strategy addresses and how they were identified (up to three).
   Click here to enter text.

9. Describe how or why the proposed strategy is developmentally appropriate for the target population.
   Click here to enter text.

10. Provide a detailed description of the core or essential components of your proposed practice or strategy.
    Click here to enter text.

11. Provide a detailed outline the implementation plans including setting, length and duration, how participants will be recruited or identified, method of delivery (virtual, face to face), who will be delivering the intervention, etc. Include your curriculum or manual if available.
    Click here to enter text.

12. Explain how you have (or intend to) evaluate the implementation (process evaluation) and effectiveness (outcome evaluation) of the proposed practice or strategy.
    Click here to enter text.

13. Provide background and contact information of the evaluator (if applicable) and implementation partners.
    Click here to enter text.

GLOSSARY

A

Adaptation: Modifications made to a chosen intervention; changes in audience, setting, and/or intensity of program delivery. Research indicates that adaptations are more effective when underlying program theory is understood; core program components have been identified; and both the community and needs of a population of interest have been carefully defined.

Addiction/stages of addiction: Compulsive physiological need for and use of a habit-forming substance (as marijuana, nicotine or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal.

Advocacy: Taking action to support an idea or a cause. Advocates educate community members, the media, and elected officials in order to raise awareness, increase understanding of key issues, and mobilize support with the goal of creating positive change.

Archival data: Data that have already been collected by an agency or organization which are in are their records or archives.

Assessment: A process of gathering, analyzing and reporting information, usually data, about your community. A community assessment should include geographic and demographic information, as well as a collective review of needs and resources within a community that indicates what the current problems or issues are that could be addressed by a coalition.

B

Behavioral health: A state of mental/emotional being and/or choices and actions that affect wellness. The term *behavioral health* can also be used to describe the service systems surrounding the promotion of mental health, the prevention and treatment of mental and substance use disorders, and recovery support.

Brainstem: The lower portion of the brain. Major functions located in the brainstem include those necessary for survival, e.g., breathing, heart rate, blood pressure, and arousal.

C

Capacity: The various types and levels of resources that an organization or collaborative has at its disposal to meet the implementation demands of specific interventions. Capacity includes both the resources a community has to address its problems (e.g., programs, organizations, people, money, expertise) and how ready the community is to take action to address its problems.

Capacity building: Increasing the ability and skills of individuals, groups and organizations to plan, undertake and manage initiatives. The approach also enhances the capacity of the individuals, groups and organizations to deal with future issues or problems. Building capacity involves increasing the resources and improving the community's readiness to do prevention.

Cerebellum: A portion of the brain that helps regulate posture, balance, and coordination.

Cerebral cortex: Region of the brain responsible for higher cognitive functions, including language, reasoning, decision making, and judgment.

CNS depressants: A class of drugs (also called sedatives and tranquilizers) that slow CNS function; some are used to treat anxiety and sleep disorders (includes barbiturates and benzodiazepines).

Coalition: A formal arrangement for cooperation and collaboration between groups or sectors of a community, in which each group retains its identity, but all agree to work together toward a common goal of building a safe, healthy and drug-free community.

Community Readiness: The degree of support for or resistance to identifying substance use and abuse as significant social problems in a community. Stages of community readiness for prevention provide an appropriate framework for understanding prevention readiness at the community and state levels.

Confidentiality: Keeping information given by or about an individual in the course of professional relationship secure and secret from others.

Co-occurring disorder: Having one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

Cultural competence: Cultural competence, at the individual, organizational, and systems levels, involves being respectful and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups.

Cultural diversity: Differences in race, ethnicity, language, nationality or religion among various groups within a community. A community is said to be culturally diverse if its residents include members of different groups.

Culture: The shared values, traditions, norms, customs, arts, history, folklore and institutions of a group of people that are unified by race, ethnicity, language, nationality or religion. C*ulture* refers to "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."

D

Depressants: Drugs that relieve anxiety and promote sleep. Depressants include barbiturates, benzodiazepines, and alcohol.

