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September 2017

Updated Inventory of Evidence-Based, Research-Based, and Promising Practices:

For Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems

Revised November 14, 2017 for technical corrections

The 2012 Legislature directed the Department of Social and Health Services to...[1]

- ✓ Provide prevention and intervention services to children that are primarily "evidence-based" and "research-based" in the areas of mental health, child welfare, and juvenile justice.

The legislation also directed two independent research groups—the Washington State Institute for Public Policy (WSIPP) and the University of Washington's Evidence-Based Practice Institute (EBPI) to...

- ✓ Create an "inventory" of evidence-based, research-based, and promising practices and services. The definitions (page 4) developed for evidence-based and research-based are high standards of rigor and represent programs that demonstrate effectiveness at achieving certain outcomes.

While the definitions used to build the inventory have not changed since the inventory was originally published in September 2012, programs may be classified differently with each update as new research becomes available. Thus, it is important to note that the inventory is a snapshot that can change as new evidence and information is incorporated.

To assemble the inventory, we operationalize each criterion for both the current law definitions for children as well as the suggested definitions of evidence-based and research-based (see page 4 for definitions).[2] For example, for the suggested definitions, the WSIPP benefit-cost model is used to determine whether a program meets the benefit-cost criterion by testing the probability that benefits exceed costs. Programs that do not achieve at least a 75% chance of a positive net present value do not meet the benefit-cost test.

The legislation required periodic updates to the inventory. This September 2017 report is the seventh update and reflects changes to the inventory from the promising program applications and WSIPP's ongoing work on systematic research reviews and its benefit-cost model. The next update is anticipated in September 2018.[3]

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[1] Engrossed Second Substitute House Bill 2536, Chapter 232, Laws of 2012.
[2] The suggested definitions have not been enacted into law; thus, we provide the classification of each program for both the suggested and current law definitions of evidence-based and research-based.
[3] This schedule was set by the two research groups and is subject to funding availability. This may change if necessary.

Creating the Children's Services Inventory

The Washington State Legislature often directs WSIPP to study the effectiveness and assess the potential benefits and costs of programs and policies that could be implemented in Washington State. These studies are designed to provide policymakers with objective information about which programs or policy options ("programs") work to achieve desired outcomes (e.g. reduced crime or improved health) and what the long-term economic consequences of these options are likely to be.

WSIPP implements a rigorous three-step research approach to undertake this type of study. Through these three steps we:

1) Identify what works (and what does not). We systematically review all rigorous research evidence and estimate the program's effect on a desired outcome or set of outcomes. The evidence may indicate that a program worked (i.e. had a desirable effect on outcomes), caused harm (i.e. had an undesirable effect on outcomes), or had no detectable effect one way or the other.
2) Assess the return on investment. Given the estimated effect of a program from Step 1, we estimate—in dollars and cents—how much it would benefit people in Washington to implement the program and how much it would cost the taxpayers to achieve this result. We use WSIPP's benefit-cost model to develop standardized, comparable results that illustrate the expected return on investment. We present these results with a net present value for each program, on a per-participant basis. We also consider to whom monetary benefits accrue: program participants, taxpayers, and other people in society.
3) Determine the risk of investment. We assess the riskiness of our conclusions by calculating the probability that a program will at least "break even" if critical factors—like the actual cost to implement the program and the precise effect of the program—are lower or higher than our estimates.

We follow a set of standardized procedures (see Exhibit 1) for each of these steps. These standardized procedures support the rigor of our analysis and allow programs to be compared on an apples-to-apples basis.

For full detail on WSIPP's methods, see WSIPP's Technical Documentation.[4]

[4] WSIPP's meta-analytic and benefic-cost methods are described in detail in our technical documentation. Washington State Institute for Public Policy (May 2017). Benefit-cost technical documentation. Olympia, WA: Author.

Exhibit 1

WSIPP's Three-Step Approach

Step 1: Identify what works (and what does not)

We conduct a meta-analysis—a quantitative review of the research literature—to determine if the weight of the research evidence indicates whether desired outcomes are achieved, on average.

WSIPP follows several key protocols to ensure a rigorous analysis for each program examined. We:

- Search for all studies on a topic—We systematically review the national and international research literature and consider all available studies on a program, regardless of their findings. That is, we do not "cherry pick" studies to include in our analysis.
- Screen studies for quality—We only include rigorous studies in our analysis. We require that a study reasonably attempt to demonstrate causality using appropriate statistical techniques. For example, studies must include both treatment and comparison groups with an intent-to-treat analysis. Studies that do not meet our minimum standards are excluded from analysis.
- Determine the average effect size—We use a formal set of statistical procedures to calculate an average effect size for each outcome, which indicates the expected magnitude of change caused by the program (e.g., group prenatal care) for each outcome of interest (e.g., preterm birth).

Step 2: Assess the return on investment

WSIPP has developed, and continues to refine, an economic model to provide internally consistent monetary valuations of the benefits and costs of each program on a per-participant basis.

