December 2018

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

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

Revised March 8, 2019 for technical corrections

Budget area	Program/intervention	Manual	Current definitions	Proposed definitions	Cost-beneficial	Reason program does not meet suggested evidence-based criteria (see full definitions below)	Percent minority
Mental health	**Anxiety**						
	Acceptance and Commitment Therapy (ACT) for children with anxiety	Yes	◉	◉	85%	Single evaluation	15%
	Group and individual cognitive behavioral therapy (CBT) for children & adolescents with anxiety	Varies*	●	◉	95%	Heterogeneity	21%
	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 children with anxiety	Varies*	◉	◉	93%	Heterogeneity	NR
	Remote cognitive behavioral therapy (CBT) for children with anxiety	Varies*	◉	◉	95%	Heterogeneity	NR
	Theraplay	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Attention Deficit Hyperactivity Disorder						
	Behavioral parent training (BPT) for children with ADHD		◉	●	75%		35%
	Barkley Model**	Yes					
	New Forest Parenting Programme**	Yes					
	Cognitive behavioral therapy (CBT) for children with ADHD	Varies*	P	Null	47%	Weight of the evidence	14%
	Encompass for ADHD	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Multimodal therapy (MMT) for children with ADHD	Varies*	◉	◉	53%	Benefit-cost	43%
	Depression						
	Acceptance and Commitment Therapy (ACT) for children with depression	Yes	◉	◉	50%	Benefit-cost/heterogeneity	NR
	Cognitive behavioral therapy (CBT) for children & adolescents with depression	Varies*	◉	◉	49%	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*	◉	◉	50%	Benefit-cost/heterogeneity	28%
	Blues Program (prevention program for students at risk for depression)	Yes	●	◉	49%	Benefit-cost	38%

● Evidence-based ◉ Research-based **P** Promising ⊘ Poor outcomes **Null** Null outcomes **NR** Not reported See definitions and notes on page 11.

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 classified as evidence-based because it meets weight of the evidence and heterogeneity criteria. It was not possible to conduct a benefit-cost analysis for this program, either because program costs are unavailable or because WSIPP's benefit-cost model does not currently include data on an appropriate comparison population for modeling long-term economic impacts.

^ Heterogeneity criterion is achieved because at lease one of the studies has been conducted on youth in Washington and a subgroup analysis demonstrates the program is effective for minorities ($p < 0.20$

December 2018

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

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

Revised March 8, 2019 for technical corrections

Budget area	Program/intervention	Manual	Current definitions	Proposed definitions	Cost-beneficial	Reason program does not meet suggested evidence-based criteria (see full definitions below)	Percent minority
Mental health (continued)	**Disruptive Behavior (Oppositional Defiant Disorder or Conduct Disorder)**						
	Behavioral parent training (BPT) for children with disruptive behavior	Varies*					
	Helping the Noncompliant Child for children with disruptive behavior	Yes	◉	P	51%	Single evaluation	31%
	Incredible Years Parent Training	Yes	●	◉	59%	Benefit-cost	41%
	Incredible Years Parent Training with Incredible Years Child Training	Yes	●	◉	2%	Benefit-cost	45%
	Parent-Child Interaction Therapy (PCIT) for children with disruptive behavior	Yes	●	◉	29%	Benefit-cost	76%
	Parent Management Training—Oregon Model (treatment population)	Yes	●	◉	71%	Benefit-cost/heterogeneity	NR
	Triple P—Positive Parenting Program: Level 4, group	Yes	●	●	97%		80%
	Triple P—Positive Parenting Program: Level 4, individual	Yes	●	◉	60%	Benefit-cost/heterogeneity	NR
	Other behavioral parent training (BPT) for children with disruptive behavior	Varies*	◉	●	96%		95%
	Brief Strategic Family Therapy (BSFT)	Yes	●	◉	61%	Benefit-cost	76%
	Collaborative primary care for children with behavior disorders	Varies*	◉	◉	60%	Benefit-cost/heterogeneity	18%
	Coping Power Program	Yes	◉	◉	54%	Benefit-cost	80%
	Child Parent Relationship Therapy	Yes	●	●	79%		62%
	Choice Theory/Reality Therapy for children with disruptive behavior	Yes	◉	P		Single evaluation	27%
	Mentoring: Community-based for children with disruptive behavior	Varies*	◉	◉	67%	Benefit-cost/heterogeneity	7%
	Multimodal therapy (MMT) for children with disruptive behavior	Varies*	P	◉	57%	Benefit-cost/heterogeneity	5%
	Stop Now and Plan (SNAP)	Yes	◉	●	86%		77%

● Evidence-based ◉ Research-based **P** Promising ⊘ Poor outcomes **Null** Null outcomes **NR** Not reported See definitions and notes on page 11.

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 classified as evidence-based because it meets weight of the evidence and heterogeneity criteria. It was not possible to conduct a benefit-cost analysis for this program, either because program costs are unavailable or because WSIPP's benefit-cost model does not currently include data on an appropriate comparison population for modeling long-term economic impacts.

^ Heterogeneity criterion is achieved because at lease 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

December 2018

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

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

Revised March 8, 2019 for technical corrections

Budget area	Program/intervention	Manual	Current definitions	Proposed definitions	Cost-beneficial	Reason program does not meet suggested evidence-based criteria (see full definitions below)	Percent minority
Mental health (continued)	**Fetal Alcohol Syndrome**						
	Families Moving Forward	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Serious Emotional Disturbance						
	Cognitive behavioral therapy (CBT) for prodromal psychosis	Varies*	◉	◉		Heterogeneity	NR
	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	◉	●			38%
	Full fidelity wraparound for children with serious emotional disturbance (SED)#	Yes	◉	●			48%
	Individual Placement and Support for first episode psychosis	Yes	◉	◉		Single evaluation	50%
	Integrated treatment for first-episode psychosis#	Varies*	◉	●			73%
	Integrated treatment for prodromal psychosis	Varies*	◉	◉		Heterogeneity	NR
	Intensive Family Preservation (HOMEBUILDERS®) for youth with serious emotional disturbance (SED)	Yes	⊘	Null		Weight of the evidence	95%
	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	◉	◉	96%	Single evaluation	49%
	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	●	P	83%	Weight of the evidence	81%
	Kids Club & Moms Empowerment	Yes	P	◉	81%	Single evaluation	48%
	Take 5: Trauma Affects Kids Everywhere—Five Ways to Promote Resilience	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Other						
	Mentoring: Great Life Mentoring (formerly 4Results Mentoring)	Yes	◉	◉		Single evaluation	18%
	Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)	Yes	◉	●	98%		78%
	Motivational interviewing to engage children in mental health treatment	Varies*	◉	◉		Heterogeneity	27%

● Evidence-based ◉ Research-based **P** Promising ⊘ Poor outcomes **Null** Null outcomes **NR** Not reported See definitions and notes on page 11.

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 classified as evidence-based because it meets weight of the evidence and heterogeneity criteria. It was not possible to conduct a benefit-cost analysis for this program, either because program costs are unavailable or because WSIPP's benefit-cost model does not currently include data on an appropriate comparison population for modeling long-term economic impacts.

^ Heterogeneity criterion is achieved because at lease 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