Developmental Approach/Perspective: A developmental approach to prevention suggests that risk and protective factors and their potential consequences and benefits are organized according to defined developmental periods. This enables practitioners to match their prevention efforts to the developmental needs and competencies of their audience. It also helps planners align prevention efforts with key periods in peoples' development, when they are most likely to produce the desired, long-term effects.

Dopamine: A brain chemical, classified as a neurotransmitter, found in regions of the brain that regulate movement, emotion, motivation, and pleasure.

E

Effectiveness: The performance of an intervention under 'real-world' conditions

Efficacy: The performance of an intervention under ideal and controlled circumstances.

Environmental strategies: Prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies.

Epidemiology: The study of factors that influence health and illness in populations. Epidemiologists study the distribution and determinants of the health and wellness of populations.

Ethics: The rules and standards governing professional conduct. Core ethical principles in prevention include: nondiscrimination, competence, integrity, nature of services, confidentiality, and ethical obligations to community and society.

Evaluation: Evaluation is the systematic collection and analysis of information about an intervention to improve its effectiveness and make decisions. A process that helps prevention practitioners to discover the strengths and weaknesses of their activities.

Evidence-based practice: "The integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences (American Psychological Association policy statement, 2005). Note that the terms "clinical" and "patient" in this definition are used in the treatment and medical community. In the broader sense, these terms apply to education, psychoeducation, intervention, and prevention strategies. A practice is broader than a program.

Evidence-based prevention programming: Interventions and policies that have been shown to be effective through rigorous evaluations in preventing the onset and continuation of substance use and other problem behaviors. A program is an operationalized plan or system toward a particular set of behavioral outcomes (IOM 2009)

Evidence-based prevention interventions: An evidence-based intervention is a prevention service (program, policy, or practice) that has been proven to positively change the problem being targeted. In general, there needs to be evidence that the intervention has been effective at achieving outcomes through some form of evaluation.

F

Fidelity: When replicating a program model or strategy, fidelity is to implement the model or strategy with the same specifications as the original program. Fidelity can be balanced with adaptation to meet local needs.

Focus group: Structured interview with small groups of like individuals using standardized questions, follow up questions, and exploration of other topics that arise to better understand participants.

G

Goal statement: A description of the specific ends you wish to achieve through the implementation of a model, plan, or program.

H

Hallucinogens: A diverse group of drugs that alter perceptions, thoughts, and feelings. Hallucinogenic drugs include LSD, mescaline, PCP, and psilocybin (magic mushrooms).

Health disparities: A "health disparity" is a difference in health that is closely linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Hippocampus: An area of the brain crucial for learning and memory.

I

Implementation: Implementation involves mobilizing support for your efforts, selecting and carrying out evidence-based programs, policies, and practices, and monitor implementation to make mid-course corrections as necessary.

Indicated intervention: Indicated prevention interventions focus on higher risk individual identified as having signs and/or symptoms or behavior foreshadowing a mental, emotional, and/or substance use disorder.

Informed consent: The process of obtaining consent from participants that includes a full description and explanation of the activity presented in a way that participants can understand and ensures that participants provide their consent willingly free from coercion or undue influence. *Active consent* requires a signature from all participants in a research project and/or their legal representatives. *Passive consent* requires a signature from only those individuals who do not agree to participate in the research activity and/or their legal representative.

> **Active consent**: Active consent requires a signature from all participants in a research project and/or their legal representatives.
>
> **Passive consent**: Passive consent requires a signature only from those individuals who do not agree to participate in the research activity and/or their legal representative.

Inhalant: Any drug administered by breathing in its vapors. Inhalants are commonly organic solvents, such as glue and paint thinner, or anesthetic gases, such as nitrous oxide.

Intervening variables: Any factor, trait or condition that helps explain the relationship between two variables; a causal factor; a contributor to (e.g., substance use or mental health disorder in the family, abuse) or mitigator of (family support and bonding, participation in positive social activities); an undesirable condition.