Benefits to individuals and society may stem from multiple sources. For example, a program that reduces the need for government services decreases taxpayer costs. If that program also improves participants' educational outcomes, it will increase their expected labor market earnings. Finally, if a program reduces crime, it will also reduce expected costs to crime victims.

We also estimate the cost required to implement an intervention. If the program is operating in Washington State, our preferred method is to obtain the service delivery and administrative costs from state or local agencies. When this approach is not possible, we estimate costs using the research literature, using estimates provided by program developers, or using a variety of sources to construct our own cost estimate.

Step 3: Determine the risk of investment

Any tabulation of benefits and costs involves a degree of uncertainty about the inputs used in the analysis, as well as the bottom-line estimates. An assessment of risk is expected in any investment analysis, whether in the private or public sector.

To assess the riskiness of our conclusions, we look at thousands of different scenarios through a Monte Carlo simulation. In each scenario we vary a number of key factors in our calculations (e.g., expected effect sizes, program costs), using estimates of error around each factor. The purpose of this analysis is to determine the probability that a particular program or policy will produce benefits that are equal to or greater than costs if the real-world conditions are different than our baseline assumptions.

Classifying Practices as Evidence-Based, Research-Based, or Promising

The 2012 legislative assignment directs WSIPP and EBPI to identify evidence-based and research-based practices for children. To prepare an inventory of evidence-based, research-based, and promising practices and services, the bill required WSIPP and EBPI to publish descriptive definitions of these terms.[5] The table below contains the definitions currently in statute prior to the passage of the 2012 law as well as the suggested definitions for evidence-based and research-based developed by the two research entities as required by the law.

Exhibit 2

Current Law and Suggested Definitions

	Current law definition for children's mental health and juvenile justice	Suggested definitions for children's services developed by WSIPP & EBPI
Evidence-based	A program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.	A program or practice that has been tested in heterogeneous or intended populations with multiple randomized and/or statistically-controlled evaluations, or one large multiple-site randomized and/or statistically-controlled evaluation, where the weight of the evidence from a systematic review demonstrates sustained improvements in at least one of the following outcomes: child abuse, neglect, or the need for out of home placement; crime; children's mental health; education; or employment. Further, "evidence-based" means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, has been determined to be cost-beneficial.
Research-based	A program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.	A program or practice that has been tested with a single randomized and/or statistically-controlled evaluation demonstrating sustained desirable outcomes; or where the weight of the evidence from a systematic review supports sustained outcomes as identified in the term "evidence-based" in RCW (the above definition) but does not meet the full criteria for "evidence-based. Further, 'research-based' means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington.
Promising practices	A practice that presents, based upon preliminary information, potential for becoming a research-based or consensus-based practice.	A program or practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the "evidence-based" or "research-based" criteria, which could include the use of a program that is evidence-based for outcomes other than the alternative use.

[5] The suggested definitions, originally published in 2012, were subsequently enacted by the 2013 Legislature for adult behavioral health services with slight modifications to relevant outcomes; however, they have not been enacted for the children's services inventory. Thus, we classify programs according to the statutory and proposed definitions (See: Second Substitute Senate Bill 5732, Chapter 338, Laws of 2013).

An application process for "promising" practices was created by EBPI to allow treatment providers to nominate practices for review. EBPI reviews the applications to determine if a program meets the criteria to be defined as promising. When outcome evaluation literature for the program exists, WSIPP then conducts a systematic review of the literature to determine if the program meets the definition of evidence-based or research-based.

For each program where research is available, we conduct meta-analysis and benefit-cost analysis to classify practices as evidence- or research-based according to the above definitions. If outcome evaluations exist but the evidence indicates a non-significant effect (p-value > 0.20) on desired outcomes in the expected direction, then the program is designated as promising. When we cannot locate rigorous outcome evaluations for a program, we rely on EBPI to determine whether the program meets the criteria for promising.

To assemble the inventory, we operationalize each criterion in the statutory and suggested definitions. These are the same criteria WSIPP has used in assembling inventories in other policy areas including adult behavioral health, adult corrections, and the Learning Assistance Program. The criteria are as follows:

1) Heterogeneity. To be designated as evidence-based, the state statute requires that a program has been tested on a "heterogeneous" population. We operationalize heterogeneity in two ways. First, the proportion of program participants belonging to ethnic/racial minority groups must be greater than or equal to the proportion of minority children aged 0 to 17 in Washington. From the 2010 Census, for children aged 0 through 17 in Washington, 68% were white and 32% were minorities.[6] Thus, if the weighted average of program participants in the outcome evaluations of the program is at least 32% ethnic/racial minority, then the program is considered to have been tested in a heterogeneous population.

   Second, the heterogeneity criterion can also be achieved if at least one of a program's outcome evaluations was conducted with K–12 students in Washington and a subgroup analysis demonstrates the program is effective for ethnic/racial minorities ($p < 0.20$).

   Programs whose evaluations do not meet either of these two criteria do not meet the heterogeneity definition.

2) Weight of evidence. To meet the evidence-based definition, results from a random effects meta-analysis (p-value < 0.20) of multiple evaluations or one large multiple-site evaluation must indicate the practice achieves the desired outcome(s).[7] To meet the research-based definition, one single-site evaluation must indicate the practice achieves the desired outcomes (p-value < 0.20).

