September 2016
Updated Inventory of Evidence-Based, Research-Based, and Promising Practices
Intervention Services and Treatment for Adult Behavioral Health

Budget area	Program/intervention	Manual	Level of evidence	Benefit-cost percentage	Reason program does not meet evidence-based criteria (see full definitions below)	Percent minority
Mental Illness	Acceptance and Commitment Therapy for schizophrenia/psychosis	Yes	⦿	58%	Benefit-cost	32%
	Acceptance and Commitment Therapy for adult anxiety	Yes	●	84%		39%
	Assertive community treatment (ACT)	Yes	⦿	12%	Benefit-cost	32%
	Assisted outpatient treatment	Varies*	⦸		Weight of evidence	52%
	Cognitive behavioral therapy (CBT) for adult anxiety	Varies*	⦿	100%	Heterogeneity	10%
	Cognitive behavioral therapy (CBT) for adult depression	Varies*	⦿	100%	Heterogeneity	19%
	Cognitive behavioral therapy (CBT) for adult posttraumatic stress disorder (PTSD)	Varies*	●	100%		42%
	Cognitive behavioral therapy (CBT) for prodromal psychosis	Varies*	⦿		Benefits & costs cannot be estimated at this time	NR
	Cognitive behavioral therapy (CBT) for schizophrenia/psychosis	Yes	⦿	61%	Benefit-cost	24%
	Collaborative primary care for depression	Varies*	●	100%		28%
	Collaborative primary care for anxiety	Varies*	●	98%		34%
	Collaborative primary care for depression with comorbid medical concerns	Varies*	⦿	92%	Heterogeneity	18%
	Crisis Intervention Team	Yes	P		Research on outcomes of interest not yet available	
	Critical Time Intervention for serious mental illness	Yes	⦿	13%	Benefit-cost	81%
	Eye Movement Desensitization and Reprocessing (EMDR) for adult posttraumatic stress disorder (PTSD)	Yes	●	100%		32%
	Forensic Assertive Community Treatment (FACT)	No	P	0%	Single evaluation	39%
	Forensic Integrative Re-entry Support and Treatment (FIRST)	Yes	P		Research on outcomes of interest not yet available	
	Forensic Intensive Supportive Housing (FISH)	Yes	P		Research on outcomes of interest not yet available	
	Illness Management and Recovery (IMR)	Yes	P	52%	Weight of evidence	41%
	Individual Placement and Support (IPS) for individuals with serious mental illness	Yes	⦿	61%	Benefit-cost	58%
	Integrated Cognitive Therapies Program for co-occurring mental illness and substance abuse	Yes	P		Research on outcomes of interest not yet available	
	Integrated Dual Disorder Treatment (IDDT)	Yes	P		Weight of evidence	28%
	Integrated treatment for first-episode psychosis	Varies*	⦿		Benefits & costs cannot be estimated at this time	73%
	Integrated treatment for prodromal psychosis	Varies*	⦿		Benefits & costs cannot be estimated at this time	NR
	Medicaid Health Homes	Yes	⦿		Single evaluation	71%
	Mental health courts	Varies*	●	99%		41%
	Mobile crisis response	No	⦿	42%	Benefit-cost	57%
	Motivational interviewing to enhance treatment engagement for serious mental illness	Varies*	⦿		Benefits & costs cannot be estimated at this time	80%
	Peer Bridger	No	P		Research on outcomes of interest not yet available	
	Peer support for serious mental illness					
	Peer support: Substitution of a peer specialist for a non-peer on the treatment team	Varies*	⦿	25%	Benefit-cost	52%
	Peer support: Addition of a peer specialist to the treatment team	Varies*	⦿	9%	Benefit-cost	56%
	Primary care in behavioral health settings	No	⦿	50%	Benefit-cost	42%
	Primary care in integrated settings (Veteran's Administration, Kaiser Permanente)	No	⦿	52%	Benefit-cost	44%
	Primary care in behavioral health settings (community-based settings)	No	⦿	28%	Benefit-cost	39%
	Posttraumatic stress disorder (PTSD) prevention following trauma	Varies*	●	100%		31%
	Wellness Recovery Action Plan (WRAP)	Yes	P		Weight of evidence	45%
	Supported housing for chronically homeless adults	Varies*	⦿	0%	Benefit-cost	64%
	Trauma Informed Care: Risking Connection	Yes	P		Research on outcomes of interest not yet available	

● Evidence-based ⦿ Research-based **P** Promising **NR** Not reported See definitions and notes on page 3.

*Varies: 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.

September 2016
Updated Inventory of Evidence-Based, Research-Based, and Promising Practices
Intervention Services and Treatment for Adult Behavioral Health

Budget area	Program/intervention	Manual	Level of evidence	Benefit-cost percentage	Reason program does not meet evidence-based criteria (see full definitions below)	Percent minority
Substance Abuse	**Early intervention (at-risk drinking and substance use)**					
	Alcohol Literacy Challenge (for college students)	Yes	⦿	48%	Benefit-cost	24%
	Brief Alcohol Screening and Intervention for College Students (BASICS): A Harm Reduction Approach	Yes	⦿	70%	Benefit-cost/heterogeneity	15%
	Brief intervention in primary care	Yes	●	93%		33%
	Brief intervention in emergency department (SBIRT)	Yes	●	75%		36%
	Brief intervention in a medical hospital	Yes	●	75%		54%
	Treatments for substance abuse or dependence					
	12-Step Facilitation Therapy	Yes	⦿	60%	Benefit-cost	48%
	Anger management for substance abuse and mental health clients: Cognitive-behavioral therapy (CBT)	Yes	P		Research on outcomes of interest not yet available	
	Behavioral Couples Therapy (marital)	Yes	P		Weight of evidence	29%
	Behavioral self-control training (BSCT)	Yes	⦿	24%	Benefit-cost	24%
	Brief cognitive behavioral intervention for amphetamine users	Yes	⦿	60%	Benefit-cost/Heterogeneity	NR
	Brief marijuana dependence counseling	Yes	●	91%		52%
	Cognitive-behavioral coping skills therapy	Yes	⦿	60%	Benefit-cost	36%
	Cognitive-behavioral coping skills therapy for opioid abuse	Yes	P		Weight of evidence	30%
	Community Reinforcement and Family Training (CRAFT) for engaging clients in treatment	Yes	⦿		Benefits & costs cannot be estimated at this time	36%
	Community Reinforcement Approach (CRA) with vouchers	Yes	⦿	56%	Benefit-cost/heterogeneity	3%
	Contingency management					
	Contingency management (higher-cost) for substance abuse	Yes (guidelines)	●	77%		48%
	Contingency management (higher-cost) for marijuana abuse	Yes (guidelines)	●	77%		48%
	Contingency management (lower-cost) for substance abuse	Yes (guidelines)	⦿	59%	Benefit-cost	57%
	Contingency management (lower-cost) for marijuana abuse	Yes (guidelines)	⦿	51%	Benefit-cost	50%
	Contingency management (lower-cost) for opioid abuse	Yes (guidelines)	⦿		Benefits & costs cannot be estimated at this time	47%
	Day treatment with abstinence contingencies and vouchers	No	P		Single evaluation	96%
	Dialectical behavior therapy (DBT) for co-morbid substance abuse and serious mental illness	Yes	⦿		Weight of evidence	22%
	Family Behavior Therapy (FBT)	Yes (for adolescents)	⦿	60%	Single evaluation	9%
	Holistic Harm Reduction Program (HHRP+)	Yes	⦿	56%	Benefit-cost	42%
	Individual drug counseling approach for the treatment of cocaine addiction	Yes	⦿	54%	Benefit-cost	44%
	Matrix Model Intensive Outpatient Treatment Program (IOP) for stimulant abuse	Yes	⦿	52%	Benefit-cost	52%
	Motivational Enhancement Therapy (MET) (problem drinkers)	Yes	P	59%	Weight of evidence	7%
	Motivational interviewing to enhance treatment engagement	Yes	⦿	62%	Benefit-cost	49%
	Node-link mapping	Yes	P		Weight of evidence	61%
	Parent-Child Assistance Program	Yes	P		Weight of evidence	64%
	Peer support for substance abuse	No	⦿	51%	Benefit-cost	86%
	Preventing Addiction-Related Suicide (PARS)	Yes	P		Research on outcomes of interest not yet available	
	Relapse Prevention Therapy	Yes	⦿	58%	Benefit-cost	77%
	Seeking Safety: A Psychotherapy for Trauma/PTSD and Substance Abuse	Yes	⦿	66%	Benefit-cost	55%
	Supportive-expressive psychotherapy for substance abuse	Yes	P	45%	Weight of evidence	50%
	Wraparound for pregnant/postpartum women in substance abuse treatment	Yes	P		Single evaluation	58%
	Therapeutic community for non-offenders	Yes	P		Research on outcomes of interest not yet available	
	Medication-assisted treatment					
	Buprenorphine/buprenorphine-naloxone (Suboxone and Subutex) treatment	Clinical guidelines	⦿	65%	Benefit-cost	46%
	Methadone maintenance treatment	Clinical guidelines	●	89%		78%

● Evidence-based ⦿ Research-based **P** Promising **NR** Not reported See definitions and notes on page 3.

Definitions and Notes:

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 under current law or the proposed definition, a program must have been tested on a "heterogeneous" population. We operationalized heterogeneity in two ways. First, the proportion of minority program participants must be greater than or equal to the minority proportion of adults 18 and over in Washington State. From the 2010 Census, of all adults in Washington, 76% were white and 24% minority. Thus, if the weighted average of program participants had at least 24% minorities then the program was considered to have been tested on a heterogeneous population.

Second, the heterogeneity criterion can also be achieved if at least one of the studies has been conducted on adults in Washington and a subgroup analysis demonstrates the program is effective for minorities ($p < 0.2$). Programs passing the second test are marked with a ^. Programs that do not meet either of these two criteria do not meet the heterogeneity definition. Programs whose evaluations do not meet either of these two criteria do not meet the heterogeneity definition.

Mixed results: If findings are mixed from different measures (e.g., undesirable outcomes for behavior measures and desirable outcomes for test scores), the program does not meet evidence-based criteria.

Research on outcomes of interest not yet available: The program has not yet been tested with a rigorous outcome evaluation.

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). To meet the research-based definition, one single-site evaluation must indicate the practice achieves the desired outcomes (p-value < 0.20).

Level of Evidence:

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 outcome. 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.

Other Definitions:

Benefit-cost percentage: The percent of the time where the monetary benefits exceed costs.

For questions about the inventory, contact Marna Miller at marna.miller@wsipp.wa.gov.

16-09-4401