J

Key informant: A person who has a specialized knowledge about a topic that you wish to understand and can convey that knowledge to you.

L

Limbic system: Area of the brain that is involved with feelings, emotions, and motivations. It is also important for learning and memory.

Lobbying: A type of advocacy that attempts to influence specific legislation.

Logic Model: The program logic model is defined as a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcome (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program

M

Media Advocacy: The strategic use of media to advance a social and/or public policy initiative.

Media Literacy: The ability to access, analyze and produce information for specific outcomes and the ability to "read" and produce media messages.

Mental disorder: Mental disorders involve changes in thinking, mood, and/or behavior. These disorders can affect how a person relates to others and make choices.

N

Neuron (nerve cell): A unique type of cell found in the brain and throughout the body that specializes in the transmission and processing of information.

Neurotransmitter: A chemical produced by neurons to carry messages to adjacent neurons.

Norms: Pattern of behavior in a particular group, community or culture, accepted as normal and to which an individual is expected to conform.

O

Objective statement: Statements that describe the specific, measurable products and deliverables that the project will deliver.

Opioids (or opiates): Controlled substances most often prescribed for the management of pain. They are natural or synthetic chemicals similar to morphine that work by mimicking the actions of encephalin and endorphin (endogenous opioids or pain-relieving chemicals produced in the body).

Outcome evaluation: Evaluation that describes the extent of the immediate effects of project components, including what changes occurred. Outcome evaluation documents whether the intervention made a difference, and if so, what changed.

Phases of the IOM continuum

Promotion: Promotion involves interventions (e.g., programs, practices, or environmental strategies) that enable people "to increase control over, and to improve, their health." The focus of promotion is on well-being.

Prevention: Prevention focuses on interventions that occur prior to the onset of a disorder and which are intended to prevent the occurrence of the disorder or reduce risk for the disorder. Prevention is also about striving to optimize well-being.

Treatment: Interventions targeted to individuals who are identified as currently suffering from a diagnosable disorder that are intended to cure the disorder or reduce the symptoms of the disorder, including the prevention of disability, relapse, and/or comorbidity**.** Treatment interventions for substance use disorders include case identification and standard forms of treatment (e.g., detoxification, outpatient treatment, in-patient treatment, medication-assisted treatment).

Recovery Management: Recovery management includes interventions that focus on compliance with long-term treatment to reduce relapse and recurrence and aftercare, including rehabilitation and recovery support.

Planning: Planning involves establishing criteria for prioritizing risk and protective factors, selecting prevention interventions, and developing a comprehensive, logical, and data-driven prevention plan.

Pre-frontal cortex: Located in the frontal lobe of the brain, this area is important for decision making, planning, and judgment.

Prevention: Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder.

Process evaluation: Evaluation that describes and documents what was done, how much, when, for whom and by whom during the course of the project. Process evaluation documents all aspects of the implementation of an intervention. It describes how the intervention was implemented.

Protective Factor: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a lower likelihood of problem outcomes.

Public health: What we, as a society, do collectively to assure the conditions for people to be healthy. The focus of public health is on the safety and well-being of entire populations by preventing disease rather than treating it.

Q

Qualitative data: Primarily exploratory research to gain an understanding of underlying reasons, opinions, and motivations. Some common methods include focus groups (group discussions), individual interviews, and participation/observations.

Quantitative data: Research that generates numerical data or data that can be transformed into useable statistics Quantitative data collection methods include various forms of surveys, longitudinal studies, polls, and systematic observation.

R

Recurrence: The return to use of a drug by a person in recovery

Resilience: The ability to recover from or adapt to adverse events, life changes and life stressors.

Resources: The various types and levels of assets that a community has at its disposal to address identified consequences of substance use disorders, including fiscal, human and organizational resources.

Risk factor: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

S

Selective intervention: A selective prevention intervention focus on individuals or sub-groups whose risk of developing mental health disorders and/or substance use disorders are significantly higher due to biological, psychological, and/or social risk factors.