   If results from a random-effects meta-analysis of multiple evaluations are not statistically significant (p-value > 0.20) for desired outcomes, the practice may be classified as "Null". If results from a random-effects meta-analysis of multiple evaluations or one large multiple-site

[6] United States Census Bureau, 2010. Retrieved from http://factfinder2.census.gov/.

[7] In order to operationalize the benefit-cost criterion, net benefits must exceed costs at least 75% of the time. After considerable analysis, we found that a typical program that WSIPP has analyzed may produce benefits that exceed costs roughly 75% of the time with a p-value cut-off of up to 0.20. Thus, we determined that programs with p-values < 0.20 on desired outcomes should be considered research-based in order to avoid classifying programs with desirable benefit-cost results as promising.

evaluation indicate that a practice produces undesirable effects (p-value < 0.20), the practice may be classified as producing poor outcomes.

3) Benefit-cost. The proposed definition of evidence-based practices requires that, when possible, a benefit-cost analysis be conducted. We use WSIPP's benefit-cost model to determine whether a program meets this criterion.[8] Programs that do not have at least a 75% chance of a positive net present value do not meet the benefit-cost test. The WSIPP model uses Monte Carlo simulation to test the probability that benefits exceed costs. The 75% standard was deemed an appropriate measure of risk aversion.

If a program is not listed on the inventory, we have not yet had the opportunity to review it or it may not meet criteria for promising. The children's services inventory is displayed at the end of this report and is also available on our website.[9] Further information on the individual programs contained in the inventory can also be found on our website.[10]

[8] For information about WSIPP's benefit-cost model see WSIPP's technical documentation.
[9] http://www.wsipp.wa.gov/ReportFile/1673.
[10] http://www.wsipp.wa.gov/BenefitCost.

Updates to the Inventory as of September 2017

WSIPP has reviewed and added 21 new programs since the last inventory was published in June 2016.

Exhibit 3

New Program Classifications

Program/intervention name	Classification*
Child welfare	
Circle of Security – Parenting (COS-P)	Promising
Juvenile justice	
Diversion, no services (vs. traditional juvenile court processing)	Evidence-based
Diversion, with services (vs. traditional juvenile court processing)	Evidence-based
Boot camps	Promising
Other group home programs (non-name brand)	Promising
Diversion, with services (vs. simple release)	Null
Intensive supervision (parole)	Null
Intensive supervision (probation)	Null
Other substance use disorder treatment for juveniles (non-therapeutic communities)**	Null
Team Child	Null
Mental health	
Acceptance and Commitment Therapy (ACT) for children with anxiety	Research-based
Acceptance and Commitment Therapy (ACT) for children with depression	Research-based
Collaborative primary care for children with behavior disorders	Research-based
Dialectical Behavior Therapy (DBT) for adolescent self-harming behavior	Research-based
Individual Placement and Support for first episode psychosis	Research-based
Motivational interviewing to engage children in mental health treatment	Research-based
Collaborative primary care for children with depression	Promising
General prevention	
Early Start (New Zealand)	Research-based
Infant Health and Development Program (IHDP)	Research-based
Home Instruction for Parents of Preschool Youngsters (HIPPY)	Promising
Substance use disorder	
Marijuana Education Initiative	Promising
Other substance use disorder treatment for juveniles (non-therapeutic communities)**	Null

Notes:

*Classifications using suggested definitions. Programs with multiple evaluations that do not demonstrate statistically significant results are classified as "Null."

**Cross-listed in both the "Juvenile justice" and "Substance use disorder" budget areas.

WSIPP has clarified classifications for programs that produce null or poor results since the last inventory update. In prior inventories, there was a single category for programs producing "null or poor outcomes." Programs with null outcomes were inconsistently categorized as either "null or poor" or as "promising." For the current inventory, WSIPP has defined two separate categories to distinguish between programs producing null results (no significant effect on desired outcomes) and those producing poor (undesirable) outcomes and has standardized the application of these definitions. Due to these changes, WSIPP reclassified seven programs.

WSIPP also corrected errors in the prior classification strategy. In particular, WSIPP reviewed all programs with no significant effects and updated classifications in line with current definitions. Due to these updates, WSIPP reclassified two programs.

Exhibit 4

Classifications Revised Due to "Null" Designation or Prior Error

Program/intervention name	Prior classification*	Current classification*	Reason for classification change
Juvenile justice			
Teaching-Family Model	Research-based	Promising	Corrected prior classification
Drug court	Research-based	Null	Corrected prior classification
Treatment for juveniles convicted of sex offenses (non-MST)	Promising	Null	Revised null definition
Mental health			
Multimodal Therapy (MMT) for children with disruptive behavior	Promising	Null	Revised null definition
Cognitive behavioral therapy (CBT) for children with ADHD	Don't do	Null	Revised null definition
General prevention			
Promoting Alternative Thinking Strategies (PATHS)	Promising	Null	Revised null definition
Substance use disorder			
Athletes Training and Learning to Avoid Steroids (ATLAS)	Promising	Null	Revised null definition
Keepin' it Real	Promising	Null	Revised null definition
Project SUCCESS	Don't do	Null	Revised null definition

Note:
*Classifications using suggested definitions.