Social Marketing: Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviors of target audiences in order to improve their personal welfare and that of their society.

Stakeholders: Stakeholders are the people and organizations in the community who have: a stake in prevention because they care about promoting health and well-being and have something to gain or lose by prevention or promotion efforts.

Stimulants: A class of drugs that elevates mood, increases feelings of well-being, and increases energy and alertness. Stimulants include cocaine, methamphetamine, and prescription drugs used to treat ADHD.

Strategic Prevention Framework: The Strategic Prevention Framework—or SPF—is a 5-step planning process used by SAMHSA to understand community needs and strengths, and to guide the selection, implementation, and evaluation of effective, developmentally and culturally appropriate, and sustainable prevention activities. The five steps are: Assessment, Capacity, Planning, Implementation, and Evaluation. Sustainability and Cultural Competence are included in all steps of the SPF.

Substance use disorder: Substance use disorder refers to the overuse of, or dependence on, a drug (legal or illegal) leading to effects that are detrimental to the person's physical and mental health, and cause problems with the person's relationships, employment and the law.

Sustainability: The likelihood of a program, coalition, or activity to continue over a period of time, especially after grant monies disappear. Sustainability is not about maintaining strategies but about achieving and sustaining positive outcomes.

T

Technical Assistance: Services provided by professional prevention staff intended to provide technical guidance to prevention programs, community organizations and individuals to conduct, strengthen or enhance activities that will promote prevention.

Theory of Change: A comprehensive description and explanation of how and why a desired change is expected to occur in a particular context. A Theory of Change defines long-term goals and then explains the causal linkages in the initiative, i.e. how the problem, intermediate variables, interventions and short-term and long-term outcomes are related to each other.

U

Universal intervention: Universal prevention interventions take the broadest approach and focus on the general public or a wide population that was not identified based on risk.

V

W

Wellness: A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

X-Y-Z

DEFINITIONS OF LEVELS OF EVIDENCE-BASED PRACTICES FOR BEHAVIORAL HEALTH SERVICES

The Evidence-based Practices Workgroup of the Governor's Council on Behavioral Health's Prevention Advisory Committee has identified three levels of evidence-based practices, policies or programs (EBPs) available for use by behavioral health care providers. Consultation with the developer or an evaluator or someone with advanced training in research and evaluation should be sought whenever an evidence-based practice is proposed for implementation or adaptation. Each level is defined below.

Level 1 – EVIDENCE-BASED PRACTICES FROM FEDERAL REGISTRIES

Definition: Registries are lists of approved or sanctioned practices, policies or programs generated by an agency, entity or organization with expertise in identifying best practices. Registries contain the following information that allows practitioners/implementers to judge the fit of the practices to their needs by providing descriptions of the following:

- The underlying research and theory of change supporting the EBP
- Consistency between the population targeted by the EBP and the population to which it would be delivered
- The outcome(s) sought and research limitations, and
- Guidelines or resources for implementation and support for fidelity.

The Evidence-based Practices Workgroup adopted the definitions and registries listed in *Identifying and Selecting Evidence-Based Interventions Revised Guidance Document for the Strategic Prevention Framework State Incentive Grant Program*.[i] The registries listed in this 2009 document included: OJJDP Model Programs Guide, Exemplary and Promising, Safe, Disciplined and Drug-Free Schools Programs, Guide to Clinical Preventive Services, and Guide to Community Preventive Services.

The following **additional registries** as potential sources of evidence-based practices, policies and programs for behavioral health, beyond those already listed in the above referenced guidance document: Collaborative for Academic, Social and Emotional Learning, Suicide Prevention Research Center, Blueprints, Guide to Clinical Practice, Patient Centered Outcome Research Initiative, Athena Forum, Find Youth.gov and Coalition for Evidence-based Practices.

Level 2 – EVIDENCE-BASED PRACTICES FROM PEER REVIEWED JOURNALS/EMPIRICAL RESEARCH

Definition: Peer reviewed journals are official publications of a professional association. Peer reviewed literature can include a single research article or summaries of a body of research or literature. Peer reviewed journals are usually widely available through research engines

associated with or used by research and academic institutions including but not limited to National Institutes of Health, and ClinicalTrials.gov. Peer reviewed journals typically have the following attributes:

- Criteria that defines the types of articles accepted
- Systematic guidelines on authorship and format
- Named editors or editorial board
- Significant reach to the associated profession

The following elements should be in place for consideration as an evidence-based practice derived from the peer reviewed literature:

1. The practice is informed by research about outcomes related to the target population, shared behavioral health risk or protective factor, or identified behavioral health risk or protective factor.

2. The practice must be informed by a clearly articulated theory of change or conceptual model.

3. The practice must contain sufficient information to identify core components of the practice or intervention.

4. The journal article should describe data collection and evaluation procedures associated with the practice.

5. The journal article describes the outcome evaluation, core components of the practice and any implementation requirements.

(See pages 16-17 SAMSHA/CSAP Identifying and Selecting Evidence-based Interventions).

Level 3 – OTHER EVIDENCE OF EFFECTIVENESS / INNOVATION

Definition: Practices or interventions not currently found in a registry or in the peer reviewed journals that have other evidence of effectiveness or are innovative. These practices may come from a related field, locally developed intervention, or presentations on emerging practices or innovations delivered at national meetings or conferences.

To be considered as being an innovative evidence-based practice or evidence-based practice based on other evidence of effectiveness, the following criteria must be met:

1. The practice is informed by recognized behavioral change theory and best practice.

2. The practice has demonstrated effectiveness within another discipline to address the condition, problem or risk or protective factor for which it was originally designed.

3. The practice addresses the behavioral health condition targeted by changing a shared risk or protective factor, intervening variable, community condition or problem behavior.

4. The practice is developmentally appropriate for the target population with which it would be implemented.

5. The practice is culturally appropriate to the setting in which it would be implemented and was developed in consultation with the target population for whom it was designed.

6. Documentation is available and defines core components of the practice/intervention in a way that would permit replication of it.

(See pages 18-19 SAMSHA / CSAP Identifying and Selecting Evidence-based Interventions).

[i] Center for Substance Abuse Prevention. *Identifying and Selecting Evidence Based Interventions Revised Guidance Document for the Strategic Prevention Framework State Incentive Grant.* HHS Pub. No (SMA) 09-4205. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

APPENDIX:
RESOURCE DOCUMENTS

Behavioral Change Theories

Frieden, T. (2010) A Framework for Public Health Action: The Health Impact Pyramid, American Journal of Public Health, vol. 100(4), 590-596.

McLeroy, K., Bibeau, D., Stickler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. Health Education Quarterly, 15, 351-377.

National Cancer Institute. (2005). Theory at a Glance: A Guide for Health Promotion Practice 2nd Edition, p. 45.

Risk and Protective Factors for Behavioral Health

Risk and Protective Factors for Mental, Emotional and Behavioral Disorders across the Life Cycle from National Research Council and Institute of Medicine. (2009).

Evidence-Based Programming

Practice Guidelines: Core Elements for Responding to Mental Health Crises. (2009). HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities. Washington, DC: The National Academies Press.

Risk and Protective Factors for Mental, Emotional and Behavioral Disorders across the Life Cycle from National Research Council and Institute of Medicine. (2009).

Promising Practices

Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Applying to Become an Evidence Based Practice for Behavioral Health in Rhode Island
FEEDBACK FORM

Introduction

This application process has been developed by the Governor's Council on Behavioral Health's Prevention Advisory Committee's Evidence Based Practices Workgroup (EBP-W). The EBP-W was convened to: (1) develop guidelines for ascertaining whether a given practice, policy or program meets existing standards for evidence-based practice in behavioral health; and (2) identify a process by which an innovative or locally developed behavioral health practice, policy or program can be designated as an evidence-based practice in RI.