WSIPP updated the analyses for 28 programs in this inventory since the last update. These updates included adding new research, revising included studies, updating statistical calculations, and/or revising program costs. Due to these changes, WSIPP reclassified 12 programs.

Exhibit 5

Classifications Revised Due to Updated Meta-Analyses or Benefit-Cost Modeling

Program/intervention name	Prior classification*	Current classification*	Reason for classification change
Child welfare			
SafeCare	Research-based	Evidence-based	Revised program costs
Parents as Teachers	Promising	Research-based	Revised included studies
Parent-Child Home Program	Research-based	Promising	Revised included studies
Functional Family Therapy – Child Welfare (FFT-CW)	Promising	Null	Included new research
Locating family connections for children in foster care^	Promising	Null	Included new research
Juvenile justice			
Family dependency treatment court^^	Promising	Research-based	Included new research
Multisystemic Therapy (MST)	Evidence-based	Research-based	Updated statistical calculations
Therapeutic communities for juveniles with substance use disorder**	Evidence-based	Research-based	Included new research
Functional Family Parole	Research-based	Null	Updated statistical calculations
Victim offender mediation	Evidence-based	Null	Included new research
Mental health			
Choice Therapy/Reality Therapy	Promising	Research-based	Included new research
General prevention			
Coping and Support Training	Promising	Evidence-based	Included new research
Substance use disorder			
Therapeutic communities for juveniles with substance use disorder**	Evidence-based	Research-based	Included new research

Notes:

*Classifications using suggested definitions.

**Cross-listed in both the "Juvenile justice" and "Substance use disorder" budget areas.

^ In the previous version of the inventory, this topic was listed as the name brand program Family Search and Engagement. The category has been expanded to include other programs aimed at identifying extended family members and increasing their connections to children in foster care.

^^ In the previous version of the inventory, this topic included a single study and was listed as King County Family Treatment Court. The category has been expanded to include family dependency treatment courts in other locations.

Limitations

The benefit-cost analyses in this report reflect only those outcomes that were measured in the studies we reviewed. We focus primarily on outcomes that are "monetizable" with the current WSIPP benefit-cost model. "Monetizable" means that we can link the outcome to future economic consequences, such as labor market earnings, criminal justice involvement, or health care expenditures. At this time we are unable to monetize some outcomes, including homelessness and placement stability.

Future Updates

The next update to this inventory will be published in September 2018, contingent on funding.

September 2017
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Budget area	Program/intervention	Manual	Current definitions	Suggested definitions	Cost-beneficial	Reason program does not meet suggested evidence-based criteria (see full definitions at the end of the inventory)	Percent minority
Child welfare	**Intervention**						
	Alternatives for Families (AF-CBT)	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Family dependency treatment court	Yes	◉	◉	7%	Benefit-cost	35%
	Fostering Healthy Futures	Yes	◉	◉		Single evaluation	56%
	Functional Family Therapy—Child Welfare (FFT-CW)	Yes	P	Null		Weight of the evidence	95%
	Including Fathers—Father Engagement Program	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Intensive Family Preservation Services (HOMEBUILDERS®)	Yes	●	●	96%		58%
	Locating family connections for children in foster care	Yes	P	Null		Weight of the evidence	66%
	Multisystemic Therapy (MST) for child abuse and neglect	Yes	◉	◉		Single evaluation	82%
	Other Family Preservation Services (non-HOMEBUILDERS®)	Varies*	P	⊘	0%	Weight of the evidence	76%
	Parent-Child Assistance Program	Yes	P	P		Single evaluation	52%
	Parent-Child Interaction Therapy (PCIT) for families in the child welfare system	Yes	●	●	95%		48%
	Parents for Parents	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Partners with Families and Children	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Pathway to Reunification	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	SafeCare	Yes	●	●	92%		33%
	Youth Villages LifeSet	Yes	◉	◉	20%	Benefit-cost	49%
	Prevention						
	Circle of Security	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Circle of Security - Parenting (COS-P)	Yes	P	P		Weight of the evidence	89%
	Healthy Families America	Yes	●	◉	42%	Benefit-cost	63%
	Nurse Family Partnership	Yes	●	◉	55%	Benefit-cost/heterogeneity	20%
	Other home visiting programs for at-risk mothers and children	Varies*	●	◉	67%	Benefit-cost	59%
	Parent-Child Home Program	Yes	◉	P		Single evaluation	NR
	Parent Mentor Program	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Parents and Children Together (PACT)	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Parents as Teachers	Yes	◉	◉	26%	Benefit-cost	66%
	Promoting First Relationships	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Safe Babies, Safe Moms	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Triple-P Positive Parenting Program (System)	Yes	◉	◉	63%	Benefit-cost	33%

● Evidence-based ◉ Research-based **P** Promising ⊘ Poor outcomes **Null** Null outcomes **NR** Not reported

Notes:

*This is a general program/intervention classification. Some programs within this classification have manuals and some do not. The results listed on the inventory represent a typical, or average, implementation. Additional research will need to be completed in order to establish the most effective sets of procedures within this general category.

** This program is an example within a broader category.

This program is a special analysis for the purpose of this inventory and does not have a program-specific webpage on WSIPP's website.

^ Heterogeneity criterion is achieved because at least one of the studies has been conducted on youth in Washington and a subgroup analysis demonstrates the program is effective for minorities ($p < 0.20$). See definitions and notes on page 20 for additional detail.

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Juvenile justice	Adolescent Diversion Project	Yes	●	●	97%		58%
	Aggression Replacement Training	Yes					
	Youth in state institutions		◉	◉	65%	Benefit-cost	34%
	Youth on probation		◉	◉	64%	Benefit-cost	34%
	Boot camps	Varies*	P	P	100%	Weight of the evidence	55%
	Cognitive behavioral therapy (CBT)	Varies*	●	●	95%		43%
	Connections Wraparound	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Coordination of Services	Yes	◉	◉	96%	Heterogeneity	23%
	Dialectical Behavior Therapy (DBT) for youth in the juvenile justice system	Yes	◉	◉	93%	Single evaluation	27%^
	Dialectical Behavior Therapy (DBT) for substance use disorder: Integrated treatment model	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Diversion	Varies*					
	No services (vs. traditional juvenile court processing)	Varies*	●	●	98%		66%
	With services (vs. simple release)	Varies*	P	Null	39%	Weight of the evidence	70%
	With services (vs. traditional juvenile court processing)	Varies*	●	●	94%		73%
	Drug court	Varies*	P	Null	43%	Weight of the evidence	40%
	Education and Employment Training (EET, King County)	Yes	◉	◉	100%	Single evaluation	74%
	Family Integrated Transitions for youth in state institutions	Yes	◉	◉	41%	Single evaluation	30%^
	Functional Family Parole	Yes	P	Null	76%	Weight of the evidence	51%
	Functional Family Therapy	Yes					
	Youth in state institutions		●	●	96%		36%
	Youth on probation		●	●	96%		36%
	Group homes						
	Teaching-Family Model	Yes	P	P	59%	Weight of the evidence	22%
	Other group home programs (non-name brand)	Varies*	P	P		Single evaluation	NR
	Intensive supervision	Varies*					
	Parole	Varies*	P	Null	76%	Weight of the evidence	74%
	Probation	Varies*	P	Null	0%	Weight of the evidence	58%
	Juvenile Detention Alternatives Initiative	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Mentoring	Yes	●	●	82%		65%
	Multidimensional Treatment Foster Care	Yes	◉	◉	70%	Benefit-cost/heterogeneity	24%
	Multisystemic Therapy (MST)	Yes	◉	◉	73%	Benefit-cost	79%
	Other family-based therapies (non-name brand)	Varies*	●	●	93%		53%
	Parenting with Love and Limits	Yes	◉	●	94%		62%

● Evidence-based ◉ Research-based **P** Promising Poor outcomes **Null** Null outcomes **NR** Not reported

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Juvenile justice (continued)	Scared Straight	Yes	⊘	⊘	2%	Weight of the evidence	NR
	Step Up	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Team Child	Yes	P	Null		Weight of the evidence	25%
	Treatment for juveniles convicted of sex offenses	Varies*					
	Multisystemic Therapy (MST) for juveniles convicted of sex offenses	Yes	●	◉	72%	Benefit-cost	51%
	Treatment for juveniles convicted of sex offenses (non-MST)	Varies*	P	Null	18%	Weight of the evidence	30%
	Treatment for juveniles with substance use disorder	Varies*					
	Multisystemic Therapy (MST) for juveniles with substance use disorder	Yes	●	◉	51%	Benefit-cost	65%
	Other substance use disorder treatment for juveniles (non-therapeutic communities)	Varies*	P	Null	42%	Weight of the evidence	68%
	Therapeutic communities for juveniles with substance use disorder	Varies*	◉	◉	74%	Benefit-cost	54%
	Vocational and employment training	Varies*	◉	◉	53%	Benefit-cost	55%
	Victim offender mediation	Varies*	P	Null	77%	Weight of the evidence	61%
	Wilderness experience programs	Varies*	●	●	96%		36%
	You Are Not Your Past	No	P	P		No rigorous evaluation measuring outcome of interest	

● Evidence-based ◉ Research-based **P** Promising ⊘ Poor outcomes **Null** Null outcomes **NR** Not reported

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Mental health	**Anxiety**						
	Acceptance and Commitment Therapy (ACT) for children with anxiety	Yes	◉	◉	99%	Single evaluation	15%
	Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote)#	Varies*	●	◉	98%	Heterogeneity	20%
	Cool Kids**	Yes					
	Coping Cat**	Yes					
	Coping Cat/Koala book-based model**	Yes					
	Coping Koala**	Yes					
	Other cognitive behavioral therapy (CBT) for children with anxiety**	Varies*					
	Parent cognitive behavioral therapy (CBT) for young children with anxiety	Varies*	◉	◉	99%	Heterogeneity	26%
	Theraplay	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Attention Deficit Hyperactivity Disorder						
	Behavioral parent training (BPT) for children with ADHD		◉	◉	91%	Heterogeneity	10%
	Barkley Model**	Yes					
	New Forest Parenting Programme**	Yes					
	Cognitive behavioral therapy (CBT) for children with ADHD		P	Null	8%	Weight of the evidence	24%
	ENCOMPASS for ADHD	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Multimodal Therapy (MMT) for children with ADHD	Varies*	◉	◉	42%	Benefit-cost	37%
	Depression						
	Acceptance and Commitment Therapy (ACT) for children with depression	Yes	◉	◉	31%	Benefit-cost/heterogeneity	NR
	Cognitive behavioral therapy (CBT) for children & adolescents with depression	Varies*	◉	◉	31%	Benefit-cost/heterogeneity	30%
	Coping With Depression—Adolescents**	Yes					
	Treatment for Adolescents with Depression Study**	Yes					
	Other cognitive behavioral therapy (CBT) for children & adolescents with depression**	Varies*					
	Collaborative primary care for children with depression	Varies*	◉	◉		Single evaluation	28%
	Blues Program (group CBT prevention program for high school students at risk for depression)	Yes	●	◉	41%	Benefit-cost	38%

● Evidence-based ◉ Research-based **P** Promising ⊘ Poor outcomes **Null** Null outcomes **NR** Not reported

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Mental health (continued)	**Disruptive Behavior (Oppositional Defiant Disorder or Conduct Disorder)**						
	Behavioral parent training (BPT) for children with disruptive behavior disorders	Varies*					
	Helping the Noncompliant Child	Yes	◉	◉	65%	Benefit-cost/heterogeneity	31%
	Incredible Years: Parent training	Yes	●	◉	55%	Benefit-cost	52%
	Incredible Years: Parent training + child training	Yes	●	◉	12%	Benefit-cost/heterogeneity	22%
	Parent Child Interaction Therapy (PCIT) for children with disruptive behavior problems	Yes	●	●	78%		47%
	Parent Management Training—Oregon Model (treatment population)	Yes	●	●	84%		34%
	Triple-P Positive Parenting Program: Level 4, Group	Yes	●	●	100%		80%
	Triple-P Positive Parenting Program: Level 4, Individual	Yes	●	●	86%		36%
	Other behavioral parent training (BPT) for children with disruptive behavior disorders	Varies*	◉	◉	89%	Heterogeneity	NR
	Brief Strategic Family Therapy (BSFT)	Yes	●	◉	43%	Benefit-cost	100%
	Collaborative primary care for children with behavior disorders	Varies*	◉	◉	73%	Benefit-cost/heterogeneity	18%
	Coping Power Program	Yes	◉	◉	55%	Benefit-cost	80%
	Choice Theory/Reality Therapy	Yes	◉	◉		Single evaluation	27%
	Families and Schools Together (FAST)	Yes	●	◉	50%	Benefit-cost	53%
	Kids Club and Moms Empowerment support groups	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Multimodal Therapy (MMT) for children with disruptive behavior	Varies*	P	Null	51%	Weight of the evidence	7%
	Stop Now and Plan (SNAP)	Yes	◉	◉	4%	Benefit-cost	77%
	Fetal Alcohol Syndrome						
	Families Moving Forward	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Serious Emotional Disturbance						
	Dialectical Behavior Therapy (DBT) for adolescent self-harming behavior	Yes	◉	◉	50%	Benefit-cost	44%
	Multisystemic Therapy (MST) for youth with serious emotional disturbance (SED)	Yes	◉	◉	61%	Benefit-cost	59%
	Full Fidelity Wraparound for children with serious emotional disturbance (SED)	Yes	◉	◉		Benefits & costs cannot be estimated at this time	61%
	Individual Placement and Support for first episode psychosis	Yes	◉	◉		Single evaluation/benefits & costs cannot be estimated at this time	50%
	Intensive Family Preservation (HOMEBUILDERS®) for youth with serious emotional disturbance (SED)	Yes	◉	◉		Benefits & costs cannot be estimated at this time	94%

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Mental health (continued)	**Trauma**						
	ADOPTS (therapy to address distress of post traumatic stress in adoptive children)	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Child-Parent Psychotherapy	Yes	⦿	⦿		Single evaluation	9%
	Cognitive behavioral therapy (CBT)-based models for child trauma	Varies*	●	●	100%		82%
	Classroom-based intervention for war-exposed children**	Yes					
	Cognitive Behavioral Intervention for Trauma in Schools**	Yes					
	Enhancing Resiliency Among Students Experiencing Stress (ERASE-Stress)**	Yes					
	KID-NET Narrative Exposure Therapy for children**	Yes					
	Teaching Recovery Techniques (TRT)**	Yes					
	Trauma Focused CBT for children**	Yes					
	Trauma Grief Component Therapy**	Yes					
	Other cognitive behavioral therapy (CBT)-based models for child trauma**	Varies*					
	Eye Movement Desensitization and Reprocessing (EMDR) for child trauma	Yes	●	●	82%		40%
	Take 5: Trauma Affects Kids Everywhere—Five Ways to Promote Resilience	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Other						
	Modularized Approaches to Treatment of Anxiety, Depression and Behavior (MATCH)	Yes	⦿	⦿		Single evaluation	65%
	Motivational interviewing to engage children in mental health treatment	Varies*	⦿	⦿		Benefits & costs cannot be estimated at this time	27%

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General prevention	Child FIRST	Yes	⦿	⦿		Single evaluation	94%
	Communities That Care	Yes	●	●	82%		33%
	Coping and Support Training	Yes	●	●	91%		51%
	Early Start (New Zealand)	Yes	⦿	⦿	2%	Benefit-cost/heterogeneity	NR
	Family Check-Up (also known as Positive Family Support)	Yes	⦿	⦿	46%	Benefit-cost	61%
	Familias Unidas	Yes	⦿	⦿	41%	Benefit-cost	100%
	Fast Track prevention program	Yes	⦿	⦿	0%	Benefit-cost	53%
	Good Behavior Game	Yes	●	⦿	70%	Benefit-cost	56%
	Guiding Good Choices (formerly Preparing for the Drug Free Years)	Yes	⦿	⦿	56%	Benefit-cost	46%
	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Yes	P	P	46%	Weight of the evidence	93%
	Infant Health and Development Program (IHDP)	Yes	⦿	⦿	16%	Benefit-cost	58%
	Kaleidoscope Play and Learn	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Mentoring for students: community-based (taxpayer costs only)	Varies*	●	⦿	72%	Benefit-cost	78%
	Big Brothers Big Sisters**	Yes					57%
	Other mentoring programs**	Varies*					92%
	4Results Mentoring	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	New Beginnings for children of divorce	Yes	⦿	⦿		Single evaluation	11%
	Nurturing Fathers	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Positive Action	Yes	●	●	87%		63%
	Promoting Alternative Thinking Strategies (PATHS)	Yes	P	Null		Weight of the evidence	49%
	PROSPER	Yes	⦿	⦿	59%	Benefit-cost/heterogeneity	15%
	Pyramid Model	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Quantum Opportunities Program	Yes	●	⦿	63%	Benefit-cost	90%
	Raising Healthy Children	Yes	P	P		Single evaluation	18%
	Reconnecting Youth	Yes	⦸	⦸		Weight of the evidence	92%
	Seattle Social Development Project	Yes	⦿	⦿	66%	Single evaluation	35%
	Strengthening Multi-Ethnic Families and Communities	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Strengthening Families for Parents and Youth 10-14	Yes	⦿	⦿	76%	Heterogeneity	21%
	Strong African American Families	Yes	⦿	⦿		Single evaluation	100%
	Strong African American Families—Teen	Yes	⦿	⦿		Single evaluation	100%
	Youth and Family Link	No	P	P		No rigorous evaluation measuring outcome of interest	

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Substance use disorder	**Prevention**						
	Alcohol Literacy Challenge for high school students	Yes	P	P	58%	Single evaluation	33%
	Athletes Training and Learning to Avoid Steroids (ATLAS)	Yes	P	Null		Weight of the evidence	22%
	Brief intervention for youth in medical settings	Yes	◉	◉	49%	Benefit-cost	65%
	Compliance checks for alcohol	Varies*	◉	◉		Single evaluation	25%
	Compliance checks for tobacco	Varies*	P	P		Single evaluation	28%
	Family Matters	Yes	◉	◉	74%	Benefit-cost/heterogeneity	22%
	Keepin' it Real	Yes	P	Null	62%	Weight of the evidence	83%
	Life Skills Training	Yes	●	◉	66%	Benefit-cost	38%
	Lions Quest Skills for Adolescence	Yes	◉	◉	68%	Benefit-cost	74%
	Marijuana Education Initiative	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Multicomponent environmental interventions to prevent youth alcohol use	Varies*	P	P	27%	Weight of the evidence	19%
	Multicomponent environmental interventions to prevent youth tobacco use	Varies*	◉	◉	86%	Heterogeneity	21%
	Project ALERT	Yes	●	◉	64%	Benefit-cost/heterogeneity	12%
	Project Northland	Yes	●	◉	73%	Benefit-cost	36%
	Project STAR	Yes	●	◉	72%	Benefit-cost/heterogeneity	5%
	Project SUCCESS	Yes	P	Null	39%	Weight of the evidence	38%
	Project Toward No Drug Abuse	Yes	●	◉	58%	Benefit-cost	70%
	Protecting You/Protecting Me	Yes	P	P		Weight of the evidence	92%
	SPORT	Yes	◉	◉	69%	Benefit-cost	49%
	STARS (Start Taking Alcohol Risks Seriously) for Families	Yes	P	P		Single evaluation	66%
	Teen Intervene	Yes	●	◉	94%	Heterogeneity	29%

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Substance use disorder (continued)	**Treatment**						
	Adolescent Assertive Continuing Care	Yes	◉	◉	36%	Benefit-cost/heterogeneity	26%
	Adolescent Community Reinforcement Approach	Yes	◉	◉		Single evaluation	59%
	Dialectical Behavior Therapy for substance abuse: Integrated Treatment Model	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Functional Family Therapy (FFT) for adolescents with substance use disorder	Yes	◉	◉	0%	Benefit-cost	74%
	Matrix Model treatment for adolescents with substance use disorder	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	MET/CBT-5 for youth marijuana use	Yes	◉	◉		Single evaluation	33%
	Multidimensional Family Therapy (MDFT)	Yes	◉	◉	24%	Benefit-cost	87%
	Recovery Support Services	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Seven Challenges	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Teen Marijuana Check-Up	Yes	●	●	100%		39%
	Treatment for youth involved in the juvenile justice system						
	Multisystemic Therapy (MST) for juveniles with substance use disorder	Yes	●	◉	51%	Benefit-cost	65%
	Other substance use disorder treatment for juveniles (non-therapeutic communities)	Varies*	P	Null	42%	Weight of the evidence	68%
	Therapeutic communities for juveniles with substance use disorder	Varies*	◉	◉	74%	Benefit-cost	54%

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Definitions and Notes:

Current Law Definitions:

Evidence-based: A program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

Research-based: A program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.

Promising practice: A practice that presents, based upon preliminary information, potential for becoming a research-based or consensus-based practice.

Suggested Definitions:

Evidence-based: A program or practice that has been tested in heterogeneous or intended populations with multiple randomized and/or statistically-controlled evaluations, or one large multiple-site randomized and/or statistically-controlled evaluation, where the weight of the evidence from a systematic review demonstrates sustained improvements in at least one of the following outcomes: child abuse, neglect, or the need for out of home placement; crime; children's mental health; education; or employment. Further, "evidence-based" means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, has been determined to be cost-beneficial.

Research-based: A program or practice that has been tested with a single randomized and/or statistically-controlled evaluation demonstrating sustained desirable outcomes; or where the weight of the evidence from a systematic review supports sustained outcomes as identified in the term "evidence-based" in RCW (the above definition) but does not meet the full criteria for "evidence-based."

Promising practice: A program or practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the "evidence-based" or "research-based" criteria, which could include the use of a program that is evidence-based for outcomes other than the alternative use.

Cost-beneficial: A program or practice where the monetary benefits exceed costs with a high degree of probability according to the Washington State Institute for Public Policy.

Reasons Programs May Not Meet Suggested Evidence-Based Criteria:

Benefit-cost: The proposed definition of evidence-based practices requires that, when possible, a benefit-cost analysis be conducted. We use WSIPP's benefit-cost model to determine whether a program meets this criterion. Programs that do not have at least a 75% chance of a positive net present value do not meet the benefit-cost test. The WSIPP model uses Monte Carlo simulation to test the probability that benefits exceed costs. The 75% standard was deemed an appropriate measure of risk aversion.

Heterogeneity: To be designated as evidence-based, the state statute requires that a program has been tested on a "heterogeneous" population. We operationalize heterogeneity in two ways. First, the proportion of program participants belonging to ethnic/racial minority groups must be greater than or equal to the proportion of minority children aged 0 to 17 in Washington. From the 2010 Census, for children aged 0 through 17 in Washington, 68% were white and 32% were minorities. Thus, if the weighted average of program participants in the outcome evaluations of the program is at least 32% ethnic/racial minority, then the program is considered to have been tested in a heterogeneous population.

Second, the heterogeneity criterion can also be achieved if at least one of a program's outcome evaluations was conducted with K–12 students in Washington and a subgroup analysis demonstrates the program is effective for ethnic/racial minorities ($p < 0.20$).

Programs whose evaluations do not meet either of these two criteria do not meet the heterogeneity definition.

Single evaluation: The program does not meet the minimum standard of multiple evaluations or one large multiple-site evaluation contained in the current or proposed definitions.

Weight of evidence: To meet the evidence-based definition, results from a random effects meta-analysis (p-value < 0.20) of multiple evaluations or one large multiple-site evaluation must indicate the practice achieves the desired outcome(s).[1] To meet the research-based definition, one single-site evaluation must indicate the practice achieves the desired outcomes (p-value < 0.20). If results from a random-effects meta-analysis of multiple evaluations are not statistically significant (p-value > 0.20) for desired outcomes, the practice may be classified as "Null". If results from a random-effects meta-analysis of multiple evaluations or one large multiple-site evaluation indicate that a practice produces undesirable effects (p-value < 0.20), the practice may be classified as producing poor outcomes.

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Washington State Institute for Public Policy

The Washington State Legislature created the Washington State Institute for Public Policy in 1983. A Board of Directors—representing the legislature, the governor, and public universities—governs WSIPP and guides the development of all activities. WSIPP's mission is to carry out practical research, at legislative direction, on issues of importance to Washington State.