Once an application is received, it will be reviewed for completeness by a staff member of the EBP-W. It will be forwarded to the EBP-W to schedule a review of the application by a panel with expertise in the behavioral health condition targeted by the practice, researchers as well as peers who have experience with implementing practices.

Once the review is completed, the expert panel will provide a recommendation to (1) recognize the practices at either Level 2 – Evidence Based Practices from Peer Reviewed Journals/Research Literature or Level 3 – Evidence Based Practices/Other Evidence of Effectiveness/Innovation, (2) request further information to complete the review, or (3) decline to recognize the practices as evidence based at the current time. Written feedback will be provided from the expert panel to the applicant regardless of the recommendation.

Name of Program/Practice: Click here to enter text.

Applicant Name and Contact Information: Click here to enter text.

Date of Application: Click here to enter text.

1. Research-Based

PURPOSE: To support the application with research articles (published or unpublished) on the proposed practice/program or why the proposed practice/program would create positive, program-specific behavioral health outcomes.

*Need a minimum average score of 2

0	**1**	**2**	**3**
Did not support the application with research articles (published or unpublished) on the proposed practice/program or why the proposed practice/program would create positive behavioral health outcomes. *When applicable, did not explain why there isn't direct research on the presented program/practice or provide complementary program research.*	*Somewhat supports the application with research articles (published or unpublished) on the proposed practice/program or why the proposed practice/program would create positive behavioral health outcomes.* *When applicable, somewhat explains why there isn't direct research on the presented program/practice or provides complementary program research.*	*Mostly supports the application with at least one research article (published or unpublished) on the proposed practice/program and why the proposed practice/program would create positive behavioral health outcomes.* *When applicable, mostly explains why there isn't direct research on the presented program/practice or provides complementary program research.*	*Strongly support the application with multiple research articles (published or unpublished) on the proposed practice/program and why the proposed practice/program would create positive behavioral health outcomes.* *When applicable, thoroughly explains why there isn't direct research on the presented program/practice or provides complementary program research.*

SCORE:

COMMENTS:

2. Theory-Based

PURPOSE: To utilize theories to explain how the behavioral change theory is incorporated into the strategies proposed in this application and include a logic model as a visual interpretation to help explain the theory behind the program/practice. Also, to explain how each identified risk/protective factors or intervening variables were selected.

*Need a minimum average score of 2

0	**1**	**2**	**3**
Did not utilize any theories to explain how the behavioral change would occur as part of this program/practice; *Did not include a logic model as a visual interpretation to explain the theory behind the program/practice and;* *Did not explain how each identified risk/protective factors or intervening variables were selected.*	*Utilized at least one theory to explain how the behavioral change would occur as part of this program/practice;* *Did not include a logic model as a visual interpretation to help explain the theory behind the program/practice and;* *Did not explain how each identified risk/protective factors or intervening variables were selected.*	*Utilized at least one theory to explain how the behavioral change would occur as part of this program/practice;* *Did include a logic model as a visual interpretation to help explain the theory behind the program/practice and;* *Did not explain how at least one identified risk/protective factors or intervening variables were selected.*	*Utilized at least one theory to explain how the behavioral change would occur as part of this program/practice;* *Did include a logic model as a visual interpretation to help explain the theory behind the program/practice and;* *Did explain how all identified risk/protective factors or intervening variables were selected.*

SCORE:

COMMENTS:

3. Unmet Need/Innovation

PURPOSE: To describe how this program is different from similar evidence-based programs/practices. This could include descriptions of different technology, new learning objectives, new populations, advanced clinical practice, etc.

0	**1**	**2**	**3**
Does not describe how this program is different from similar evidence-based programs/practices.	*Somewhat describes how this program is different from similar evidence-based programs/practices.*	*Mostly describes how this program is different from similar evidence-based programs/practices.*	*Thoroughly describes how this program is different from similar evidence-based programs/practices.*

SCORE:

COMMENTS:

ADDITIONAL FEEDBACK: