Mental Health Evidence Based Practices (EBPs) in Washington State

The 2007 Evidence-Based Practices (EBP) Survey

Mental Health Evidence Based Practices (EBP) in Washington State

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The authors would like to thank the literally hundreds of people that contributed to the success of this project. First, we would like to thank our funders, specifically the Washington State Mental Health Transformation Project, the Mental Health Division (MHD), and the Division of Alcohol and Substance Abuse (DASA). Without their support, this project would not have been possible. The 2007 EBP Survey originated with and was developed by the Evaluation Task Group, which is comprised of mental health consumers, family members, social scientists, and Department of Social and Health Services (DSHS) administrators. We want to thank all of our colleagues who are members of the Task Group as well as non-members, such as Mark Snowden and Kate Comtois, and Susan Bullerdick, who participated in various phases of this project. Finally, we would like to thank everyone who took the time and effort to complete the survey. The survey respondents are key personnel in the fields of mental health, chemical dependency, juvenile rehabilitation, and children's services. We are particularly thankful to staff at the Juvenile Rehabilitation Administration (JRA), the Children's Administration (CA), and DASA for assistance with obtaining data from their agencies.

Executive Summary

The current project is part of Washington State's Mental Health Transformation effort and was developed to identify and assess the utilization of *mental health* "Evidence Based Practices" (EBPs) in Washington State. To conduct this assessment a survey was administered to providers of publically funded social services. The Mental Health Division (MHD), the Division of Alcohol and Substance Abuse (DASA), the Juvenile Rehabilitation Administration (JRA), and the Children's Administration (CA) all participated in the survey. The intent of the survey is to inform state policymakers, providers, consumers, and other stakeholders about the current status of mental health EBP implementation in Washington State. Results are intended to directly inform planning and programming efforts, as well as serve as a baseline for tracking EBP implementation in the future.[1]

Defining Evidence Based Practices

Selecting EBPs to include in the survey was an iterative process that involved multiple stakeholders, including mental health consumers, family members, researchers, and service providers. A literature search uncovered nearly 350 practices that were classified as being either a "true" evidence based practice, a promising practice, or an emerging practice. A "decision rule" involving nine key sources containing definitions and rating criteria for mental health EBPs was used to identify which of these would be considered evidence based practices for this assessment. The decision rule was based upon the number of times the practice was endorsed by each of the nine sources, the level of research support that each practice received, and whether or not the practice was currently offered in Washington State. From these criteria, 34 EBPs were selected and included in the survey.

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The Survey Instrument

The same iterative process used for identifying EBPs also was used to identify items for the instrument, and involved multiple stakeholders, including mental health consumers, family members, researchers, service providers, and administrators. In addition to agency characteristics the survey asked about each agency's *utilization* of EBPs, the agency's *target population*, if *fidelity* is measured, if *training* is offered and from where, how successful the *implementation* of EBPs has been, what *barriers* have been encountered, how *effective* EBPs have been in improving client outcomes, how interested the agency is in *continuing/beginning to use EBPs*, what *initiatives* have been used to promote EBPs, and what are the agency's *client counts* overall in 2007 as well as how many clients received each EBP.

Survey Participants

Provider agencies funded by the Mental Health Division (N = 156), Division of Alcohol and Substance Abuse (N = 239), Children's Administration (N = 15), and Juvenile Rehabilitation Administration (N = 17) were contacted to participate in the survey. Of the 427 eligible provider agencies in the sample universe, 281 agencies completed the survey, yielding a 65.8% response rate across all four DSHS Division/Administrations: Mental Health Division (N = 96, 61.5%), Division of Alcohol and Substance Abuse (N = 154, 64.4%), Children's Administration (N = 14, 93.3%), and Juvenile Rehabilitation Administration (N = 17, 100%). Agency providers themselves completed the survey in both MHD and DASA. To reduce the administrative burden on provider agencies within the Children's Administration (CA) and Juvenile Rehabilitation Administration (JRA), surveys were not sent to each of the individual agencies but instead were completed by staff members working directly for JRA and CA.

Selected Findings

Service Provision

- Most agencies (88%) provide intake, assessment, and referral services. While 92% of the MHD agencies indicated that they provide mental health services, less than half of the other agencies provide mental health services (DASA = 42%, JRA = 29%, CA = 14%).
- Half of the agencies in MHD and DASA offer Co-Occurring Disorder (COD) treatment.

Utilizing Evidenced Based Practices

- Of the 34 practices identified as Evidenced Based Practices in this study, 33 are being used in mental health (MHD) agencies and 31 are being used in chemical dependency (DASA) agencies.
- Cognitive Behavior Therapies (CBT) were the most widely used EBPs for MHD agencies (73%). The next most commonly utilized EBPs were Medication Management and Motivational Interviewing (both 47%) and Dialectical Behavioral Therapy (DBT) (44%).
- Motivational Interviewing is the most commonly used EBP among DASA agencies (64%). This is followed by CBT (53%) and then DBT (31%).
- Parent-Child Interaction Therapy is the most widely used EBP among CA agencies (72%). This is followed by Multidimensional Treatment Foster Care (21%.). DBT is the most often used EBP among JRA (59%) agencies, followed by Functional Family Therapy (35%) and Aggression Replacement Training (29%).
- MHD agencies offer an average of six different EBPs per agency. DASA offer an average of 3.6 EBPs per agency. JRA and CA offer an average of 1.6 and 1.4 EBPs per agency, respectively.
- Forty percent of the MHD agencies and 17% of DASA agencies offer seven or more EBPs per agency. All of the JRA and CA agencies offer less than 3 EBPs per agency;

Fidelity

- Forty-three percent of the agencies indicated that they are assessing or monitoring program fidelity for the EBPs they provide.

Training

- Seventy-five percent of the agencies use internal staff for EBP training purposes. Provider-to-provider training is the second most commonly used training mechanism (35%), followed by outside accreditation (35%).

Targeted Populations

- EBPs that MHD (73%) and DASA agencies (70%) provide are used most frequently with adult populations. Not surprisingly, EBPs that CA agencies (88%) provide are used most frequently with children. One-hundred percent of the EBPs that JRA agencies offer are used with adolescents. About half of the agencies in MHD and DASA target adolescent populations with the EBPs they provide; 53% of DASA agencies, 41% of MHD agencies and 63% of JRA agencies target co-occurring disorders (COD).

Implementation Success and EBP Effectiveness

- More than half of the respondents report that they are very successful (45%) or extremely successful (15%) at implementing the EBPs that they provide. Only about 1% said that they are not at all successful.
- More than half of the respondents indicate that EBPs provided by their agency are "Very" (45.3%) or "Extremely" (14.9%) effective at producing positive client outcomes. JRA agencies have an overall lower rating of perceived effectiveness of their EBPs than the other Agency Types.

Future EBP Utilization

- When asked to select "any EBPS that you are NOT currently using but want to use in the future," over three-fourths of the respondents from DASA (81.2 %), MHD (84.4 %), and JRA (76%) indicate that they wanted to implement new EBPs in the future. Fourteen percent of the CA agencies want to implement any new EBPs in addition to what they are currently using.

Barriers

- A shortage of an appropriately trained workforce is the most often cited barrier to implementing EBPs (48%). Financing issues related to paying for EBPs were the second

most often cited barrier (44%). For MHD agencies, a shortage of an appropriately trained workforce (45%) and financing issues (49%) were fairly even. For DASA agencies, financing (40%) was less of a problem than having a trained workforce (48%). In JRA and CA agencies there was a greater problem with having a trained workforce (84%, 77% respectively). Financing was much less of a problem in JRA (34%) than in CA (71%).

Populations Served With No Known EPBs

- More than one-third of the agencies report that they serve clients whose needs are not met by currently available EBPs. For MHD and DASA agencies, minority populations were the most frequently identified, in JRA it was youth with sex offenses and cognitive impairment, and in CA it was clients with co-occurring issues and parents referred for neglected children.

Interest in EBP Implementation

- Three-quarters of all agencies are either *very* interested (38%) or *extremely* interested (35%) in the continued use of EBPs. Twenty percent were *somewhat* interested, while only six percent had little or no interest in using EBPs within their treatment programs.

Initiatives to Promote EBPs

- Ninety-three percent of all surveyed agencies state that they are implementing initiatives to promote the adoption of EBPs. The majority indicate that they are promoting EBPs by increasing awareness about them and implementing training for this purpose.

Systematic Assessment of Effects of EBPs

- Less than 40% of the agencies surveyed report that they conduct systematic assessment(s) of the effects of evidence-based interventions (107 of 281).

Client Counts

- The 34 EBPs were offered 636 times across 281 agencies in 2007. On average, 192 clients received an EBP each time it was offered. The most frequently received EBPs were Cognitive Behavior Therapy (29,623), Medication Management (18,849), Motivational Interviewing (17,205) Peer Support (8485), Family Psychoeducation (7209), and Dialectical Behavioral Therapy (7709).

Introduction

In October 2005, Washington State was one of seven states awarded a Mental Health Transformation State Incentive Grant from the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (SAMHSA/CMHS). The grants are intended to support infrastructure and service delivery changes that will advance the goals of the final report of the President's New Freedom Commission on Mental Health (NFC) and lead to the development of systems and services that facilitate recovery and resilience among youth, families and adults. To help assess this effort, an Evaluation Task Group was put in place that consists of a team of researchers and consumers from the state's Department of Social and Health Services (DSHS), the University of Washington, and the Washington Institute for Mental Illness: Research and Training (WIMIRT).

One objective of the Evaluation Task Group is to identify and assess the utilization of *mental health* "Evidence Based Practices" (EBPs) in Washington State. To conduct this assessment, a survey was administered to providers of publically funded social services. The Mental Health Division (MHD), the Division of Alcohol and Substance Abuse (DASA), the Juvenile Rehabilitation Administration (JRA), and the Children's Administration (CA) all participated in the survey. This is a report of the findings of the survey.

To conduct the survey, the Mental Health Transformation Project contracted with the Washington Institute for Mental Illness: Research and Training (WIMIRT) to develop and administer an "online" survey. The intent of the survey is to inform state policymakers, providers, consumers, and other stakeholders about the current status of mental health EBP implementation in Washington State. Results are intended to directly inform planning and programming efforts, as well as serve as a baseline for tracking EBP implementation in the future.

To begin our inquiry, a literature search was conducted that resulted in two products. The first was a table showing the Transformation activities of nine states that received Transformation grants from SAMHSA. Included were the individual states' transformation priorities, evaluation

approach, and most relevant to our purposes here, an EBP work plan identifying the evidence based practices recognized by the other states. The table summary appears in Appendix A.

The second product emerging from the literature review was a *matrix* showing mental health practices identified in the literature as being either a "true" evidence based practice, promising practice, or emerging practice. Each practice is cross-referenced by the status of the evidence (the sources identifying the practice as being evidence based) and information about the practice's use in Washington. In addition to the matrix, rating system definitions and references are included. The matrix is used as a basis for categorizing and tracking EBP use in the state as well as an initial "wide net" of practices for use in developing survey materials. This matrix served as a starting point for the development of the survey and appears in Appendix B. We begin by describing how the evidence based practices were identified and selected for the survey. We then move on to describing the development of the survey as to what information was wanted about EBPs in the state, describe the survey method, and, finally, to the findings.

Defining Evidence Based Practices

The concept and general guidelines for developing and conducting the EPB survey were identified by the Evaluation Task Group. Selecting EBPs to include in the survey was a complex and iterative process that involved multiple stakeholders, including mental health consumers, family members, researchers, and service providers.

The literature search uncovered nearly 350 practices that were classified as being either a "true" evidence based practice, promising practice, or emerging practice (see Appendix B). A mechanism or "decision rule" needed to be made to identify which of these would be considered *true* "evidence based practices" for the purposes of this assessment. We started with the Institute of Medicine (2001) which offers the most widely used definition:

> Evidenced based practice is the integration of best research evidence with clinical expertise and patient values. *Best research evidence* refers to clinically relevant research, often from the basic health and medical sciences, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination); the power of prognostic markers; and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. *Clinical expertise* means the ability to use clinical skills and past expertise to rapidly identify each

> patient's unique health state and diagnosis, individual risks, and benefits of potential interventions, and personal values and expectations. *Patient values* refers to the unique preferences, concerns, and expectations that each patient brings to a clinical encounter and that must be integrated into clinical decisions if they are to serve the patient. .[2]

A more abbreviated version is identified by Drake and colleagues (2005): "*Evidenced Based Practices* – means employing clinical interventions that research has shown to be effective in helping consumers recover and achieve goals."[3]

Roberts and Yeager (2004) identified four "Levels of Evidence."[4] The level of evidence indicates the degree to which the practice has been tested; 1 meeting the highest standard, 4 meeting the lowest:

Level	Description
1	Meta-analysis or replicated randomized controlled trials (RCT) that include a placebo condition/control trial or are from well-designed cohort or case control analytic study, preferably from more than one center or research group, or national consensus panel recommendations based on controlled, randomized studies, which are systematically reviewed.
2	At least one RCT with placebo or active comparison condition, evidence obtained from multiple time series with or without intervention, or national consensus panel recommendations base on uncontrolled studies with positive outcomes or based on studies showing dramatic effects of interventions.
3	Uncontrolled trial observational study with 10 or more subjects, opinions of respectful authorities, based on clinical experiences, descriptive studies, or reports of expert consensus.
4	Anecdotal case reports, unsystematic clinical observation, descriptive reports, case studies, and /or single-subject designs.

[2] Institute of Medicine (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy Press.

[3] Drake, R. E., Merrens, M. R., & Lynde, D.W. (2005) Evidenced-Based Mental Health Practice. WW Norton & Co. p.67.

[4] Roberts, A.R, & Yeager, K. (2004). Systematic reviews of evidence-based studies and practice-based research: How to search for, develop, and use them. In Roberts, A.R. & Yeager, K.R. (Eds.). Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services, (pp.3-14). Oxford: Oxford University Press.

While these definitions are widely used in the literature, we discovered that the major sources we identified had varying criteria to classify the evidence base for each practice. As will be seen below, most of these are similar to the criteria recommended by Roberts and Yeager (2004).

Nine sources were identified that contained definitions and rating criteria for Mental Health Evidence Based Practices (see Appendix B). These sources were used to select the EBPs for the survey:

1. WIMIRT Literature Review and Resource Guide on Evidence Based Best and Promising Mental Health Practices;
2. Data Infrastructure Grants (DIGs) (SAMHSA);
3. Tool Kit (SAMHSA);
4. National Registry of Evidence Based Practices (SAMHSA);
5. Model Programs (SAMHSA);
6. Transformation Grant's Evidence/Consensus Based/Promising/Emerging practices (ECBPEP) Supplemental Report on EBPs;
7. Children's Mental Health EBP Expert Panel report;
8. Alcohol and Drug Institute's (ADAI) EBP database; and
9. Washington State Institute for Public Policy (WSIPP).

The *decision rule* to determine whether a practice qualified for inclusion as a true EBP in this study was based upon the number of times the practice was endorsed by the nine sources, the level of research support that each practice received, and whether or not the practice was currently offered in Washington State. While the rating criteria varied across the 9 sources, each could be categorized into three general levels: 1= lowest level (e.g., emerging practice); 2= middle level (promising practice); and 3 = highest level (e.g., evidenced based practice). The score of each practice was calculated by summing the number of endorsements across the nine EBP sources (range = 1-9) multiplied by the level of evidence of each practice within each source (range = 1-3):

Final score = SUM (Number of sources that endorse each EBP X Level of Evidence).

To be included as an EBP in this study a practice had to achieve a minimum score of "5." In addition, those practices with scores of 5 or 6 also had to be known to be currently offered in Washington State. For example, on page B-2 of Appendix B, the third practice listed is Assertive

Community Treatment (ACT). ACT was endorsed by six of the nine sources. Five of the sources rated it at the highest level (3) and one rated it at the lowest level (1). Hence, the score for PACT is 16 [Score = (5 x 3) + (1 x 1) = 16]. The practice "Applied Behavior Analysis" (not shown) received a score of 6 but was not included because it is not currently being offered in Washington State. "Aggression Replacement Training" also received a score of 6 and was included because it is currently being offered in Washington State. Applying this decision rule resulted in 32 practices. Two additional practices were added. "Peer Support" was added because of special interest in this practice by members of the Evaluation Work Group and "Supported Housing" was added because it was needed for SAMHSA's Data Infrastructure Grant (DIG) report. Supporting Housing received a score of 4 and Peer Support received a score of 2.

Methodology

Developing the Survey Instrument

Once the EBPs were selected, the survey instrument was developed. The same iterative process used for identifying EBPs also was used to identify items for the instrument, and involved multiple stakeholders, including mental health consumers, family members, researchers, service providers, and administrators. Many of the questions developed for the survey were adapted from the following sources: the State Mental Health Agency Profiles System developed by the NASMHPD Research Institute (NRI); the National Survey of Substance Abuse Treatment Services (N-SSATS) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA); and the Adolescent Substance Abuse Treatment Improvement Survey developed by DASA. A final draft of the mental health EBP survey as well as brief descriptions of each EBP are presented in Appendix C.

Selecting Participants

The goal of this project is to identify *mental health* EBP utilization in Washington State's social and health service system. Administrators representing the Mental Health Division (MHD), Division of Alcohol and Substance Abuse (DASA), Children's Administration (CA), and

Juvenile Rehabilitation Administration (JRA) agreed to use the inventory of MH EBPs.[5] "Provider agency" within each Division/Administration is the unit of analysis. Lists of eligible provider agencies were provided by each of the four Divisions/Administrations: MHD (N = 156); DASA (N = 238); JRA (N = 17); and CA (N = 15). Participant selection in each of the Divisions/Administrations differed. Each process is described below. It is important to note that agency providers themselves completed the survey in both MHD and DASA; however, among CA and JRA agencies, surveys were not sent to each of the individual agencies but instead were completed by staff members working directly for JRA and CA.

Mental Health Division (MHD)

The list of publically funded mental health agencies (MHD) was compiled from three sources:

1. The Washington State Mental Health Division provided WIMIRT with a list of mental health agencies that were certified and/or licensed to provide mental health services by the Washington State Department of Social and Health Services (DSHS) in 2007.[6] Certified agencies included providers that supplied one or more of the following services: (1) inpatient evaluation and treatment; (2) outpatient treatment services; and/or (3) emergency crisis intervention services. Licensed agencies included providers that met minimum standards for one or more of the following types of services: (1) Emergency crisis intervention services; (2) Case management services; (3) Psychiatric treatment, including medication supervision; (4) Counseling and psychotherapy services; (5) Day treatment services; and/or (6) Consumer employment services.
2. A second list was provided by Regional Support Network (RSN) Directors, and included any additional agencies that the RSNs wanted surveyed.
3. The third list was provided by the Eastern Branch of WIMIRT and consisted of 11 Washington State Clubhouses.

From the three lists identified above, 175 agencies were initially selected. This number decreased as we found out that two agencies were closed or no longer existed and four agencies were actually duplications of other agencies under different names. Because the focus of this project was on the implementation of EBPs among publically funded agencies providing *direct treatment services*, four agencies were excluded for the following reasons: 1) one agency was a utilization management company, 2) one agency provided Ombuds services only, 3) one agency

[5] Two other Departments, the Department of Corrections (DOC) and the Aging and Disability Services Administration (ADSA), were also considered for inclusion. Including DOC proved to be beyond the scope of this assessment. ADSA was invited to participate but did not provide us with data after several requests.
[6] See WAC 388-865-400

provided ITA assessment services only, and 4) one agency was a crisis line in Oregon. An additional nine facilities whose survey responses were "rolled into" another agency's characteristics and client counts were also excluded from the agency counts in this report.

These exclusion criteria resulted in 156 agencies that were eligible to complete the survey. Unless instructed otherwise by administrative staff at the RSN- or mental health agency-level, all contacts with agencies in the MHD sample were sent to the agency director via email.

Division of Alcohol and Substance Abuse (DASA)

The list of chemical dependency treatment agencies was obtained from DASA and initially consisted of 266 publicly funded chemical dependency treatment agencies in Washington State. This number decreased as we learned that nine agencies/programs no longer existed and that the results of 18 agencies were included or "rolled" into the survey responses of another agency.

Taking these exclusion criteria into account, 239 unduplicated agencies were eligible to complete the survey. In addition to agency name and location, each of the agencies in the DASA sample was entered into a database that included the name and email address of an agency contact person that was selected to complete the survey.

Children's Administration (CA)

The sample of agencies from CA was obtained from the Children Administration's Evidence-Based Programs Manager and included 16 unduplicated agencies. This number decreased to 15 as we learned that EBP utilization and client count information from one CA agency was included in the survey responses of another agency. In order to reduce the administration burden on agency staff, the EBP Programs Manager completed a separate survey for each of the eligible agencies. The CA EBP Program manager was unable to obtain the total number of clients served in FY2007 by agency and therefore this information is reported.

Juvenile Rehabilitation Administration (JRA)

The sample of JRA agencies was obtained from the Clinical Director of JRA and included 17 unduplicated agencies. To reduce the administrative burden on agency staff, staff working directly for the Juvenile Rehabilitation Administration (JRA) completed separate surveys for each of the identified agencies.

Conducting the Survey

Survey procedures for the DASA and MHD samples were based upon those recommended by Dillman (2000) to maximize response rates through multiple contacts.[7] He recommends that potential respondents are contacted by mail or email at least four times, with an additional "Special" contact (e.g., a telephone call) provided to persistent non-responders. The process and timeline used to administer the survey for each of the four DSHS Divisions/Administrations is outlined in Table 1 below. During the data collection phase, WIMIRT personnel were available by phone and email to answer questions that potential respondents had about the survey.

Table 1: Timeline for distribution of survey materials and contacts

Division/ Administration	Pre-notice	Survey Material	Email Reminder	Email- Final Notice	Follow-up Phone Call
MHD	July 2-3	July 5-6	July 20	July 31	August 9-10, 13
DASA	August 16	August 20	August 29-30	September 13	September 20-21
DASA-Overlap	September 18	September 19	October 1	----	October 10
JRA	July 17th	July 19th	----	----	----
CA	July 17th	July 19th	August 14	September 26	October 2

Mental Health Division (MHD)

The first contact sent to each mental health agency director was a pre-notice e-mail explaining the purpose of the EBP survey and alerting them to expect it by email in the next several days. Less than one week later, the survey, as well as instructions, a unique login ID, and brief

[7] Dillman, D.A. (2000). Mail and Internet Surveys: The Tailored Design Method – Second Edition. John Wiley & Sons, New York, New York.

descriptions of each EBP were emailed to each agency administrator in the sample.[8] For agencies that did not complete the survey, the agency director was contacted up to three more times after the original survey materials were sent. The final contact was a follow-up phone call. A follow-up phone script was provided to interviewers to inform the respondents that the survey was sent to them previously, and to explain that the call was being made to see if they had any questions about the project. Potential respondents were also encouraged to complete the survey as soon as possible.

Division of Alcohol and Substance Abuse (DASA)

Although similar, the data collection procedures used with the DASA sample differed slightly from those used with the MHD sample. One important difference was the inclusion of more than 30 substance use EBPs in the DASA version of the survey.[9] A consequence of including chemical dependency EBPs in the DASA version of the survey was that it was very long, and could only be completed online. Another procedural difference in the protocol used with DASA agencies was that the pre-notice contact was an actual memo written and signed by the Director of DASA and was sent to DASA agency contacts via e-mail and postage mail.

A third procedural difference was related to variability in the DASA sample itself. Because fifty-seven (57-DASA Overlap) agencies from the DASA sample were also duplicated in the MHD sample, they were surveyed separately. These 57 agencies were surveyed separately primarily to draw attention to the fact that the DASA EBP survey also included chemical dependency EBPs, unlike the MHD EBP survey which only included mental health EBPs. The overlap sample inclusion criteria was based on the following decision rule: 1) the DASA licensed/certified agency had the same name as the MHD licensed/certified agency or; 2) the DASA licensed/certified agency had the same address as the MHD licensed/certified agency. For disposition reporting purposes, both samples have been combined into one sample.

[8] For the MHD sample, agency administrators were encouraged to complete the survey online, they were also given the option of completing an electronic or paper copy of the survey.

[9] Substance use EBPs included in the DASA version of the survey were obtained from the Alcohol and Drug Abuse Institute's (ADAI) website: http://adai.washington.edu/ebp/matrix.pdf

Children's Administration (CA) and Juvenile Rehabilitation Administration (JRA)

The timeline for JRA and CA consisted of a pre-notice telephone call from WIMIRT with management from both Administrations. Similar to the purpose of the pre-notice email sent to DASA and MHD agencies, the purpose of the pre-notice telephone call to JRA and CA was to ask them to complete the EBP Survey and that they would be receiving it in the next several days. The Evidence Based Practices (EBP) Manager from CA and Clinical Director from JRA were asked to complete a separate survey for each of the individual agencies within their Administration and to enter the responses online.

Response Rate

Of the 427 eligible provider agencies in the sample universe, 281 agencies completed the survey, yielding a 65.8% response rate across all four DSHS Division/Administrations (see Table 2 below). The response rate was lowest for mental health agencies (61.5%), followed by chemical dependency treatment agencies (64.4%). JRA staff completed a separate survey for each of their 17 provider agencies, yielding a 100% response rate. Because client count information could not be obtained for one agency in the CA sample, the response rate for the CA agencies was 93.3%.

Table 2: Number of Eligible Agencies that Completed the Survey by DSHS Division/Administration

Division/Administration	Responding Agencies	Non-Responding Agencies	Total	Response Rate (%)
Mental Health Division (MHD)	96	60	156	61.5%
Division of Alcohol and Substance Abuse (DASA)	154	85	239	64.4%
Children's Administration (CA)	14	1	15	93.3%
Juvenile Rehabilitation Administration (JRA)	17	0	17	100.0%
Total	**281**	**145**	**427**	**65.8%**

Representativeness

Our interest in conducting a statewide survey is to be able to generalize the findings to the statewide publically funded mental health service provider population. In this case it would be those provider agencies funded by the MHD, DASA, JRA, and CA. If we had obtained a 100% response rate from the four Divisions and Administrations this would not be questionable. A response rate of 62% from the MHD agencies and 65% from DASA requires us to exercise some caution in making generalizations across the state since the possibility exists that those that did not respond differ from those that did respond in some systematic way. If this were the case, then the sample may not represent the true population, and thus would have poor "representativeness."

Representativeness may better be assessed if we had common indicators for both those agencies that did respond and those agencies that did not respond to the survey. This would allow us to see if these two groups differed in any appreciable ways that may affect their survey responses (e.g., size of agency, location, urban vs. rural). The only indicator that we have for both those that responded and those that did not is their location (see the map in Appendix D showing the location of the provider agencies by agency type and whether or not they responded to the survey). The distributions of MHD and DASA agencies that completed and did not complete the survey appear relatively evenly distributed across the state. JRA and CA agencies are confined primarily to urban areas. Included in Appendix D are the percentage of agencies within each county that completed the survey and a list of agencies that completed or did not complete the survey.

Findings

The survey inquires about agency characteristics (e.g., services offered, size of service area served) and the following content areas:

9 *UTILIZATION OF EBPS.* Utilization of EBPs is based on the percent of responding agencies currently providing each of the EBPs that are listed;

- *FIDELITY.* For each EBP that the agencies utilizes, respondents were asked to indicate whether they measure or monitor program fidelity. The specific fidelity measure or method being used was also collected.

- *TRAINING.* Respondents were asked to indicate how staff were trained to utilize each EBP that their agency provides: 1) Internal Staff; 2) Collaboration with Universities; 3) Provider to Provider training; 4) Expert Consultants; 5) Outside Accreditation; 6) Other (specify:____); 7) None.

- *TARGET POPULATION.* For each EBP, the respondents was asked to indicate which of the following six populations they were offering the EBP to: 1) children; 2) adolescents; 3) Adult; 4) Elderly; 5) Co-occurring disorders; 5) Other;

- *IMPLEMENTATION SUCCESS* is based on the percent of respondents who indicate their agency is "Not at All", "A Little", "Somewhat", "Very" or "Extremely" successful at implementing the EBPs they currently provide.

- *EBP EFFECTIVENESS* is based on the percent of respondents who indicate the EBPs their agency provides are "Not at All", "A Little", "Somewhat", "Very" or "Extremely" effective and producing positive client outcomes.

- *FUTURE EBP UTILIZATION.* Respondents were asked to indicate whether there are any EBPs that they do not currently use but want to utilize in the future.

- *BARRIERS.* For each EBP that an agency utilizes or wants to utilize, respondents were asked whether each of the listed barriers interfered with EBP implementation: 1) Shortage of appropriately trained workforce; 2) Financing issues in paying for EBPs; 3) Modification of EBP to fit local needs; 4) Attaining or maintaining fidelity to EBP model standards; 5) Resistance to implementing EBPs from practitioners; 6) Other (Specify:___); 7) None.

- *MOST NEEDED ASSISTANCE TO ADOPT EBPS* is based on the percent of responding agencies that endorse each of the following areas: 1) None; 2) Appropriately Trained Workforce; 3) Financing issues in paying for EBPs; 4) Modification of EBPs to fit local needs;5) Attaining or Maintaining fidelity to EBP model standards; 6) Resistance to implementing EBPs from practitioners; 7) Other.

- *POPULATION SERVED BY NO KNOWN EBPs.* Respondents were asked if they are serving populations for which there are no known or available EBPs, and if so, which one(s).

- *INTEREST IN EBP IMPLEMENTATION* is based on the percent of respondents who indicate their agency is "Not at All", "A Little", "Somewhat", "Very" or "Extremely" interested in continuing/beginning to utilize EBPs.

- *EBP INITIATIVES* is based on the percent of responding agencies that indicate "Yes" for each of the following methods used to promote EBP implementation: 1) Increase awareness about EBPs; 2) Training; 3) Incorporation of EBPs in contracts; 4) Monitoring of fidelity; 5) Modification of information systems/data reports; 6) Modification of paperwork; 7) Financial incentives; 8) Other; 9) None.

- *SYSTEMATIC ASSESSMENT OF EBP EFFECTS.* Respondents were asked whether any systematic assessments are being utilized to measure EBP effectiveness.

- *CLIENT COUNTS* are based on the average number of people served in FY2007 by agency and by each EBP.

In discussing the findings below, reference will be made to Appendix E and F that contain all the major tables for each question (Appendix E) as well as a complete listing of the "Other" responses for each question (Appendix F). Including this material in the text would be too cumbersome. Instead, a series of "figures" have been included that summarizes some of the main findings from the tables. Information from the "Other" responses is added when appropriate. The reader is encouraged to refer to Appendix E and F for more specifics on each question. A Table of Contents has been included in each appendix for reference.

Data Considerations and Limitations

Certain procedural considerations and limitations should be taken into account when interpreting the results of the 2007 EBP Survey. First, it should be noted that survey participation was voluntary. One of the consequences of voluntary participation is missing data. With the exception of JRA, the response rate for the EBP survey was less than 100% across the other three DSHS Division/Administrations. Therefore, it is unknown the extent to which the facility characteristics, utilization of EBPs, and client counts of responding agencies generalize to those of non-responding agencies, particularly among mental health and chemical dependency service systems.

Second, the survey respondents varied across the four DSHS Agency Types (i.e., CA, MHD, JRA, and DASA). Whereas the primary respondents for the MHD and DASA samples were employed by the local service provider agencies, the primary respondents for the CA and JRA samples were employed directly by CA and JRA.

Third, the survey instrument completed by DASA agencies was different from the survey instrument completed by MHD, CA, and JRA agencies. Specifically, the DASA version of the EBP survey included chemical dependency *and* mental health EBPs. It is unknown the extent to which the addition of chemical dependency EBPs might have altered the response to mental health EBPs.

Agency Characteristics

Figure 1 below shows that when all of the DSHS agencies are combined, intake, assessment, or referral services are the most frequently offered services overall (87.5%). Chemical dependency (67.6%) and mental health (56.6 %) treatment are provided by more than half of the agencies. Co-occurring disorder services are provided by slightly less than half (47.7%) of the agencies in the overall sample and 41% of the agencies reported offering services other than or in addition to those described above.

Each DSHS Agency Type differs from the next in the emphasis they place on each service. Not surprisingly, most of the agencies in the MHD sample provide mental health treatment (91.7%) whereas most of the agencies in the DASA sample provide chemical dependency treatment (98.1%). One hundred percent of the JRA agencies provide intake, assessment, or referral services, and 100% of the CA agencies offer "Other" services. Most of the "Other" services listed by CA are MTFC and PCIT (See Appendix F. p. F-3). Of the four Agency Types, only one, the Children's Administration, did not provide all five listed services. The "other" services listed by each agency type are provided in Appendix F.

Figure 2 below shows the percent of agencies that are operated as a solo office with a single practitioner or therapist. Overall, only 2.5% of all agencies are being operated as a solo practice. These solo practices are all DASA affiliated agencies (4.5%).

Figure 3 below shows that agencies that serve populations between 50,001 and 500,000 had the greatest representation (41.3%) when responding agencies from all four DSHS systems were combined. Agencies with service areas of 5000 or less were the least represented overall (11.0%).

Although both MHD and DASA agencies tend to service populations of 50,001-500,000, DASA agencies are more likely to service lesser populated areas than MHD. Furthermore, the CA agencies that responded only service areas of 50,001 or more people. JRA agencies only service areas with populations lower than 5000 (5.9%) or greater than 500,000 (94.1%). A likely reason for the large number served by JRA agencies in areas greater than 500,000 is that clients from across the state are sent to JRA treatment facilities that are located in these larger areas.

Figure 1. Agency Characteristics: Services Offered by DSHS Administration

Q1. Which of the following services are offered by this agency?

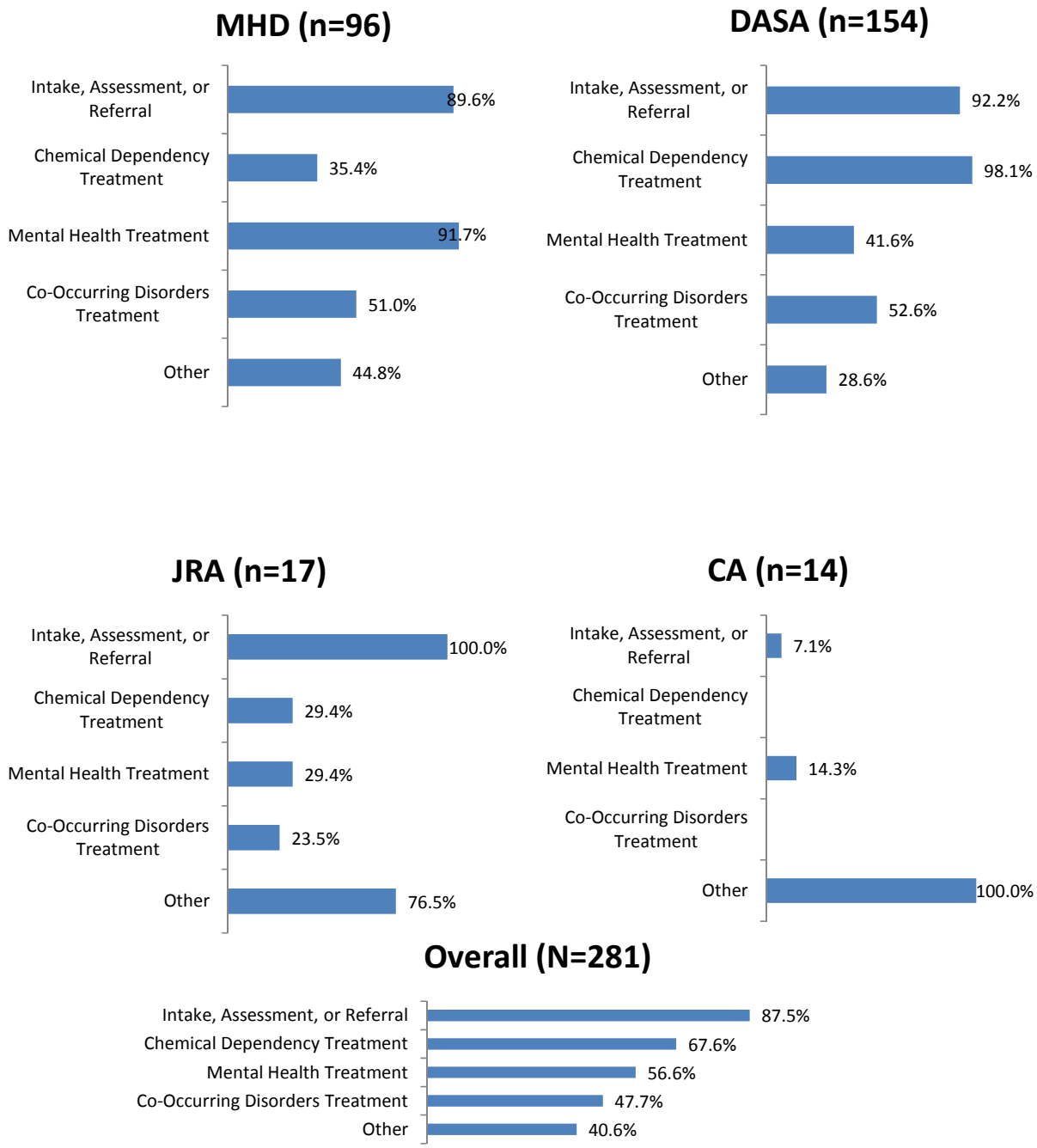


Figure 2. Agency Characteristics: Solo Practice by DSHS Administration

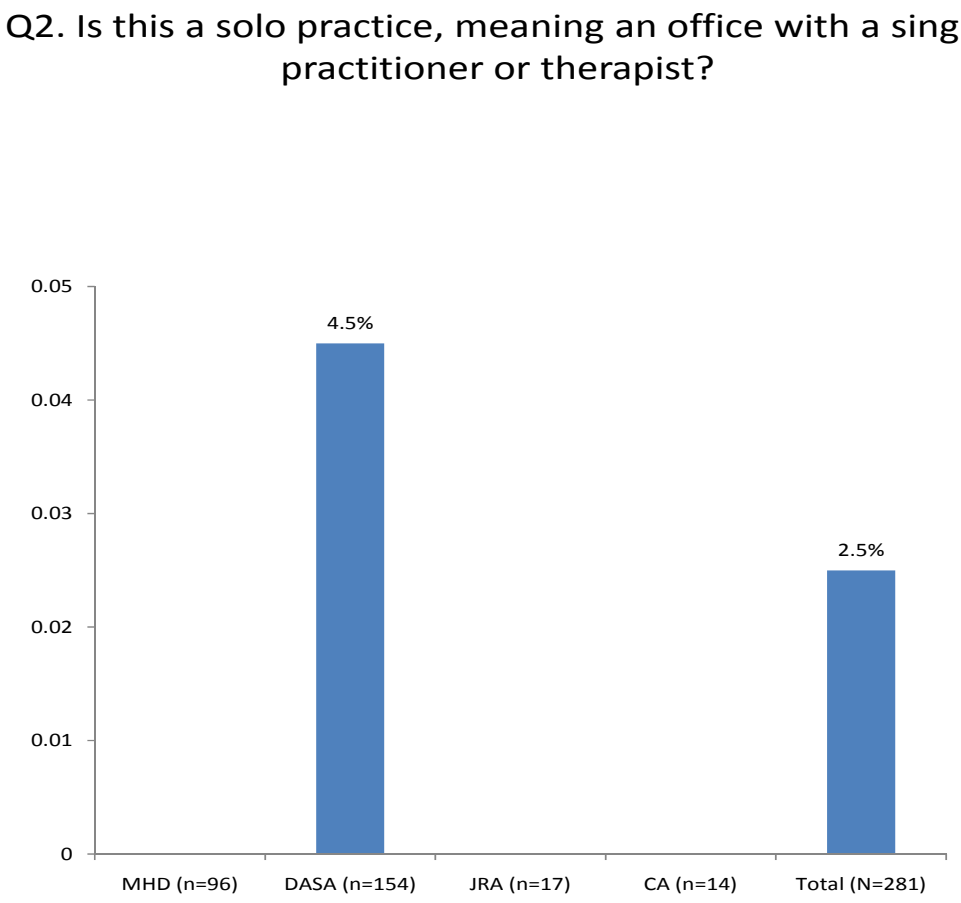
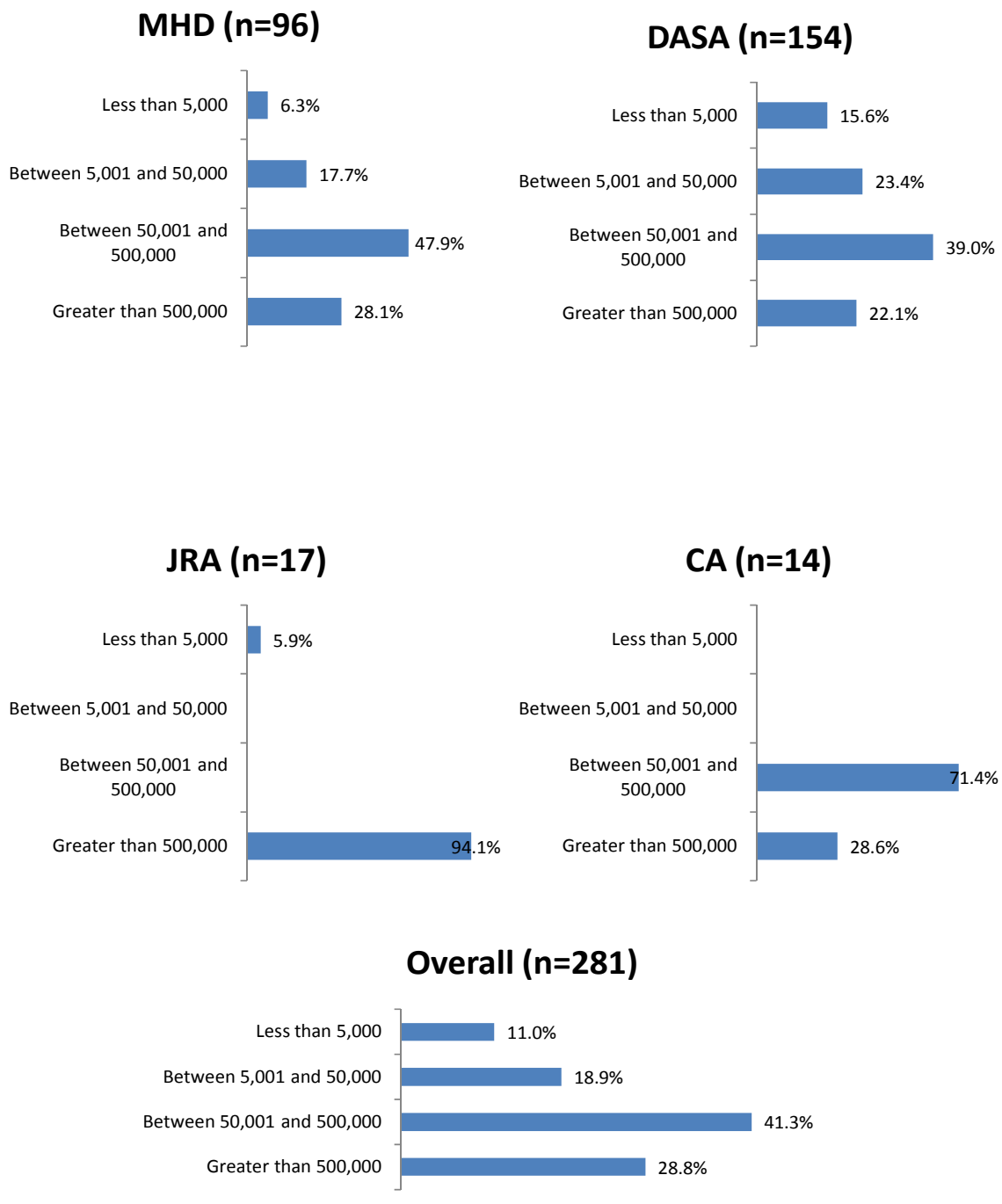


Figure 3. Agency Characteristics: Service Population

Q3. What is the population of the service area for your agency?



Utilization of EBPs

Q4: In the list below, please indicate which of following evidence based practices (EBPs) your agency currently provides.*

There are 34 EBPs that are under consideration in this study (see the section above "Defining Evidence Based Practices" for the decision rule used to select EBPs). Figure 4a1 and Figure 4a2 below show the percent of agencies in each Agency Type (i.e., MHD, DASA, JRA, or CA) that are using each EBP. The actual percentages are shown in Table Q4a in Appendix D. Cognitive Behavior Therapies (CBT) were the most widely utilized EBPs among MHD agencies (73%). This is followed by Medication Management and Motivational Interviewing (both 47%) and Dialectical Behavioral Therapy (DBT-44%). Motivational Interviewing was the most commonly utilized EBP among DASA agencies (64%). This is followed by CBT (53%) and then DBT (31%).

The number of EBPs utilized by both JRA and CA is far less than the number in use by MHD and DASA agencies, at least for these 34 EBPs. Figure Q4a2 shows that Parent-Child Interaction Therapy is the most commonly utilized EBP among CA agencies (72%). This is followed by Multidimensional Treatment Foster Care (21%). Few other EBPs are identified. DBT (59%) is the most often used by JRA, followed by Functional Family Therapy (35%) and Aggression Replacement Training (29%). There is a large percentage of "other" EBPs identified by JRA.

Tables Q4a_other35 and Q4a_other36 in Appendix F show the "Other" practice responses by Agency type. For each practice an "inclusion score" is included if the practice appeared on our original list of 350 practices (See Appendix B). If a score is not entered, the practice does not appear on the list of 350. The majority of "Other" practices do not appear in the list of 350. The ones that do appear on the list have relatively low scores.[10] Most of the "Other" practices were identified by only one agency. The exceptions were "Moral Reconation Therapy in DASA and Functional Family Parole Services in JRA.

[10] Some of the services placed in the "Other" category may belong in the list of 34 (e.g., Trauma based CBT) but were left in the "Other" category since it was left up to the respondent to decide where the practice belonged.

Table 3 below shows the average number of EBPs offered per site by agency type (i.e., MHD, DASA, JRA, or CA). Among MHD, each agency offered on average six different EBPs, with a range between zero and 22. DASA agencies offered an average of 3.6 EBPs per site, with a range of 0 to 18. JRA and CA offered an average of 1.6 and 1.4 EBPs per agency, respectively.

Table 4 below shows that 26% of MHD agencies offered between one and three EBPs and 26% offered between four and six EBPs per agency. Ninety-three percent of CA agencies and 94% of JRA agencies offered between one and three EBPs. Among DASA agencies, offering between one and three EBPs per site (39.6%) was the most frequent pattern of EBP utilization.

Figure 4a1. Utilization of EBPs by MHD and DASA

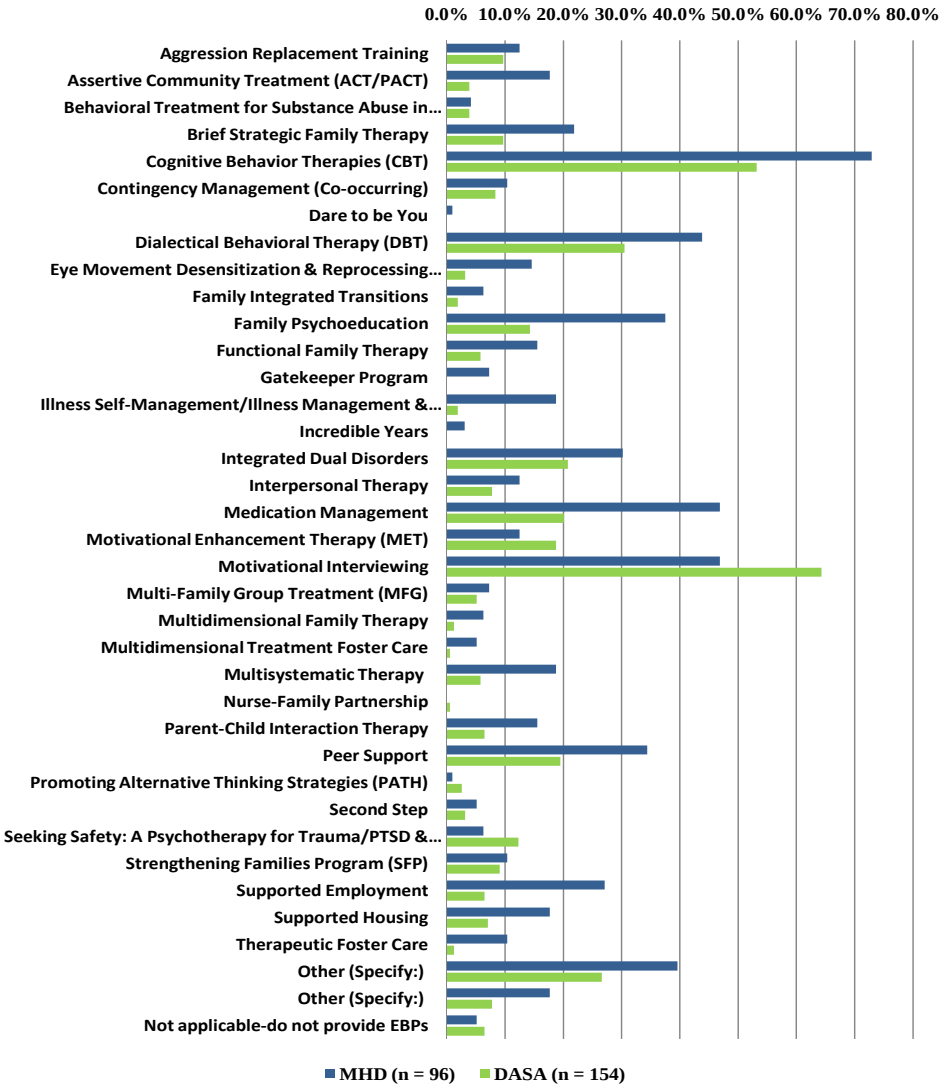


Figure 4a2. Utilization of EBPs by JRA and CA

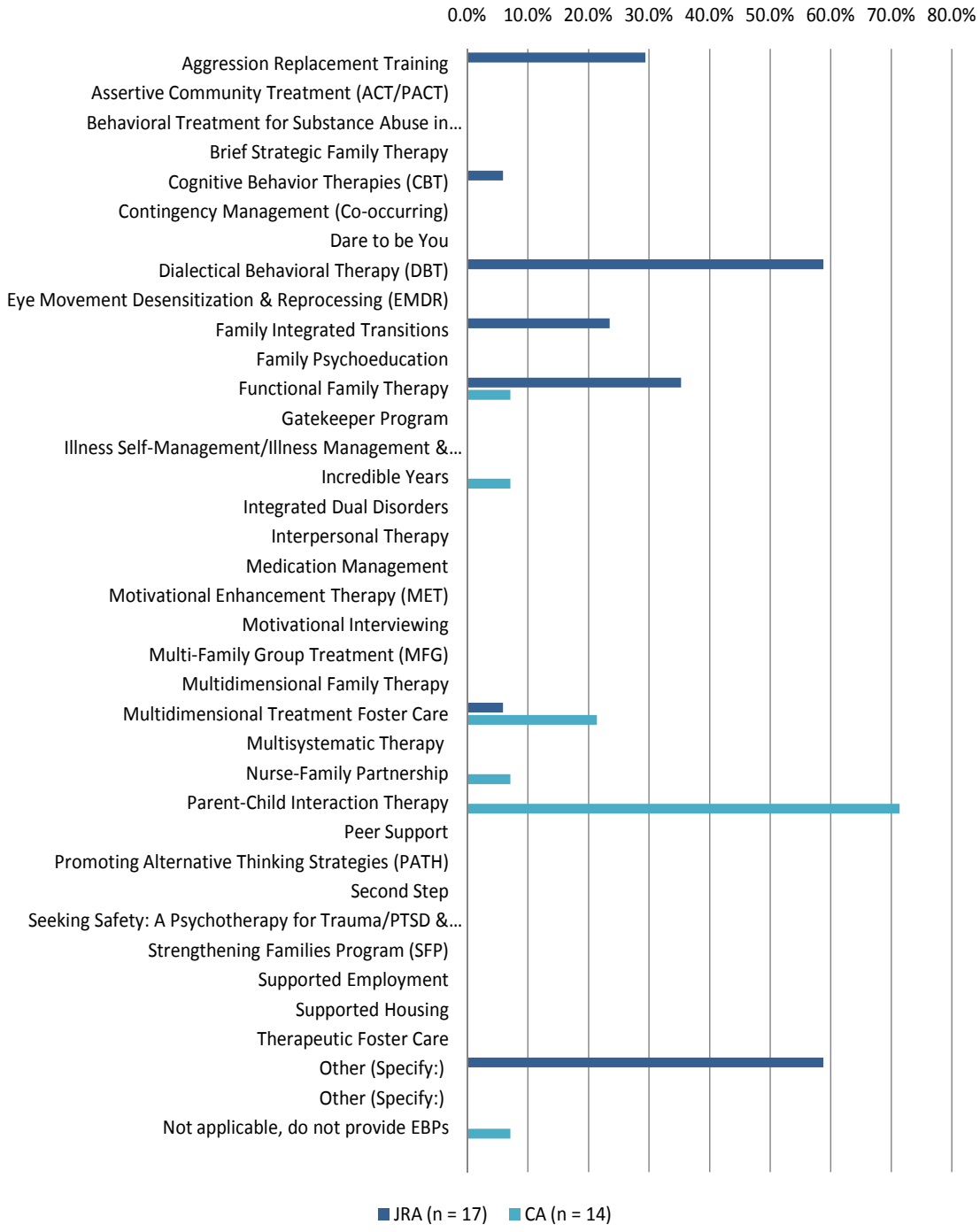


Table 3: Average Number of EBP's Offered Per Site by Agency Type

Agency Type	N	Min.	Max.	Mean
MHD	96	.00	22	6.0208
CA	14	.00	2	1.1429
JRA	17	.00	3	1.5882
DASA	154	.00	18	3.6039

Table 4: Number and Percent of EBP's Offered Per Site by Agency Type

Agency Type	# of EBPs	Percent
MHD	0	8.3
	1-3	26.0
	4-6	26.0
	7-9	16.7
	10+	22.9
	Total	100.0 (N = 96)
Children's Admin	0	7.1
	1-3	92.9
	Total	100.0 (N = 14)
JRA	0	5.9
	1-3	94.1
	Total	100.0 (N = 17)
DASA	0	20.1
	1-3	39.6
	4-6	23.4
	7-9	10.4
	10+	6.5
	Total	100.0 N = 154)
Total	0	14.6
	1-3	40.9
	4-6	21.7
	7-9	11.4
	10+	11.4
	Total	100.0 (N = 281)

Fidelity

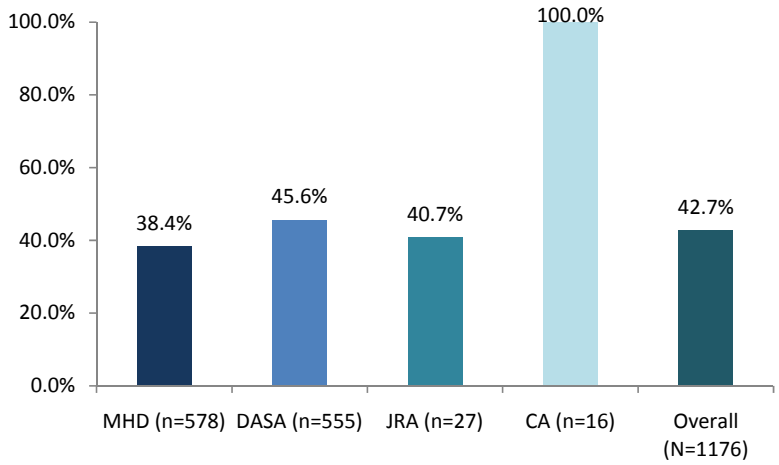
Q4b. Indicate whether program fidelity is assessed or monitored (i.e., the practice is being implemented as intended according to established guidelines and/or manuals) for those practices you are currently providing and if so, what fidelity measure or method you are using.

Fidelity refers to whether a program or practice is being implemented as intended according to established guidelines or manuals (e.g., SAMHSA Fidelity Scales). To collect this information, all respondents were asked if they monitored the fidelity of the EBPs being provided by their agency. If fidelity is being monitored, respondents were also asked to indicate which measure or method is being used. The percent of EBPs being monitored for fidelity by agency type is presented in Figure 4b below. Table Q4b in Appendix E shows the percent of EBPs being monitored for fidelity broken down by EBP.

Overall, the respondents indicated that of the EBPs that are being used, 43% are being monitored for fidelity (see Figure 4b below); however, the likelihood that an EBP is being monitored for fidelity varies by agency type. Within the Children's Administration (CA), for example, it was reported that 100% of the EBPs being provided are monitored for fidelity. MHD agencies are the least likely to monitor EBP fidelity (38%).

Appendix G shows the fidelity measures and methods being used broken down by EBP and agency type. From these tables, it appears that fidelity is being measured in a variety of ways with a range of psychometric rigor and reliability. Videotape and chart reviews, supervision, quality assurance monitoring, consultation, as well as unspecified adherence measures are commonly reported methods used to assess fidelity. For a minority of EBPs, specific measures are identified (e.g., Dartmouth Assertive Community Treatment Scale, Integrated Dual Disorders Treatment Fidelity Scale, Supported Employment Fidelity Scale). Most of the fidelity measures cited are those developed or provided by SAMHSA.

Figure 4b. EBP Fidelity



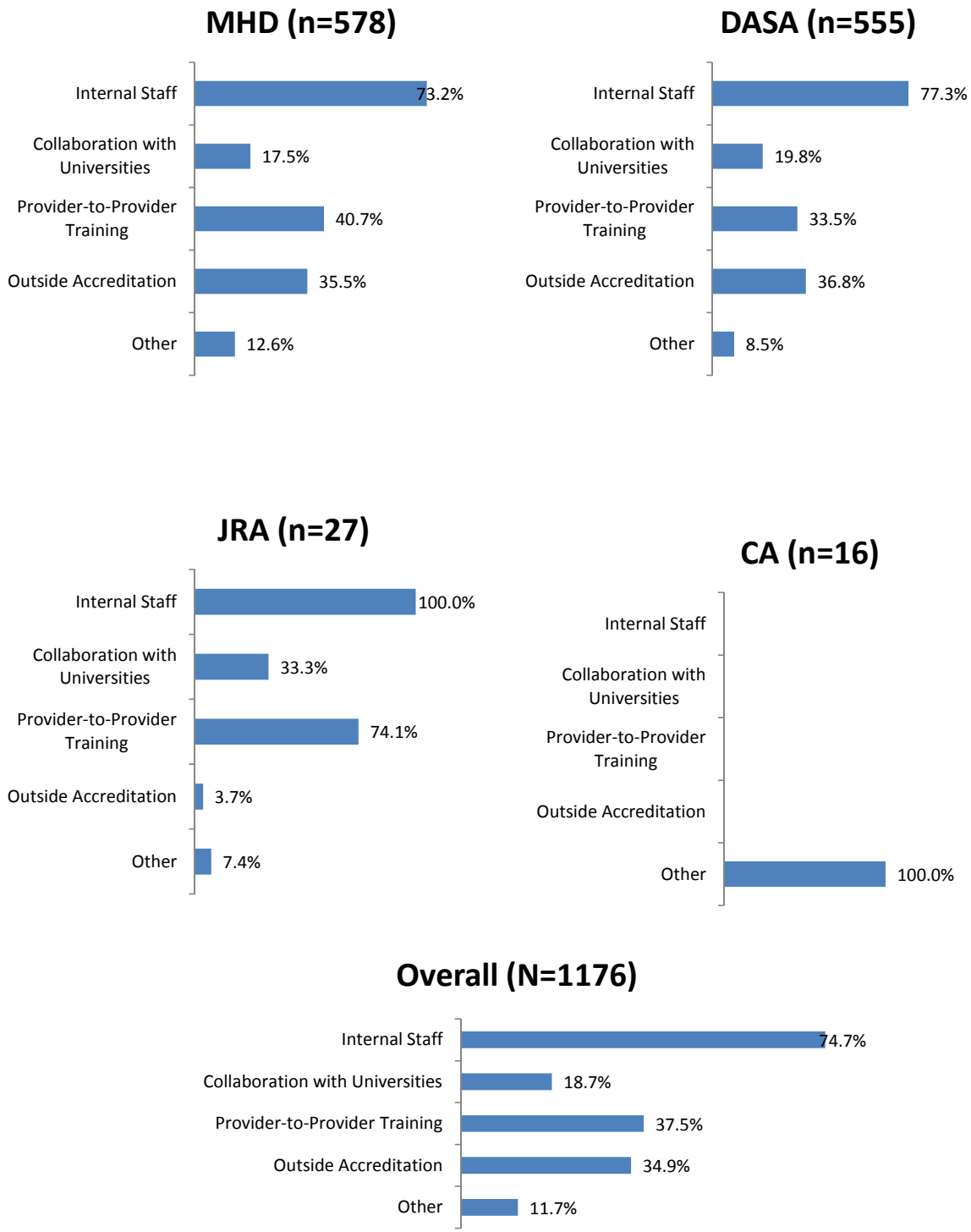
Training

Q5: For the practices your agency currently provides please indicate which mechanisms are used to provide training.

Respondents were asked to indicate how agency staff are trained to use each EBP (see Figure 5 below). Overall, the most commonly used mechanism for EBP training is internal staff, which is used for 75% of all EBPs. Provider-to-provider training (38%) is the second most common training mechanism followed by outside accreditation (35%). Of the five categories, collaboration with universities and "Other" are the least commonly used mechanisms of training.

This same overall pattern of results is evident within MHD. However, DASA agencies report a slightly higher percentage for outside accreditation (36.8%) than provider-to-provider training (33.5%). JRA and CA exhibit different patterns. JRA agencies report greater use of internal staff (100%), provider-to-provider training (81.3%) and collaboration with universities (30.2%) than any of the other agencies. In contrast, 100% of CA sample report using "Other" training (CA uses State contracted PCIT consultants as its only training mechanism (see Table Q5_Other in Appendix F). Results for individual EBPs are reported by agency and overall in Table Q5 in Appendix E.

Figure 5. Training in EBP Utilization



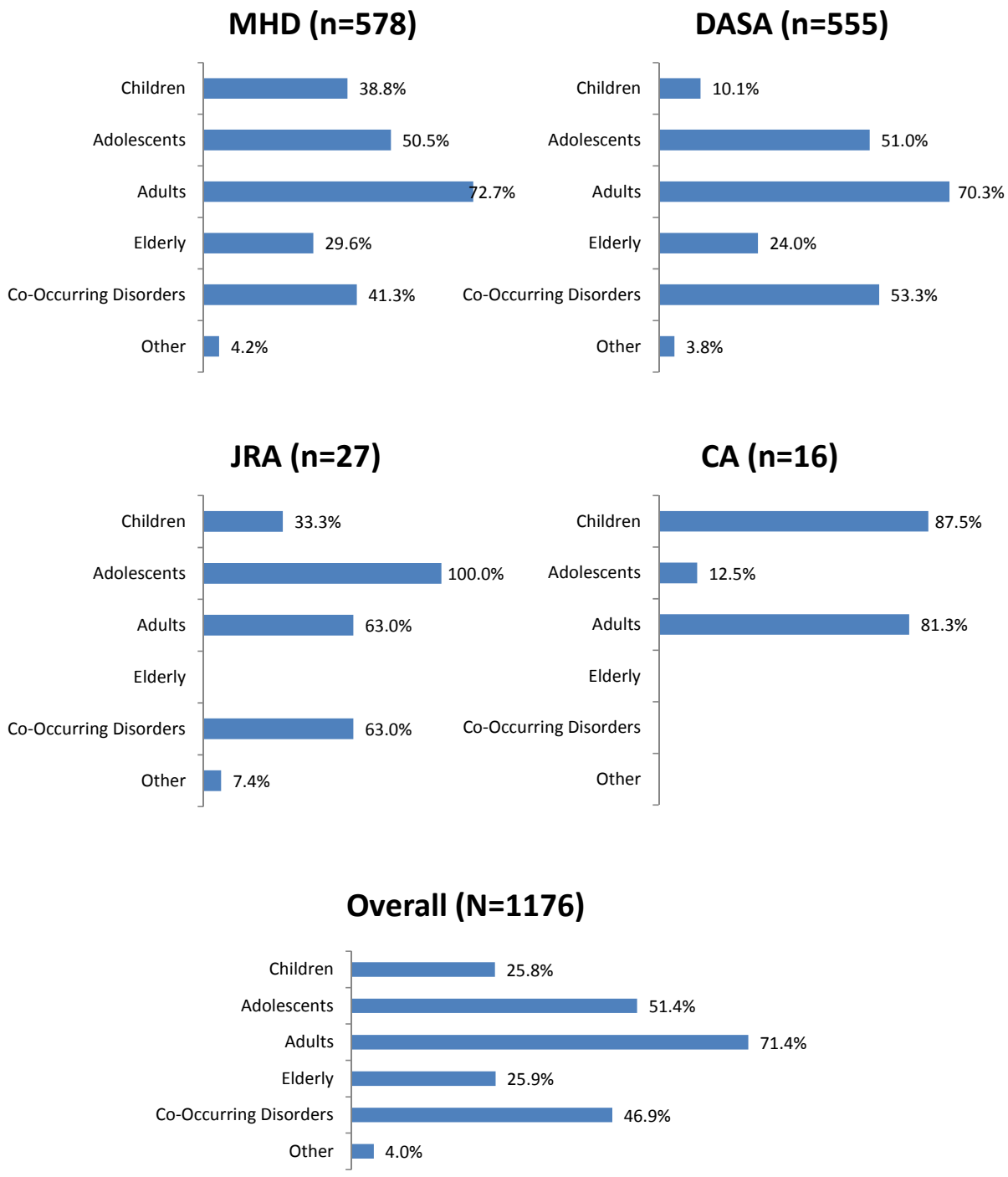
EBP Target Population

Q6: For the practices your agency currently provides please indicate which target populations you are providing the EBP.

Respondents were asked to indicate who their target populations are for each EBP being currently offered (i.e., Children, Adolescents, Adult, Elderly, Co-occurring Disorders, and Other). Figure 6 below shows that, overall, EBPs are most often used with adult (71%), adolescent (51%), and co-occurring disorder (47.0%) populations. Moreover, nearly 26% of the agencies were utilizing EBPs with children and 26% with the elderly. Only 4% of the EBPs target "Other" populations (see Appendix F). The EBPs in use by MHD and DASA mainly target adults (70% and 78% respectively). As expected, JRA and CA serve mostly adolescents and children. However, each serves a large number of adults as well (JRA-71.9%; CA-80.8%).

In addition, adolescents are targeted by half of the agencies in MHD and DASA using EBPs, but only by 13% of the CA agencies. Regarding children, 39% of the MHD and 33% of JRA agencies target these populations. Ten percent of DASA's EBPs target children. Further, the co-occurring disorders population is targeted by a larger percentage of EBPs from JRA (63%) than DASA (53%), MHD (41%), or CA (0%). Neither JRA nor CA agencies provide EBPs to the elderly. Details of targeted populations by each EBP and agency type appear in Table Q6 of Appendix E. The "Other" responses appear in Appendix F.

Figure 6. Target Populations



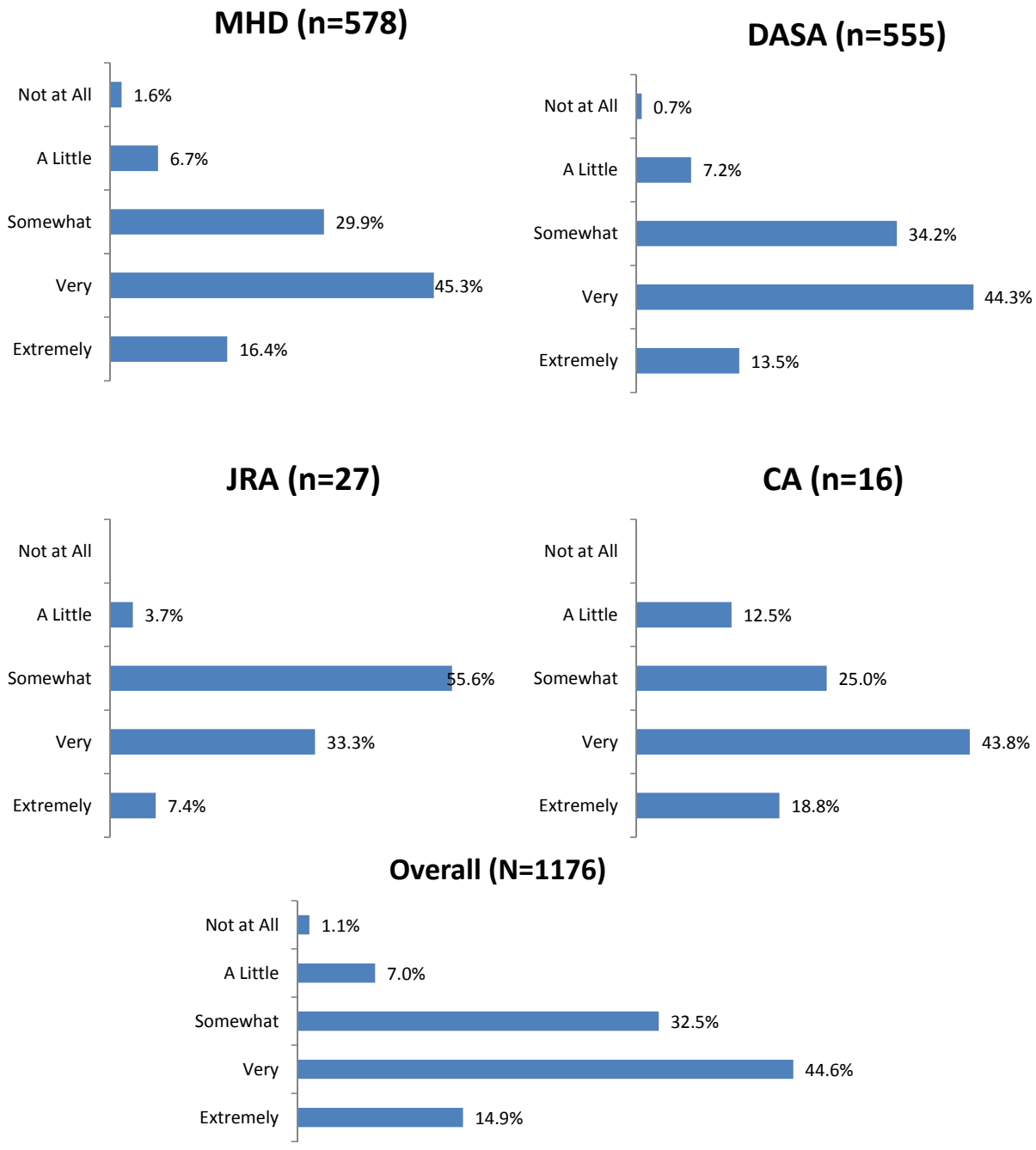
EBP Implementation Success

Q7: For the practices your agency currently provides (see question #4), please indicate how successful your agency has been in implementing the EBP(s) listed below.

Success with EBP implementation is summarized in Figure 7 below. Overall, agencies report that they are *very* or *extremely* successful in implementing 60% of the EBPs their agency offers. Agencies indicate that they are somewhat successful in implementing an additional 33% of their EBPs. Less than 10% of the EBPs have little or no success in implementation. This same pattern of results is evident among MHD, DASA, and CA. JRA reported less success in implementing EBPs than did the other agency types.

In reviewing individual EBPs, 92% of the 13 agencies using Family Integrated Transitions report that they are *very* or e*xtreme* successful in implementation. Sixty-two percent of 21 agencies using Illness Self-Management/Illness Management & Recovery reported that implementation was *very* successful. The EBP that agencies report having the least success in implementing is Multi-Family Group Treatment (MFG). Forty percent of 15 agencies report little or no success in implementing this EBP. Additional results about individual EBPs can be found in Table Q7 in Appendix E.

Figure 7. EBP Implementation Success

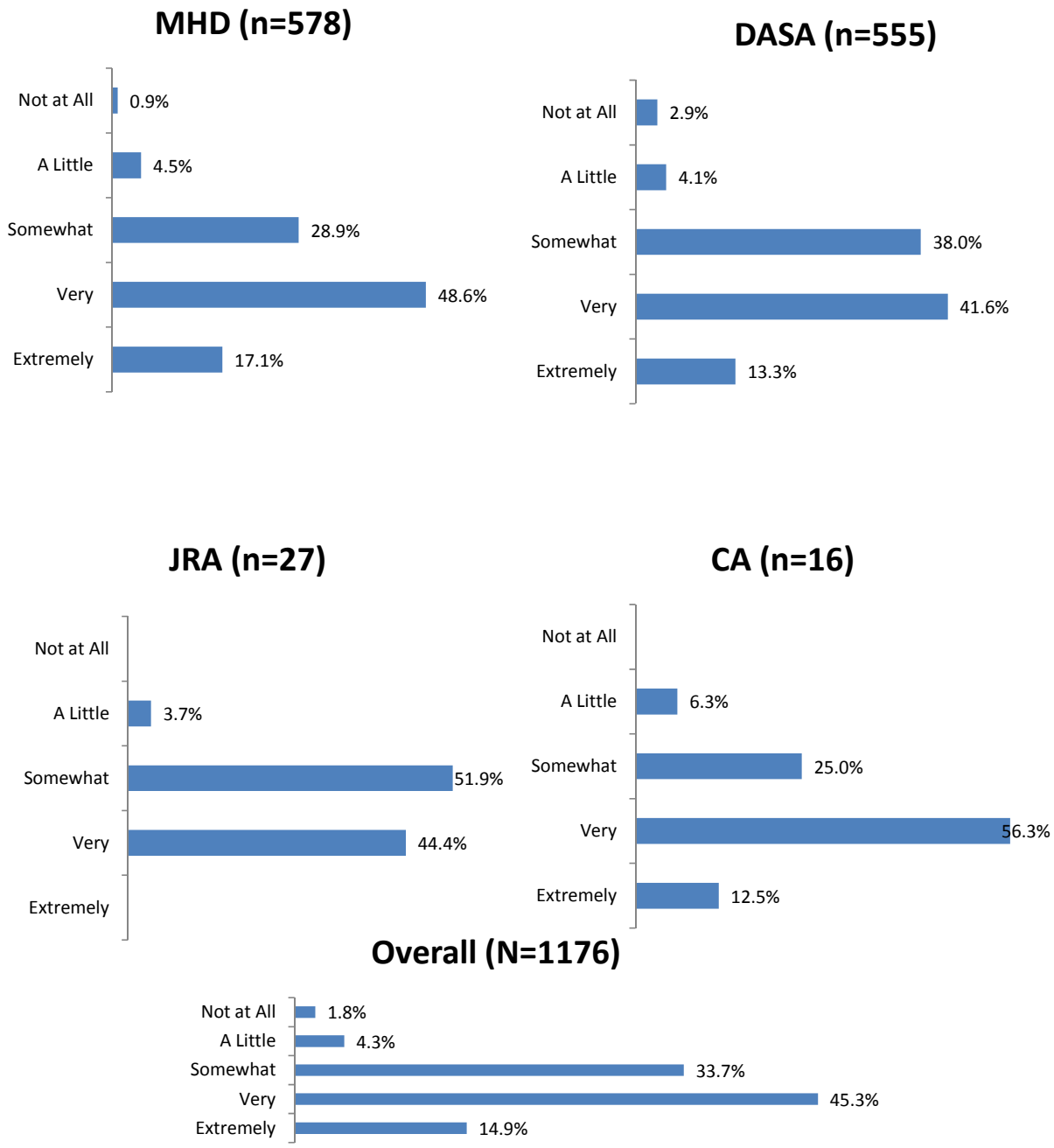


Effectiveness of EBPs

Q8: For the practices your agency currently provides, how effective do you think the EBP is at producing positive client outcomes?

Figure 8 below shows respondent ratings of EBP effectiveness by agency type. Overall, more than half of the respondents indicate that EBPs provided by their agency are "Very" (45.3%) or "Extremely" (14.9%) effective at producing positive client outcomes. This overall pattern of response is also observed across three of the four agency types (i.e., MHD, DASA, CA). The exception is JRA. JRA indicates lower effectiveness overall, with the majority of respondents indicating the EBPs they provide are only "Somewhat" effective (51.9%). Table Q8 in Appendix E shows the ratings of effectiveness for each EBP broken down by agency type.

Figure 8. Effectiveness of EBPs



Future EBP Utilization

Q9: Are there any EBP's that you are NOT currently using but want to use in the future?

Respondents were asked to indicate whether there are EBPs their agency does not currently use but would like to provide in the future. Answers to this question by agency type are presented in Figure 9a and Figure 9b below.

Over three-fourths of the respondents from DASA (81.2 %) and MHD (84.4 %) indicate that they want to implement new EBPs in the future. Illness Self-Management & Recovery (19.8%) and Motivational Interviewing (19.8%) are the most frequently cited EBPs among the MHD respondents, whereas Brief Strategic Family Therapy (13.6%) and Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse (13.6 %) are the most frequently indicated EBPs among the DASA respondent sample.

When asked to select "any EBPS that you are NOT currently using but want to use in the future", "None" was identified by CA agencies 85.7% of the time and by JRA agencies 24% of the time. JRA most frequently cite Aggression Replacement Training (41.2%) and Dialectical Behavior Therapy (35.3%) as the EBPs they want to use in the future. The difference in responses among the four agency types was of concern to administrators of these agencies. One of the agency administrators offered the following explanation for this difference:

> "Participating DSHS Departments, Children's Administration, Juvenile Rehabilitation Administration and Division of Alcohol and Substance Abuse responded to the EBP survey questionnaire. Their responses reflect that individual efforts in implementing Evidenced Based Programs that provide services for the clients they serve. The answers did not address the cross system need that supports the MHD in developing more EBP infrastructure so that other clients (DSHS or not) and common clients may access EBP services earlier and potentially not progress to requiring the services of the responding agencies."[11]

[11] Children's Administration TWG representative Barbara Putnam, personal communication with MHTG Project Director Ken Stark, January 28, 2008.

Figure 9a. Future EBP Utilization by MHD and DASA Agencies

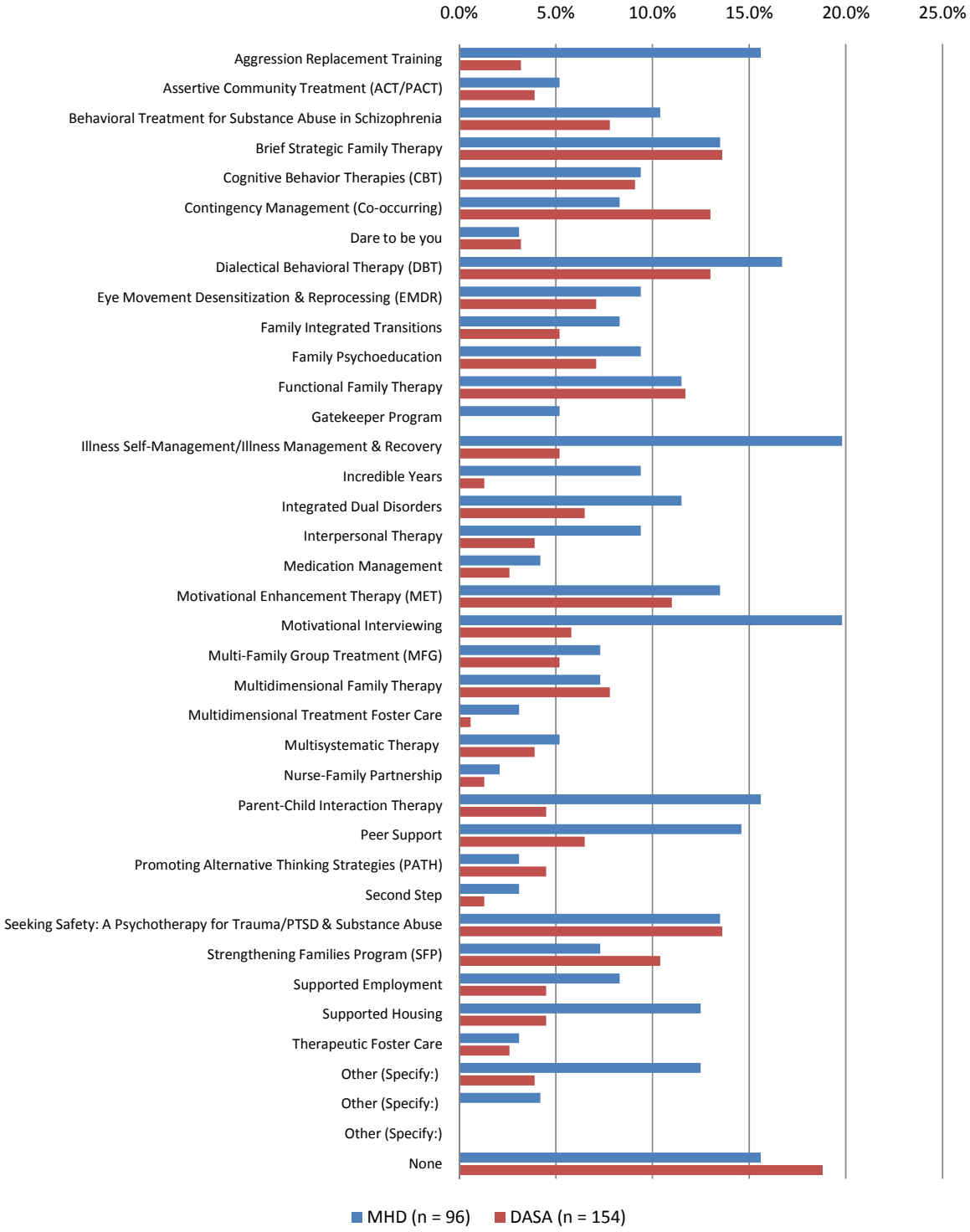
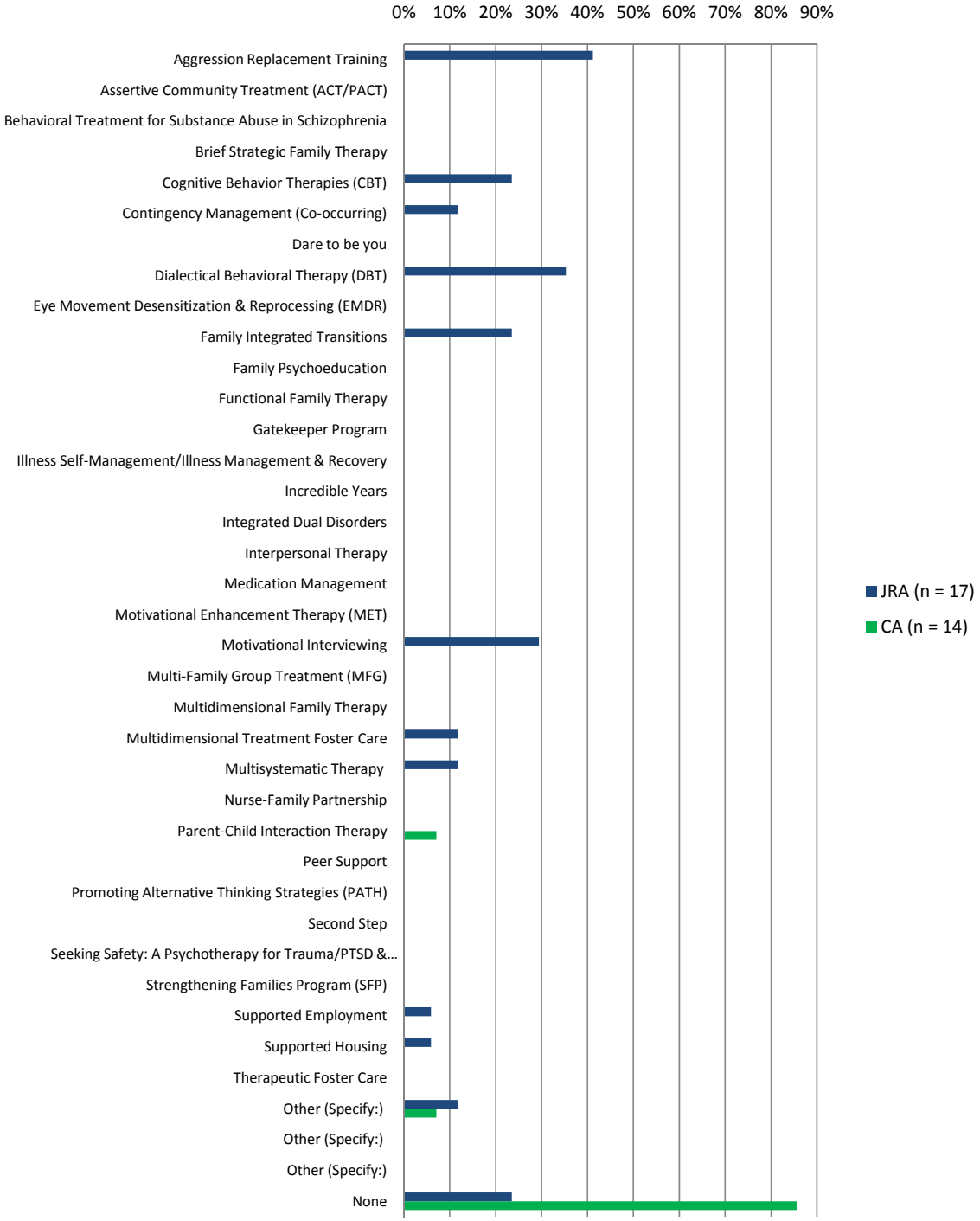


Figure 9b. Future EBP Utilization by JRA and CA Agencies



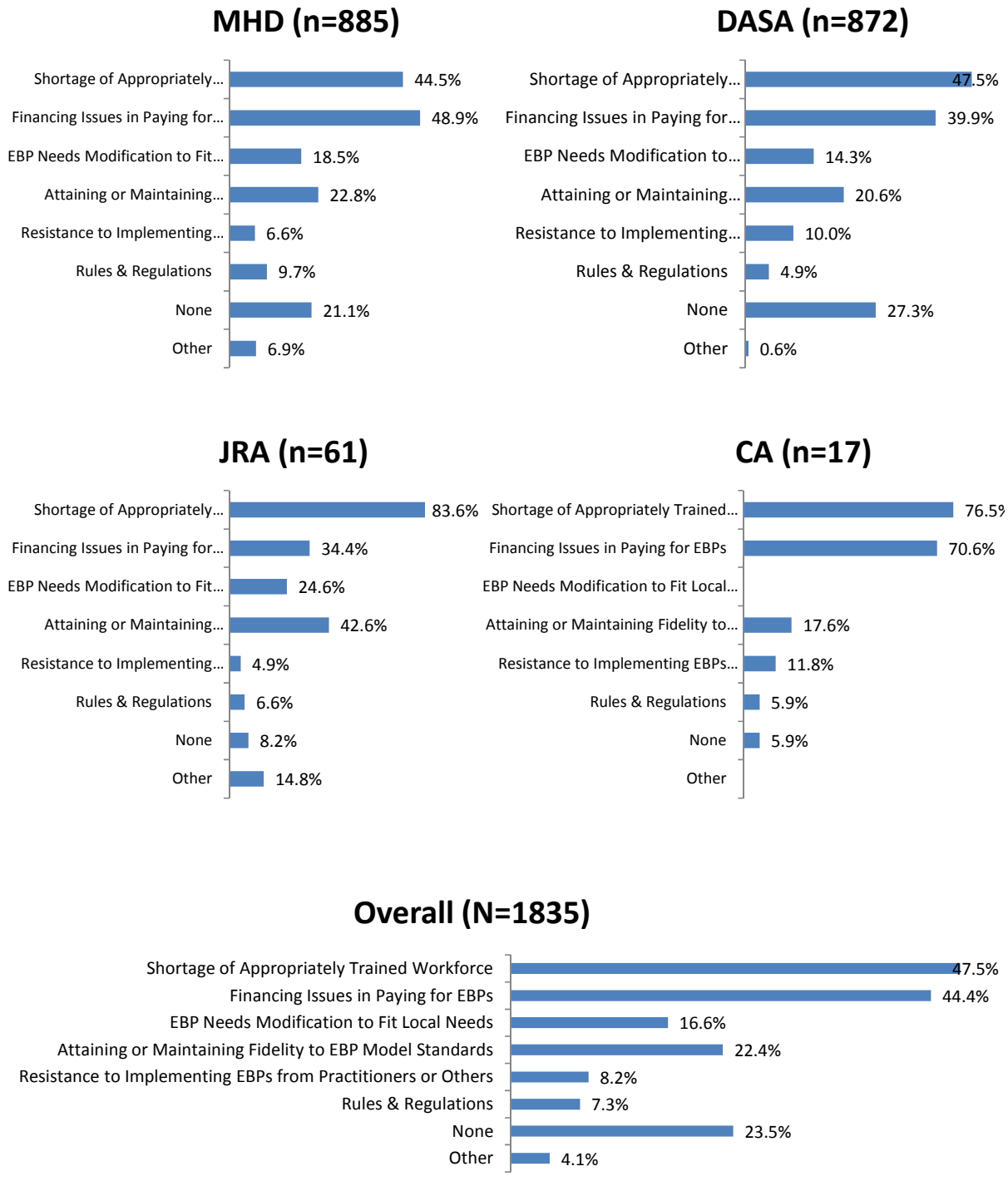
Barriers

Q10: Please indicate whether any of the barriers listed below interfere with your agency in providing EBPs you are using or want to use?

Respondents were asked to indicate which barriers were interfering with each EBP's implementation or utilization. These data are summarized in Figure 10 below. Overall, a "Shortage of an Appropriately Trained Workforce" (47.5%) is the most frequently cited barrier interfering with EBP implementation, followed by "Financing Issues in Paying for EBPs" (44.4%). This same pattern is seen across three of the four agency types (DASA, JRA, and CA). For mental health agencies, "Financing Issues in Paying for EBPs" (48.9%) is the most commonly cited barrier, followed by "Shortage of an Appropriately Trained Workforce" (44.5%).

Barriers to EBP implementation broken down by each EBP and agency type are presented in Table Q10 in Appendix E. "Other" barriers identified for each EBP appear in Appendix F, Table Q_10.

Figure 10. Barriers



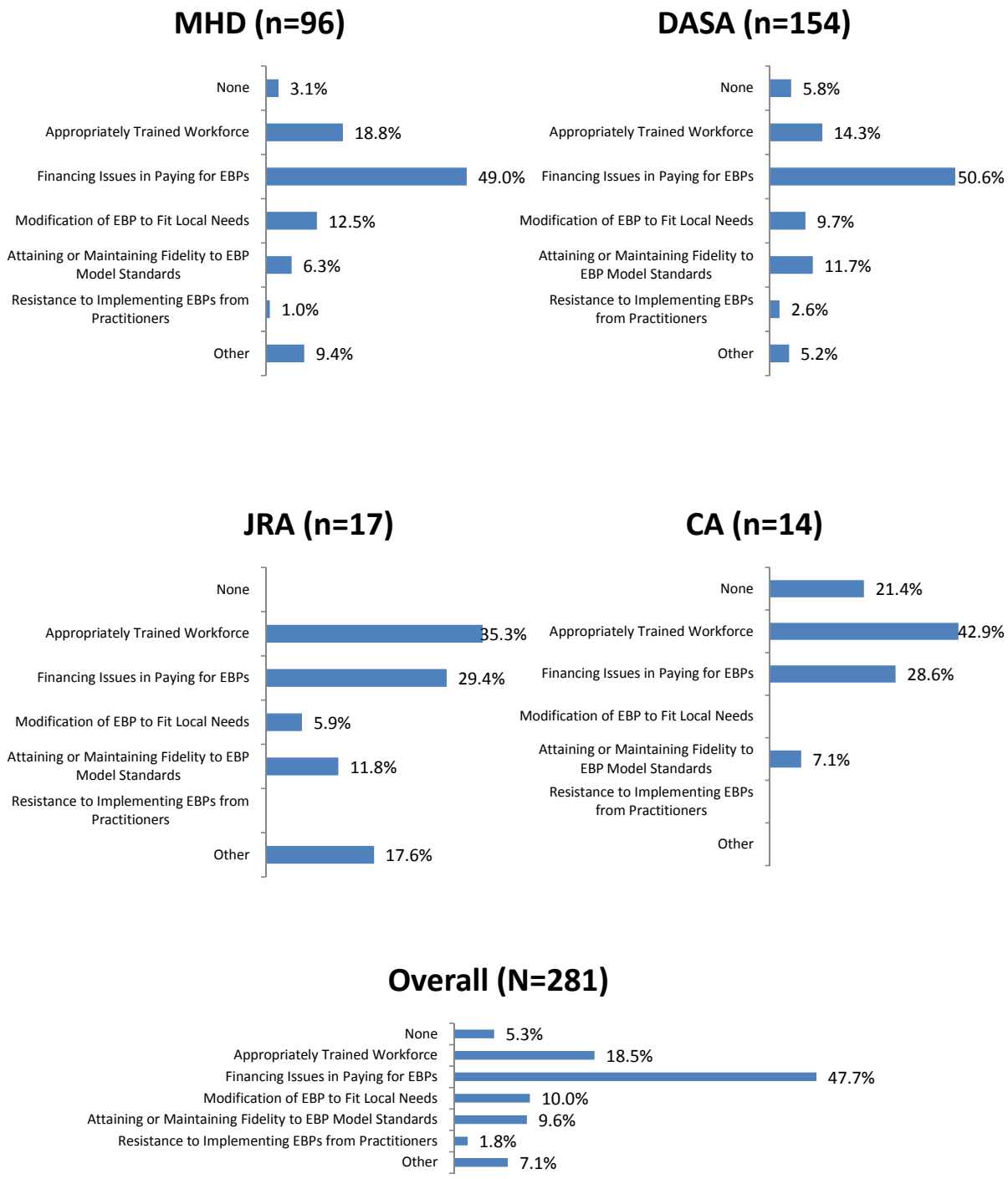
Most Needed Assistance in Adopting EBPs

Q11: What type of assistance is most needed by your agency to help facilitate the adoption and implementation of evidence based practices?

The type of assistance that is most needed to facilitate the adoption and implementation of EBPs by agencies is displayed in Figure 11. Almost half of the agencies report that financial assistance would be most helpful for adopting and implementing EBPs. However, nearly 20% of the agencies disagree and report that appropriately trained workforce would be most beneficial to them in implementing EBPs. Only a small percentage of agencies (5.3%) indicate that no additional assistance is needed to facilitate their use of EBPs.

Within each agency type, both MHD and DASA agencies report financing issues as the most needed assistance, while both JRA and CA agencies report appropriately trained workforce as most necessary overall. Furthermore, resistance from practitioners did not seem to be a major issue, as neither JRA nor CA report so and only a small amount of MHD (1.0%) and DASA (2.6%) agencies indicate such. Assistance most needed by agencies in adopting/implementing EBPs broken down by agency type is presented in Table Q11 in Appendix E. "Other" needed assistance is reported in Table Q11_Other in Appendix F.

Figure 11. Most Needed Assistance to Adopt EBPs



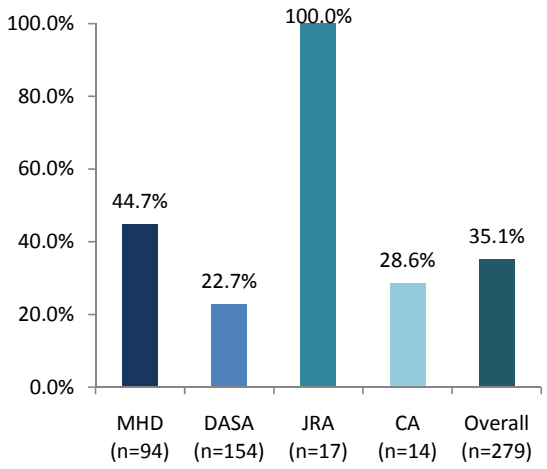
Populations Served by No Known EBPs

Q12: Does your agency serve populations or address specific client needs for which there are no known or available evidence-based practices?

Respondents were asked if their agencies served populations or addressed specific client needs for which there are no known or available evidence-based practices. These data are summarized in Figure 12a. More than one-third of the agencies overall report that they serve clients whose needs are not met by currently available EBPs. JRA report that all (100%) of their agencies serve populations that have needs outside the scope of the available EBPs. Overall, DASA (23%) and CA (29%) agencies both report lower percentages than MHD (45%) or JRA agencies.

Appendix F, Table Q12b shows the populations that agencies in each agency type identified as not having any known EBPs. For MHD and DASA minority populations are the most frequently identified, in JRA it is youth with sex offenses and cognitive impairment, and in CA it is clients with co-occurring issues and parents referred for neglected children.

Figure 12a. Populations Served by No Known EBP



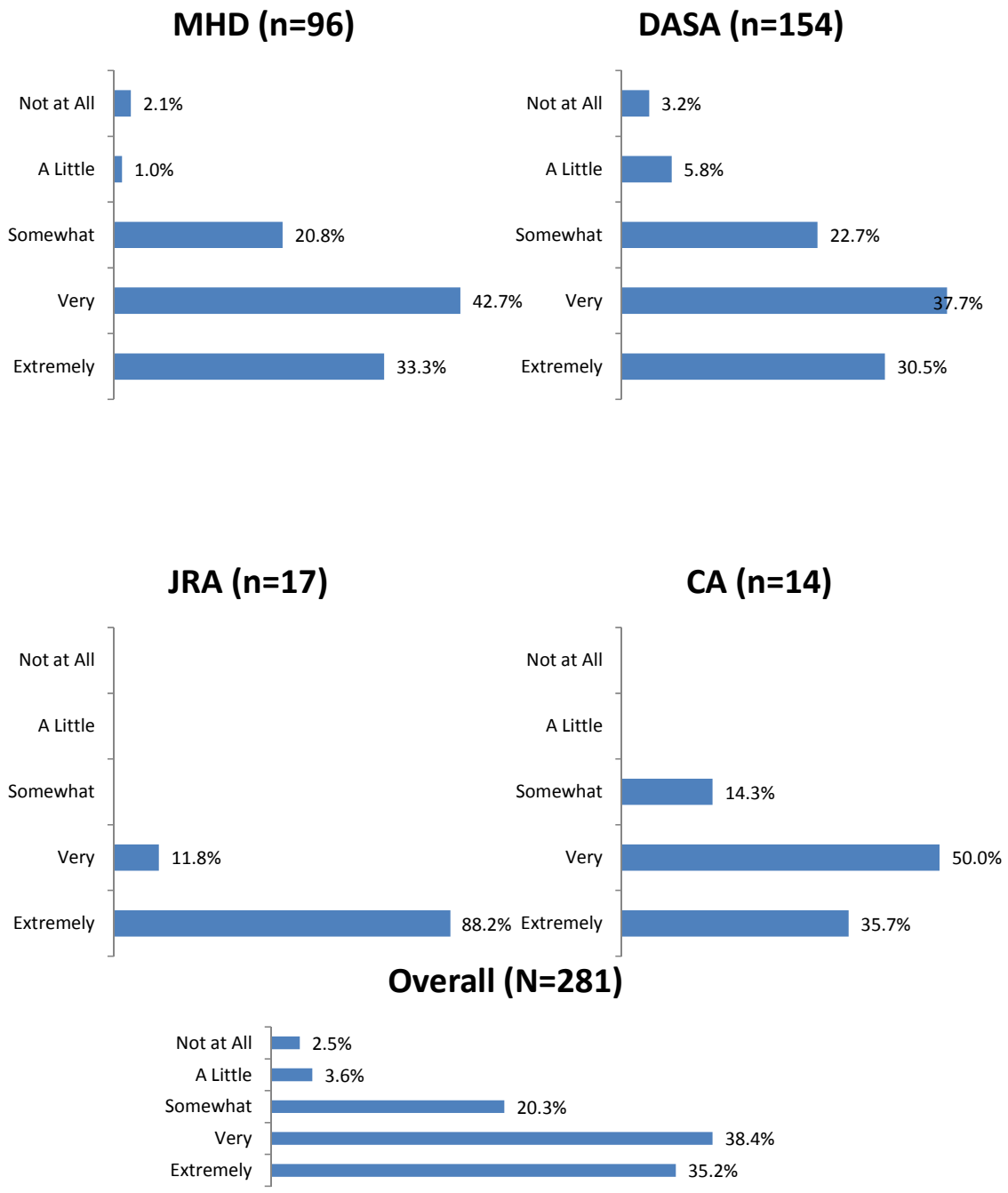
Interest in EBP Implementation

Q13: Please rate your agency's interest in continuing/beginning to implement EBPs into your treatment program.

Ratings of interest in continuing/beginning to implement EBPs into one's treatment program are provided in Figure 13. Overall, most agencies are either *very* interested (38.4%) or *extremely* interested (35.2%) in the continuing or beginning to use EBPs. Twenty percent are *somewhat* interested, while only six percent had little or were not at all interested in using EBPs within their treatment programs.

This same overall pattern of interest was evident within DASA and MHD agencies. However, in DASA compared to MHD and the other agency types, a slightly larger percentage report little or no interest in implementing EBPs (9%). JRA agencies report the greatest amount of interest in the continuation of EBPs. All of JRA's agencies report that they are either extremely or very interested in using EBPs in their treatment program.

Figure 13. Interest in EBP Implementation



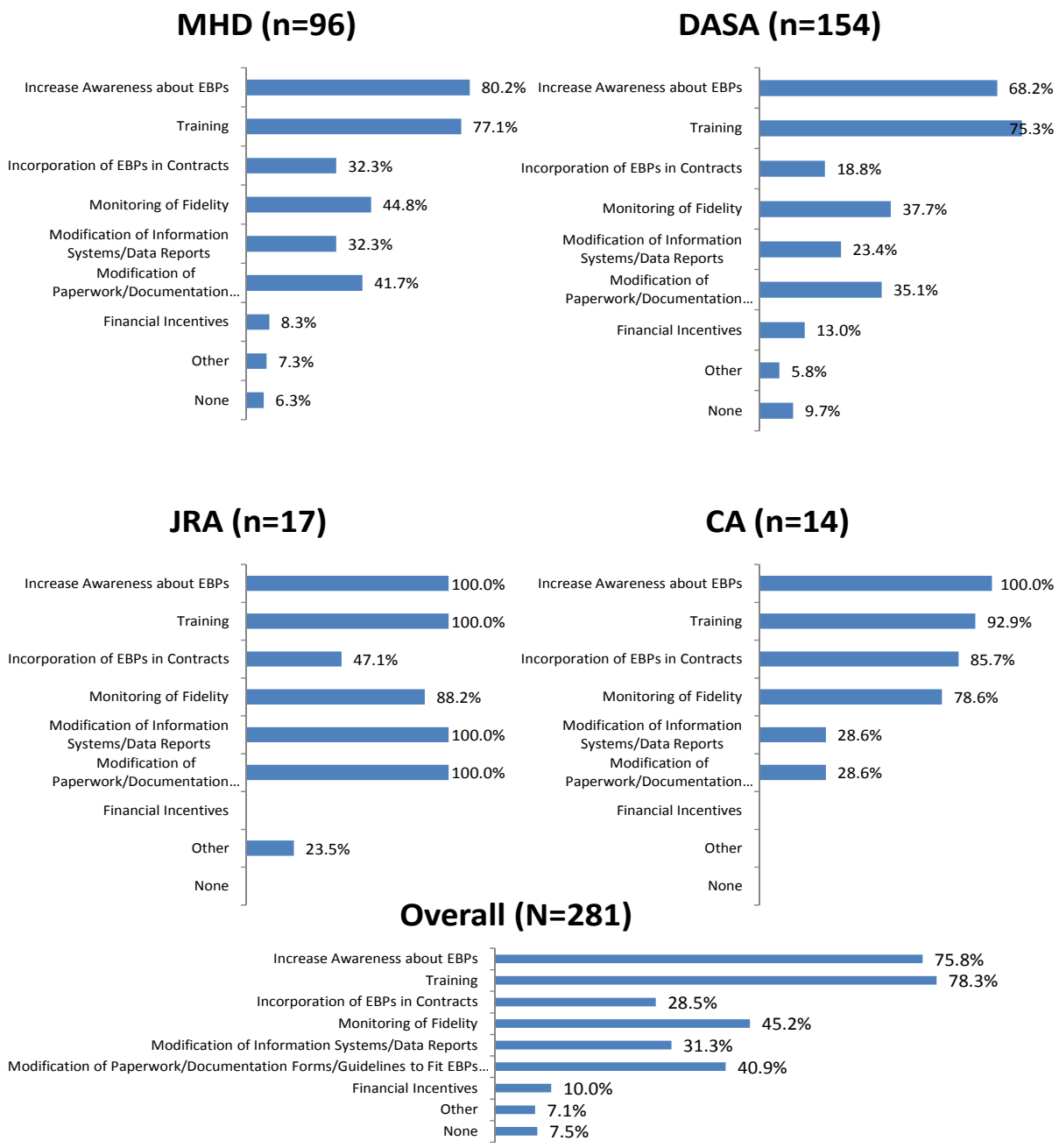
Initiatives to Promote EBPs

Q14: What initiatives, if any, is your agency implementing to promote the adoption of evidence-based practices (EBPs)?

Respondents were asked to indicate which initiatives they are using to promote EBPs (see Figure 14 below). Over 90% of the agencies state that they are implementing some type of initiatives to promote the adoption of EBPs. Seventy-six percent indicate that they are promoting increased awareness about EBPs. In addition, 76% are implementing training for this purpose. Fidelity monitoring (45.2%), modification of documentation forms (40.9%), and financial incentives (10%) are also initiatives receiving support by agencies.

For the individual agency types, the patterns in MHD and DASA are very similar. All of the JRA agencies are incorporating increasing awareness, training, modification of data reports, and modification of documentation forms as initiatives. Neither JRA nor CA says that they use financial incentives to promote the use of EBPs.

Figure 14. Initiatives to Promote EBPs



Systematic Assessment of Effects of EBPs

Q15: Is your agency conducting any systematic assessment of the effects of the evidence-based interventions that you are using?

Respondents were asked whether any systematic assessments of the effects of EBPs are being conducted within their agencies. If respondents conduct such assessments, they were then asked to identify the type of assessment being used. Of the 281 agencies surveyed, 107 (38%) reported that they conduct systematic assessment(s) of the effects of evidence-based interventions (Figure 15). Of these 107 agencies, 83% use outcome monitoring, 79% use program evaluation, 28% used Benchmarking and only 3% identified some other method. This same pattern of results is evident among MHD, DASA and CA agencies. All of the JRA agencies report using program evaluation to assess their EBPs' effects.

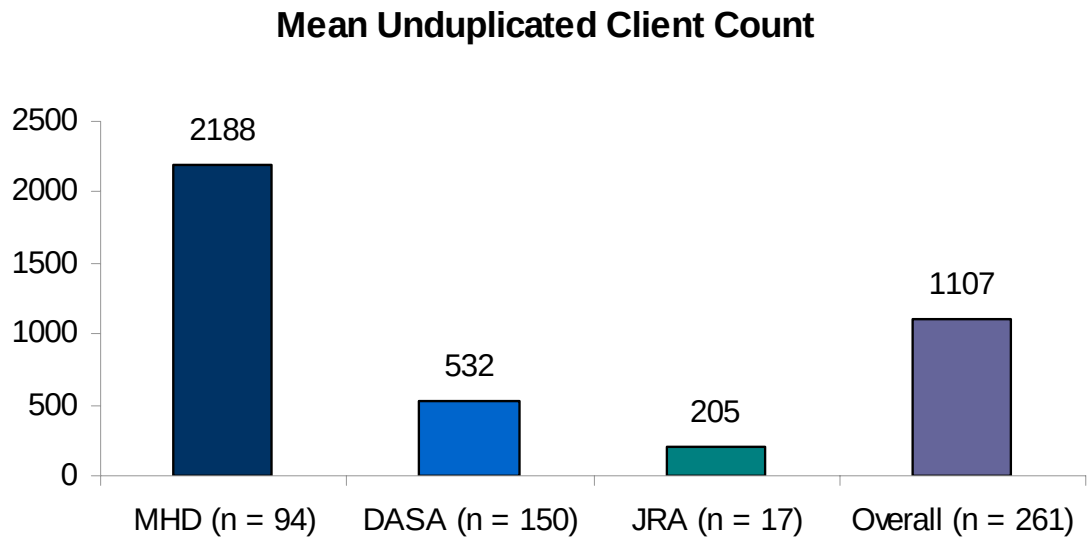
Figure 15. Systematic Assessment of Effects of EBPs

Annual Client Counts

Q16: How many unduplicated clients did your agency serve in Fiscal Year 2007 (July 1, 2006 – June 30, 2007)?

Respondents were asked to provide the unduplicated client count for the Fiscal Year 2006. These data are provided in Figure 16. The overall mean or average of unduplicated client counts was 1107. The highest average client count resulted from MHD (2188), followed by DASA (532), and JRA (205). Annual client counts in FY2007 were not available for CA agencies and are not reported in Figure 16.

Figure 16. Annual Client Count



* Client counts for Fiscal Year 2007 could not be obtained from CA Agencies and are not included in this figure.

Client Counts by EBP

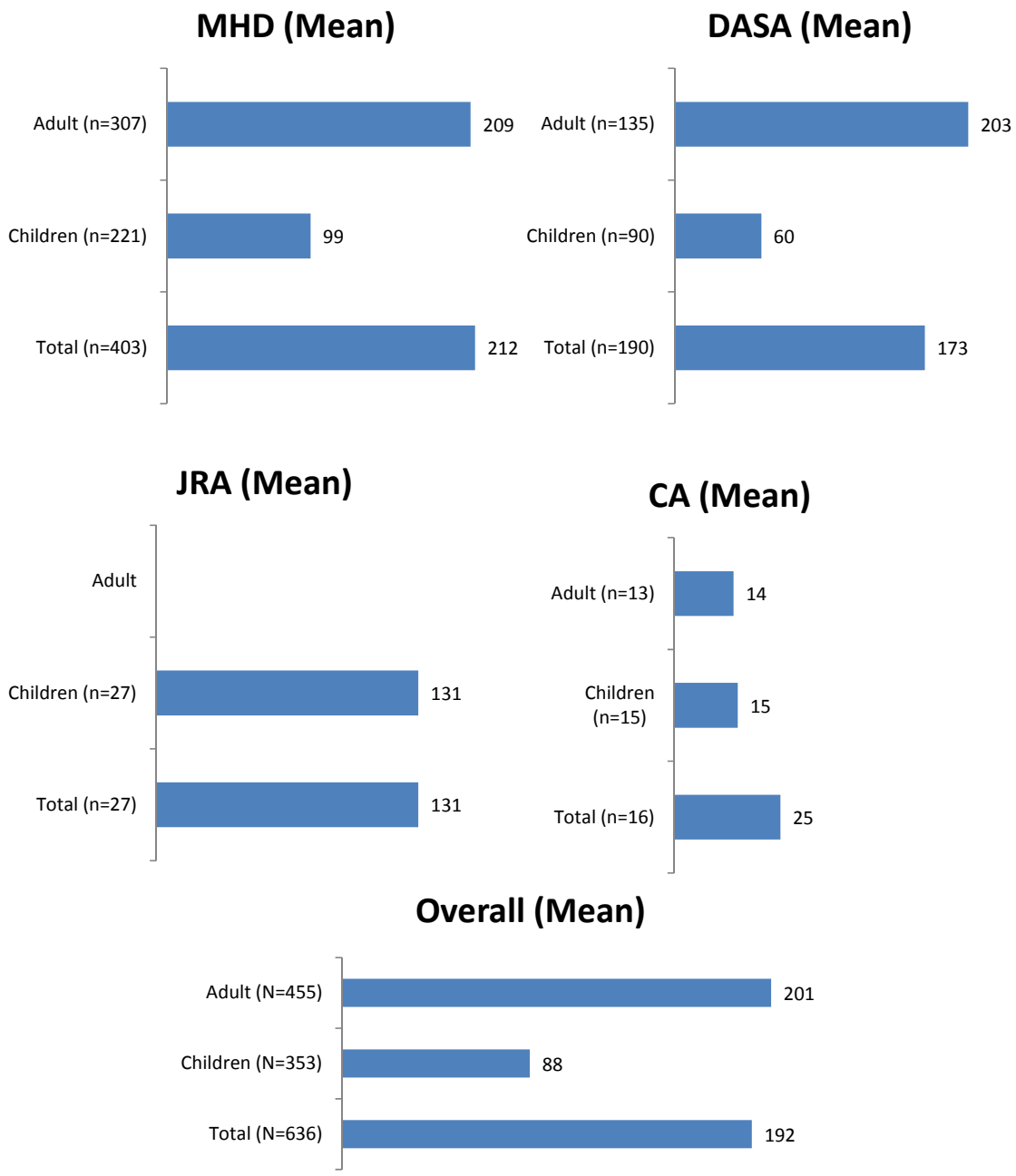
Q17: For each EBP that you are currently providing, please provide the total number of unduplicated clients served in FY 2007 (July 1, 2006 – June 30, 2007). Also provide the number of adults and number of children who received each practice.

The overall children, adult, and total average client counts for each EBP offered by each agency (EBP/agency count) for Fiscal Year 2006 are provided in Figure 17. The individual EBPs *by* agency average client counts appear in Tables Q17a, Q17b, and Q17c in Appendix E. The N sizes in the figure below show the total average client counts that appear in the "column totals" in Tables Q17a, Q17b, and Q17c in Appendix E. The N sizes may be thought of as a total of "EBP/Agency" counts since they reflect the total number EBPs offered by all agencies. Since one agency can offer more than one EBP the N size is larger than the total number of agencies. For instance, a single agency that offers 7 EBPs would have an EBP/Agency count of 7; 96 agencies that each offers 7 EBPs would have a total EBP/Agency count of 672 (7 x 96).

Figure 17 shows that the total EBP/Agency count is 636, for agencies that serve children it is 353 and for those that serve adults it is 455. Hence, the 34 EBPs were offered 636 times across 281 agencies in 2007. On average, 192 clients receive each of the 636 EBP/agency units. Based upon our sample the total number of clients receiving EBPs is approximately 122,112 (636 X 192) as reported by the surveyed agencies; for children it is 31,064 and Adults it is 91,455. The total count does not exactly reconcile with the addition of the adult and child counts because some agencies may use the same EBP for adults and children.

According to Table Q17a, the highest number of clients served per EBP is as follows: Cognitive Behavior Therapy (29,623), Medication Management (18,849), Motivational Interviewing (17,205) Peer Support (8485), Family Psychoeducation (7209), and Dialectical Behavioral Therapy (7709).

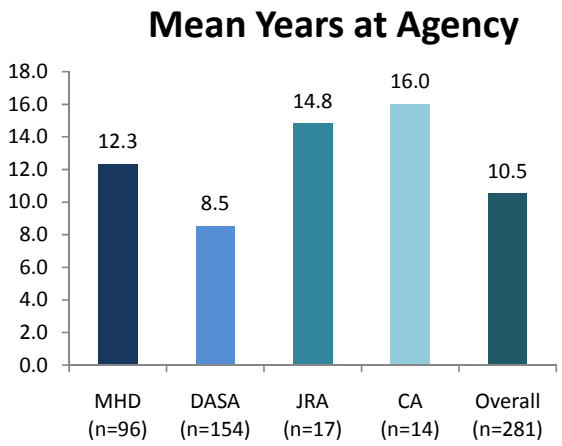
Figure 17. Client Counts by EBP



Respondent Average Number of Years at Agency

The average number of years that the survey respondent had worked at his or her agency is summarized in Figure 18. These data revealed that survey respondents worked an average of 10.5 years at their agencies, overall. CA averaged the highest number of years (16 years), followed by JRA respondents who averaged 14.8 years. MHD respondents worked an average of 12.3 years, while DASA averaged the fewest number of years at work with 8.5 years overall.

Figure 18. Respondent Average Number of Years at Agency



APPENDIX A

Transformation Granted States and Evidence-Based Practices

Compiled February 2007

Transformation Granted States and Evidence-Based Practices
February 2007

State	Priorities	Evaluation	EBP Work Plan	Evidence-Based Practices
Connecticut [i,ii,iii]	Has transformation plan in place based on recommendations made from gathering data from various sources described under evaluation. The State used the New Freedom Commission goals and a template adapted from the Ohio Department of Mental Health Needs Assessment and Inventory of Resources to organize the information they had gathered in order to prioritize recommendation for transformation work. Recommendations include: 1. Expand upon suicide prevention guidelines by the Department of Education. 2. Develop, implement and provide incentives to programs to adopt a	*Connecticut Citizens Phone Survey* (prevalence of mental health symptoms, severity, seeking help, consumer satisfaction, recommendations for transformation, N= 557) *Dept. of Mental Health and Addiction Services Agency Recovery Self-Assessment* (assesses if provider meets criteria important to a recovery-oriented system, distributed to directors of DMHAS funded agencies, N=114) *Elements of Recovery Facilitating System* (measuring the progress of local systems as they shift toward recovery in line with transformation goals and public policies) *Department of Children and Families: Mental Health Transformation Survey*	It is stated in the Mental Health Plan that it will support services that are recovery and resilience oriented, culturally responsive and evidenced based. Evidence-based practices are cited in the plan as: in the juvenile and State entities that serve children and youth criminal and justice systems continue to adopt evidence-based practices and early interventions that eliminate racial, ethnic and gender disparities (The Department of Correction provides comprehensive health care to the offender population that meets a community standard of care, and includes medical, mental	Individual work groups are exploring evidence-based practices based on the scope of the work group. For example one group is focused on suicide prevention in schools and is examining EBP in this area.

	recovery oriented performance measures system, including a universal satisfaction survey for children and adults. 3. Develop an integrated information system across agencies. 4. Increase timely access to services by maximizing Medicaid funding and other financially related policies. 5. Prevent or minimize further criminal justice involvement by creating systemic and policy changes. 6. Develop a consumer/family/provider-friendly resource information system. 7. Train mental health workforce and other health and human service personnel. 8. Protect and enhance the rights of persons with mental illness.	(a self-reported survey that seeks input from parents and providers throughout CT on how the form and function of the state's mental health system could be improved)	health, dental, addiction and ancillary services, in compliance with applicable state and federal laws and consent decrees. This spectrum of health care is carried out through a partnership the Department has established with the services of the University of Connecticut, Correctional Managed Health Care). advance evidence-based practices using dissemination and demonstration projects, and create a public-private partnership to guide their implementation providers must receive appropriate training and agencies or systems need to support evidence-based practices in order to achieve positive results Reference to specific evidence-based practices, implementation, and fidelity were not found in the plan.	

State	Priorities	Evaluation	EBP Work Plan	Evidence-Based Practices
Hawaii [iv,v]	Transformation work is in the beginning stages. Transformation grant was given by SAMSHA September 2006. <u>AMHD Guiding Principles</u>: The following guiding principles apply to persons with SPMI who also have: • Co-occurring medical conditions • Substance use disorders • Homelessness • Mental retardation • Involuntary civil or penal commitment status. 1.Informed Self Directed Recovery is the foundation on which all mental health services are provided. 2.All mental health services are based on the individual's needs, strengths and desires. 3.Empathic and hope instilling relationships are an essential	During FY 2006, in addition to the Center for Mental Health Services (CMHS) National Outcome Measures and the State Selected Outcome Measures (Consumer Survey including MHSIP items), the AMHD and CAMHD activities and initiatives will focus on continuing to transform the mental health system of care consistent with the President's New Freedom Commission goals.	As a step toward further improvement of treatment of services, CAMHD convened the Task Force for Empirical Basis to Services in 1999. In August 2002, the Task Force became a standing committee known as the CAMHD Evidence Based Services Committee (EBS Committee) The overarching goals continue to be to broaden and update the summary of scientific information regarding effective interventions for youth with behavioral and emotional needs used to guide decisions about care. The EBS Committee publishes reports on effective, evidence based interventions on a biennial basis. These reports are made available to the public on the Department of Health website.	Specific EBP's regarding AMHD and CAMHD can be found on the state's website and under the Evidence-Based Services Committee Examples include: Illness management: Recovery Family psycho-education Assertive community treatment Integrated services for adults with co-occuring mental illness and substance abuse Medication management Supported employment

	component of all services. 4.The major goal of services is a safe and decent place to live, meaningful relationships and activities. 5.Consumers are an integral component of the service system design throughout AMHD. 6.Everyone is mindful, respectfully inquires, and makes adjustments to behave in a culturally informed, sensitive and responsive manner. 7.Services are provided that is in the least restrictive, most integrated community settings, which are warm, welcoming, and respectful of consumers. 8.Service standards are based on professional, national standards and Evidence Based Practices. 9.Significant others are involved and supported to maintain relationships that are critical for healthy community living. CAMHD The seven priority areas that are currently guiding CAMHD and its provider agencies in our		http://www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html	

	agencies in our service to Hawaii's children and youth and their families are: • Decrease stigma and increase access to care • Implement and monitor effectiveness of a comprehensive resource management program • Implement a publicly accountable performance management program • Implement and monitor a comprehensive practice development program • Implement and monitor a strategic personnel management plan • Implement and monitor a strategic financial plan • Implement and monitor a strategic information technology program			
State	**Priorities**	**Evaluation**	**EBP Work Plan**	**Evidence-Based Practices**
Maryland [vi,vii]	A transformation work group (TWG) was formed as part of the MHS SIG. It includes various state agencies as well as consumer and family member groups. The Mental Hygiene Administration has collaborative working relationships and service	It appears that evaluation work is being conducted regarding the integration of evidence-based practices. The extent of this needs further exploration.	Maryland partially funded the National Wraparound Initiative and adopted the NWI practice model for Maryland. Maryland has a nationally recognized model of jail-based mental health services, which, in several programs, includes trauma treatment. Effort are underway to establish Medicaid	The Mental Hygiene Administration (MHA) is launching an initiative that promotes evidence based practices (EBP) to improve the quality of services provided to individuals with mental illness. Evidence-Based Practices (EBPs) represent those standardized clinical or rehabilitative interventions for which clear, consistent research data derived from controlled research experiments

	projects that have been developed with other TWG organizations. Cross-agency efforts are common in Maryland and will be enhanced by the MHS SIG.		benefits within 24-48 hours of release and expedite the availability of necessary medications. Through partnership with Maryland Department of Education, Division of Rehabilitative Services, and the University of Maryland, 10 mental health vocational programs have received training in the evidence- based practice, "Supported Employment" with additional planned for 2007.	demonstrate that employing such an approach improves the outcomes for recipients of the service intervention. Over the past several years MHA, through University of Maryland Evidence Based Practice Center, has been providing technical assistance and consultation to programs in implementing EBPs. At this time, MHA is planning to develop new rates for programs implementing EBP in the areas of **Supported Employment, Family Psychoeducation, and Assertive Community Treatment (ACT)**. Over the next year MHA is planning to implement additional EBPs and provide rate incentives to agencies.
State	**Priorities**	**Evaluation**	**EBP Work Plan**	**Evidence-Based Practices**
Missouri [viii]	Missouri was awarded a SAMHSA Mental Health Grant in October of 2006. The primary focus of the first year is the development of a Comprehensive State Mental Health Plan by the Transformation Leadership Workgroup. This workgroup, established by			

	Governor Matt Blunt and includes senior leaders from the departments of Mental Health, Social Services, Health and Senior Services, Corrections, Public Safety, and Elementary and Secondary Education, along with mental health consumers, family.			
State	**Priorities**	**Evaluation**	**EBP Work Plan**	**Evidence-Based Practices**
New Mexico [ix,x,xi]	A plan specifically addressing the "transformation"of the mental health system was not found. What follows is taken from the 2004 and 2006 reports titled Comprehensive and Strategic Health Plan Principles of the 2004 New Mexico Comprehensive Strategic Plan include: To support the development of a system of health services that balances needs, quality, safety and available resources.	According to the 2006 Comprehensive and Strategic Health Plan Completion of the provider capacity survey, report, and training. Complete consumer / family satisfaction surveys for FY 06. Evaluation process underway including process, system performance and customer/family outcomes.	The initial focus of the 2004 Comprehensive and Strategic Health Plan was on prevention and early intervention. Four health status indicators were to be the focus statewide: • Childhood immunizations • Obesity • Teen pregnancy • Youth suicide According to the 2006 Comprehensive and Strategic Health Plan: The Consortium for BH Training	Both the 2004 and 2006 Comprehensive and Strategic Health Plans minimally addressed specific evidence-based practices. Below are two specific practices mentioned in the 2006 report: Implement Functional Family Therapy statewide for at-risk child welfare and juvenile justice adolescents. Train providers in Eye Movement Desensitization and Reprocessing, a therapeutic intervention recommended for Post Traumatic Stress by the Veterans Administration and the

	To promote consumer choice within the constraints of funding. To involve communities and providers in the design and coordination of New Mexico's health care delivery system. To support community-based and home-based services. To promote culturally appropriate services. To provide a venue for health care providers in order to address the holistic needs of clients in an integrated manner. To encourage individuals to make responsible choices for their own health and health care. Highlighted updates from the 2006 report include: Creation of 34 additional school-based health centers with BH components Housing plan beginning, with emphasis on adults with serious mental illness and youth in transition to adulthood Primary care and BH interface to		and Research (CBHTR) kicked off with new Department of Higher Education to address workforce and evidence-based practices development and Dissemination. Plan to identify matching funds and include increased evidence-based and promising practices in the Medicaid state plan. Plan to increase provider capacity to deliver evidence-based practices and new changes to Medicaid state plan.	Department of Defense.

	address pharmacy and psychiatric consultation based on acuity rather than diagnosis, especially for rural areas Provide intensive services/supports for children/ adolescents with behavioral health needs in custody or at-risk of out-of home placement. Implement Functional Family Therapy statewide for at-risk child welfare and juvenile justice adolescents. Increase services for persons with behavioral health needs leaving jails or prisons, including youth leaving the juvenile justice system. Explore and implement inclusion of traditional healers and culturally specific healing practices in service definitions. Work with State and local military and veteran's organizations to develop programs and services that address suicide-related issues for veterans and their families.			

	Develop a state-wide pool of therapists that are specifically trained to treat veterans with Post Traumatic Stress Disorder associated with service in war zones and the related challenges facing their families.			
State	**Priorities**	**Evaluation**	**EBP Work Plan**	**Evidence-Based Practices**
Ohio [xii,xiii,xiv]	The State of Ohio used the goals stated in The President's New Freedom Commission on Mental Health as the basis for their transformation plan. State-of-the-art mental health practices are a key element of transformation. The ODMH Office of Clinical Best Practices promotes recovery and resiliency through workforce development activities focusing on the accelerated adoption of evidence-based mental health services. Initiatives supported by the office improve the capacity of the community mental health workforce to use the best available approaches to support good mental health. The office partners with colleges, universities, and other	Coordinated Centers of Excellence are grounded in ongoing research and evaluation. Refer to individual centers for specifics on evaluation.	9 Coordinated Centers of Excellence Include: Treatment/SAMI CCOE Supported Employment/SE CCOE Cluster-Based Planning Alliance CCOE Mental Illness/Mental Retardation, Developmental Disability CCOE Criminal Justice CCOE Center for Learning Excellence CCOE Center for Innovative Practices CCOE	Examples of evidenced-based practices include: **Sequential Intercept Model:** Working with the National GAINS Center, the CJ/CCOE has been elaborating a model to encourage communities to approach jail diversion systematically, at multiple levels. The Sequential Intercept Model proposes that there are a number of "points of interception" or opportunities where an intervention can be made with a person with mental illness that will keep that individual from entering or going "deeper" into the criminal justice system. Conceptually, more people will be intercepted at each level than at the subsequent level. Screening tool: Brief Mental Health Screen (BJMHS).

	stakeholders in Ohio's public mental health system to reach this goal. Included in these partnerships are the Coordinating Centers of Excellence (CCOEs), which teach and train practicing mental health professionals about effective approaches; the Residency and Traineeship Programs, which expose individuals entering the workforce to evidence-based practices in public mental health; and other programs of vital importance to mental health in Ohio, such as the Tobacco Dependence Project. The selection of CCOE's was based on two criteria: 1) level of evidence suggesting that the practice is effective; 2) the level of salience, the extent to which the issues and populations addressed by the practice are priorities for the public mental health system and the state as a whole. Ohio.s Networks and CCOEs serve as expert resources providing technical assistance and consultation to improve		Wellness Management and Recovery CCOE Consolidated Culturalogical Assessment Tools CCOE	**Supported Employment (SE)** is an evidence-based practice that helps people with severe symptoms of mental illness identify, acquire, and maintain competitive employment in their communities. SE is assertive about helping people find the job they want as soon as they express the desire to work. New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) The Cluster-Based Planning Alliance The Sequential Intercept Mode Multisystemic Therapy (MST) Illness Management and Recovery (IMR) Program and the Consumer Education component of the Ohio Medication Algorithm Project (OMAP) Consolidated Culturalogical Assessment Tools (C-CAT) Assertive Community Treatment

	quality by promoting Best Clinical Practices. These practices integrate the desires and values of consumers, the knowledge and skills of the practitioners, and the best research evidence that links a particular intervention with a desired outcome. Mental health agencies can support the transformation of mental health care in Ohio by committing to recovery and resilience, adopting Best Clinical Mental Health Practices, measuring their effectiveness through Consumer-focused Outcomes, and using proven Quality Improvement tools and techniques.			
State	**Priorities**	**Evaluation**	**EBP Work Plan**	**Evidence-Based Practices**
Oklahoma [xv,xvi,xvii]	Oklahomans understand that having good mental health and being free from addictions is essential to overall health. • Suicide prevention strategies • Intersect with primary care • Continuity between levels of care Care is consumer and family	An initial Needs Assessment - Resource Inventory was conducted and informed the final goals for transformation. Focus groups were conducted with mental health consumers and family members, CMHC staff and management, substance abuse service providers, and substance abuse clients and family members.	The Innovation Center was developed and hosted by the Oklahoma Department of Mental Health and Substance Abuse Services to provide strategic resources to enhance and sustain transformation. The Innovation Center is a specialty technical assistance center. Primary clients for the	The Innovation Center website does not list out particular EBP's. It does provide a link to the SAMSHA evidence-based practices website. The 2006 Oklahoma Substance Abuse and Mental Health Services: Comprehensive Plan highlights various practices that have or will be implemented Statewide. Some of these include:

	driven • Recovery support specialist capacity • Consumers & families as trainers • Expand understanding and decrease stigma within other systems Disparities in services are eliminated • Employment for consumers from minority populations • One-stop access to services • Linkages with public schools Early screening, assessment, and referral to services are common place • Holistic and integrated assessment tools and techniques • Transitions services for older youth Excellent care is delivered and research is accelerated • Evidence based practice training in educational institutions • Trauma training for	The Innovation Center website provides links to SAMSHA and the Human Service Research Institute.	Center are the staff of partnering agencies and communities committed to change in order to improve services for consumers. The 3 main areas of focus listed under the Innovation Center website include: Evidence-based practices as defined and listed by SAMHSA Reducing stigma Mental health in schools	All Certified Community Mental Health Centers (CMHC) must provide either Clubhouse or a general psychosocial rehabilitation (PSR) program for adults. Programs of Assertive Community Treatment (PACT) Wraparound services

	emergency, law enforcement, and clergy • Science-based knowledge for prescribers of medication Technology is used to access care and information • Consumer access to technology • JOIN and Oklahoma 2-1-1 • Interagency agreements to better utilize technology & information sharing • Technology (telemedicine, teleconferencing, etc.)			
State	**Priorities**	**Evaluation**	**EBP Work Plan**	**Evidence-Based Practices**
Texas [xviii,xix,xx]	Texas was awarded the Mental Health Transformation grant in 2006. It has provided the resources and brought together the state's leadership and stakeholders to provide guidance and direction to unite these fragmented activities, develop and implement new initiatives, and take the state behavioral health system to a higher, significant level of	An assessment was carried out with the goals of the original grant application at the forefront, which included a preliminary assessment of needs and had the broad support of the Governor and the Transformation Working Group (TWG) agencies and consumers. This expanded assessment allowed for further exploration of agency, consumer, and community needs and resources	With a public health approach, Texas will make the following a priority of all agencies. Focus on prevention and early intervention and adopt a family based approach. Implement national outcome measures and focus on how cultural issues impact disparities in access and	

	transformation. Priorities include: • Consumer and family member voice • Public health approach • Returning vets • Early intervention • Crisis services • Recovery orientation	for behavioral health transformation as well as to maximize consumer voice and participation in the process. The assessment will attempt to collectively present information for a more comprehensive view of the needs and resources that exist in the state and will be used to inform development of the comprehensive mental health plan. The assessment included: • Data gathered and presented in the original application. • Data gathered from consumers at town halls, public forums, via letter and email, and published documents. • Data gathered from TWG agencies through interviews and review of historical documents. • Statistical data gathered from agencies and reports. Questions asked of consumers included: 1) What is working well in the system? 2) What is not working well? 3) What changes would you recommend? Questions asked of TWG agencies included: 1) What are your agency priorities?	outcome. Expand the use of cutting edge technology. Demonstrate successful integration of physical and behavioral health. Seek public/private partnerships. Work to develop and maintain shared transformation agenda with stakeholders at both the state and local levels. Texas will approach this by: Developing and supporting local behavioral health collaboratives. Using cutting edge technology to change work processes across agencies. Improvement of the system will be targeted to the IOM Quality Chasm principles: • Apply evidence to health care delivery • Use information	

		2) What are your needs for behavioral health? 3) What are your areas of interest in behavioral health transformation? The evaluation of the Texas Mental Health Transformation project is to be carried out by the Center for Health and Social Policy at the LBJ School of Public Affairs, The University of Texas. The purpose of the evaluation is to inform the transformation process as it evolves. Evaluation tools include: Government Performance Results Act (GPRA) measures SAMHSA'S National Outcomes Measures (NOM'S). Some of the features of the initial conceptual design include: • A focus on business processes, including the internal workflow of agencies, the relationships among agencies, information flow, and the roles of consumers and family members • Consumers and family member experiences • Outcome indicators related to	technology • Align payment policies with quality improvement • Prepare the workforce	

		plan strategies • Measures related to infrastructural components of transformation, including those related to organizational culture.		
State	**Priorities**	**Evaluation**	**EBP Work Plan**	**Evidence-Based Practices**
Washington[xxi,xxii,xxiii]	Year one of the Transformation Grant has been devoted to developing a shared understanding and common agenda for transformation. It is our vision that all people in the state of Washington who experience mental health challenges will lead productive and fulfilling lives, free of stigma, in a safe and least restrictive environment. We have engaged in a broad public process to develop a roadmap for achieving this vision. We are ready for change. The Transformation effort relies on the participation of consumers, families, and youth including their membership in the Transformation Work Group (TWG), in outreach, education and training, policy formation, evaluation and public education	The evaluation process will be consumer and family driven. A transformed mental health system centers on development of an infrastructure that allows consumers, family members and other stakeholders to monitor progress, evaluate outcomes, and assess the need for mid-course corrections. The principle components of the evaluation process include: 1. Development and Implementation of Government Performance and Results Act (GPRA) measures 2. Collection and reporting of SAMHSA's National Outcome Measures across all agencies engaged in the transformation 3. Implementation of a Theory of Change evaluation to assess the overall impact of the Initiative on achieving the six original goals of the President's New Freedom Commission and two goals on	Providers, some consumers, researchers, and policymakers in the mental health and social service community in Washington State have been involved for some time in a passionate discussion about evidence-based practices. This debate is not theoretical; it has emerged as the DSHS Juvenile Rehabilitation Administration, Mental Health Division and Children's Administration move to require/facilitate the adoption of evidence-based practices. The discussion revolves around a number of issues which in many ways echo similar discussions within the research community.	Mental health providers in Washington State have been working for years to "train up" to the programs state policy-makers want to fund – as well as those programs their own review of the literature suggests are most effective. However, their training budgets are limited, so there are lags in their ability. Below are a list of evidence-based practices that some part of the mental health systems is now mandating. Aggression Replacement Therapy Assertive Community Treatment Dialectical Behavior Therapy Elderly Depression Screening & Treatment Family Psychoeducation Functional Family Therapy Family Integrative Therapy Illness Self-Management & Recovery Integrated Co-Occurring Disorders Medication Management Multi-Systemic Treatment

	campaigns. This approach of bringing consumers, family members and youth into the transformation effort as full partners ensures the transformation process will result in a comprehensive, culturally competent, fully integrated, consumer-, family- and youth-centered system committed to continuous improvement. Washington's MHTP has been built on the foundation of the President's New Freedom Commission Report. However, what is emerging in Washington State is unique to the needs of the consumers, family members and youth of Washington. The MHTP is building the infrastructure to support an on-going process of planning, action, learning and innovation that will result in measurable improvements in the lives of both young and old throughout the State. The Transformation Work Group was charged with developing the Transformation Plan. To accomplish this, the	employment and housing added by Washington State's Transformation Work Group. The primary responsibility for the evaluation will remain with the Transformation Grant staff, who will coordinate the work with the primary contractors for this project: • DSHS, Division of Research and Data Analysis • DSHS Division of Mental Health Research Division • The University of Washington, Division of Justice and Health Policy • The Cecil G. Sheps Center for Health Services Research, University of North Carolina-Chapel Hill In 2006, the WA Mental Health Division (MHD) contracted with the University of Washington Institute for Mental Illness Research and Training (WIMIRT) to conduct a statewide survey of mental health providers. The goal of the survey was to collect information about the utilization of Evidence-Based Practices (EBPs) in Washington State. Of		Parent Training Trauma-Focused Cognitive Behavior Therapy Wraparound

	TWG established an ambitious Year 1 work plan first identifying seven areas for analysis, focusing on target populations: 1. Children/Youth and Parents/Families 2. Adult Consumers and Families 3. Older Adult Consumers and Families 4. Youth Transitioning into Adulthood 5. Homeless Population 6. Criminal Justice-Juveniles and Adults 7. Co-Occurring Disorders (Dual Diagnoses) Subcommittees were developed to examine these seven areas and to recommend key outcomes for further exploration and development.	150 eligible mental health facilities, 67 completed the survey, yielding a 45% response rate.		

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APPENDIX B

Evidence Based Practices Selection Criteria and Definitions

Part 1a: Matrix of Practices by Administration Types and Rating Sources
Part 1b: Rating Systems Definition

Part 1c: References

Part 2: Evidence Based Practices Inclusion Criteria

Part 3: Evidence Based Practices Definitions

Part 1a: Matrix of Practices by Administration Types and Rating Sources

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
1-2-3 Magic[9]						X							Level 2			C	
ABC Model for Foster Parents[7]						X						Promising				C	
Abuse Focused CBT[9]						X							Level 2			C	
Across Ages[19,22]						X	Best				Model					C	
Aggression Replacement Training[7,9]	X	X	X									Level 1	Level 1			C	
All Stars [22]						X					Model					C	
AL Juvenile Court Liasons[7]						X						Model					
Al's Pals:Kids Making Healthy Choices [22]						X					Model					C	
American Indian Life Skills Development[22]						X					Effective					C	
Anger Coping Therapy/Anger Coping Self-Instruction Training[7,9]						X						Level 2	Level 2			C	
Anger Focused CBT[9]						X							Level 2			TBD	
Anger Management for Substance Abuse and Mental Health Clients[13,29]						X								EBP	EBP	A	
APIC Model (An Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders)[19]						X	Best									A	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Applied Behavior Analysis[7,9]						X						Level 1	Level 1			C	
Asian Youth Alliance [19,22]						X	Not Rated				Promising					C	
Assertive Community Treatment(ACT/PACT)[3,7,19,27,29]		X					Best	EBP	EBP			Evidence Based	Level 3		EBP	B	X
Assisted Recovery from Trauma and Substances (ARTS)[19]						X	Not Rated									A	
Auditory Integration Training[7,9]						X						Level 3	Level 4			C	
Be A Star [22]						X					Promising					C	
Behavioral Activation[7]						X						Effective				A	
Behavioral Couples Therapy for Alcoholism and Drug Abuse[30]						X				EBP						A	
Behavioral Family Intervention (BHI)[9]						X							Level 3			C	
Behavioral Monitoring and Reinforcement Program [22]						X					Promising					C	
Behavioral Parent Training[7,9]						X						Level 2	Level 1			C	
Behavioral Therapy for Anxiety[29]						X									EBP		
Behavioral Tailoring[7]						X						Effective				A	
Behavioral Treatment of Panic Disorder[29]						X									EBP		

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Behavioral Treatment for Substance Abuse in Schizophrenia[7,19,29]						X	Not Rated					Effective			EBP	A	X
Bernalillo County Juvenile Detention Center[7]						X						Model					
Beyond the Baby Blues[7]						X						Emerging				C	
Big Brothers/Big Sisters of America[22]						X					Effective					C	
Bilingual/Bicultural Counseling and Support Services[22]						X					Promising					C	
Blue Bay Healing Center[19]						X	Promising									C	
Boston Juvenile Court Clinic[7]						X						Model					
Boys and Girls Club: North Cheyenne Smart Moves Program[19]						X	Promising									C	
Brain Power[22]						X					Promising					C	
Brief Psychodynamic Psychotherapy for Depression[19,29]						X	Promising								EBP	A	
Brief Strategic Family Therapy[9,13,19,22]						X	Not Rated				Model		Level 1	EBP		C	X
Build Respect Stop Bullying[30]						X				EBP							
California Infant-Parent Program[7]						X						Evidence Based				C	
CASA Start[9,22]						X					Model		Level 4			C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Center for Older Adults and Their Families[19]						X	Promising									A	
Child and Family Focused CBT[9]						X							Level 2			C	
Child Development Project [22]						X					Model					C	
Child/Infant - Parent Psychotherapy[7]						X						Evidence Based				C	
Children of Divorce Intervention Program (CODIP)[22]						X					Effective					C	
Children in the Middle[22,30]						X				EBP	Model					C	
Circle of Security[7,9]		X										Promising	Level 4			C	
Clinician Based Psychoeducational Intervention for Families[30]						X				EBP						B	
Clubhouse (e.g., Fountain House Model)[7]		X										Evidence Based				A	
Clubhouse-based Transitional Employment Services (TES)[7]						X						Evidence Based				A	
Cognitive-Behavioral Social Skills Training[22]						X				EBP						TBD	
Cognitive Behavior Therapies[7,9,19,22,29,30]	X	X	X				Promising					Evidence Based	Level 1		EBP	B	X
Cognitive Processing Therapy (CPT)[9]						X							Level 3			C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support										Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)[22]	X										Promising					C	
Cognitive Therapy for Depression[19,29]						X	Not Rated								EBP	B	
Colorado Crisis Intervention Team[7]						X						Model				TBD	
Colorado Youth Leadership Project[22]						X					Promising					C	
Community Contacts for the Widowed[19]						X	Promising									A	
Community Reinforcement Approach to Substance Abuse Treatment[19]						X	Promising									A	
Comprehensive Assessment Reporting Evaluation (CARE)[19]						X	Promising									A	
Concurrent Treatment of PTSD and Cocaine Dependence[19]						X	Not Rated									A	
Contingency Management (co-occurring)[7,9,13]	X											Evidence Based	Level 3	EBP		A	X
Cook County Juvenile Court Clinic[7]						X						Model				C	
Coping Cat[30]						X				EBP						TBD	
Coping Power[22]						X					Effective					C	
Co-treatment Oriented Courts[7]						X						Emerging				B	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Creating Lasting Family Connections[19,22]						X	Best				Model					C	
Crisis Intervention for People with Severe Mental Illness[29]						X									EBP		
Crisis Intervention Team (CIT)[7]		X										Evidence Based				B	
Critical Time Intervention[30]						X				EBP							
Cultural Enhancement Through Storytelling[19]						X	Best									C	
Dando Fuerza a la Familia[19,22]						X	Not Rated				Promising					C	
Dare to Be You[19,22,30]						X	Best			EBP	Model					C	X
Daughters of Tradition[19]						X	Promising									C	
Delores Mission Women's Cooperative[19]						X	Not Rated									A	
Dementia Care Project in Boarding Homes[19]						X	Promising									A	
Diagnostic and Assessment Units[7]						X						Model				C	
Diagnostic Classification System of Mental Disorders or Infancy and Early Childhood (DC:0-3)[7,19]						X	Promising					Promising				C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Dialectical Behavioral Therapy[7,9,13,19,30]	X	X	X				Not Rated			EBP		Evidence-Based	Level 2	EBP	EBP	B	X
Domestic Violence Pilot Projects[19]						X	Promising									C	
Dreamcatcher Meditation[19]						X	Promising									C	
Dual Focus Schema Therapy[19]						X	Not Rated									A	
Early Childhood Mental Health Consultation[7]						X						Promising & Emerging				C	
Early Head Start[7]						X						Promising				C	
Early Intervention Foster Care program[7]						X						Evidence Based				C	
East Texas Experiential Learning Center[22]						X					Effective					C	
Effects of Clazapine on Substance Use in Schizophrenia[29]															EBP		
Elder Substance Abuse Outreach Program[19]						X	Promising									A	
Elder Wrap-Around Team[7,19]						X	Promising					Emerging				A	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Electroconvusive Therapy for Schizophrenia[29]						X									EBP		
Emerson David Family Development Center[19]						X	Not Rated									C	
Expanded Community Services (ECS)[7]						X						Emerging				A	
Exposure with Response Prevention[7,19]						X	Not Rated					Effective				A	
Eye Movement Desensitization & Reprocessing (EMDR)[7,9]		X										Level 2/Effective	Level 2			B	
Faith Based Prevention Model[19]						X	Not Rated									A	
Families and Schools Together (FAST)[7,19]						X	Best					Level 2				C	
Families That Care - Guiding Good Choices[19,22]						X	Best				Model					C	
Family Caregiver Counseling Service[19]		X					Promising									C	
Family Development Research Project[22]						X					Effective					C	
Family Effectiveness Training[9,19]						X	Best						Level 4			C	
Family Focused Child Centered Treatment (FTI)[7,9]						X						Level 2	Level 2			C	
Family Group Conferences[7]						X						Level 1				C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support										Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Family Health Promotion[22]						X					Promising					C	
Family Integrated Transitions[7,9]		X	X	X								Evidence Based	Level 2			C	
Family Intervention for Dual Disorders[19,29]						X	Not Rated								EBP	C	
Family Intervention Resources Services Team (FIRST)[7]						X						Model				C	
Family Intervention Specialists[7]						X						Model				C	
Family Matters[22,30]						X				EBP	Model					C	
Family Psychoeducation[3,7,27]		X						EBP	EBP			Effective				C	X
Family Support Services (PACE) Program[19]						X	Not Rated									C	
Family Therapy (anorexia only)[7,9]						X						Level 2	Level 2			C	
Family Treatment/ Dependency Court[7]						X						Promising				C	
FAN (Family Advocacy Network) Club[22]						X					Effective					C	
Fast Track Project[19]						X	Promising									C	
Focus on Families[22]						X					Promising					C	
Foster parents mentoring birth parents[7]						X						Emerging				C	
Friendly PEERsuasion[22]						X					Effective					C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Functional Communication Training[7,9]						X						Level 3	Level 4			C	
Functional Family Parole[7]			X									Promising				B	
Functional Family Therapy[7,9,19,27]	X	X	X	X			Best	EBP				Evidence Based	Level 1			C	X
Gatekeeper program[7,19,22]						X	Best				Promising	Promising				A	X
GentleCare Prosthetic Life Care System[19]						X	Promising									A	
Geriatric Mental Health Outreach Program[19]						X	Promising									A	
Geriatric Mental Health Specialty Training[7]		X										Emerging				A	
Geriatric Regional Assessment Team (GRAT)[7,19]		X					Promising					Emerging				A	
Get Real About Violence[22]						X					Promising					C	
Good Behavior Game[22]						X					Effective					C	
Great Body Shop[22]						X					Promising					C	
Greater Access to EAPS (GATE)[22]						X					Effective					A	
Group Counseling Theory[19]						X	Promising									B	
Guiding Good Choices[9]						X							Level 4			C	
Hamilton County Individualized Disposition Docket[7]						X						Model					
Head Start[9]						X							Level 1			C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Healing Lodge of the Seven Nations[19]						X	Promising									C	
Helping the Non-Compliant Child[22]						X					Effective					C	
Home Instruction Training for Pre-School Youngsters[9]						X							Level 1			C	
Home Visiting Family Support Program[7]						X						Promising				C	
Home-Based Behavioral Systems Family Therapy[22]						X					Effective					C	
Houston Parent-Child Development Program[22]						X					Effective					C	
I Can Problem Solve[9,22]						X					Promising		Level 2			C	
Illinois Mental Health Juvenile Justice Initiative[7]						X						Model					
Illness Self-Management/Illness Management & Recovery[3,7,,27]		X						EBP	EBP			Effective				A	X
Improving Children's Mental Health through Parent and Community Empowerment[7]						X						Emerging				C	
Improving Mood: Promoting Access to Collaborative Treatment (IMPACT)[7,19]						X	Promising					Evidence Based				A	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
In the Company of Their Peers: Geriatric Peer Counseling[19]						X	Promising									A	
Incredible Years[7,9]		X										Evidence Based	Level 1			C	
Indiana Family Project[7]						X						Model				C	
Individual Placement and Support (IPS)[7,22]						X					Effective	Evidence Based				A	
Ingersoll Gender Center[19]						X	Promising									A	
Integrated Dual Disorders Treatment[3,9,13,19,27,29]	X	X					Not Rated	EBP	EBP			Effective		EBP	EBP	A	X
Integrated Group Therapy[7]						X						Evidence Based				A	
Integrated Group Treatment for Bipolar and Substance Use Disorders[19,29]						X	Not Rated								EBP	A	
Integrated Program for Comorbid Schizophrenia & Substance Use[29]						X									EBP		
Integrated Treatment Model[11]			X													C	
Intensive Family Preservation Services[7,9]			X									Level 3	Level 1			C	
Interpersonal Therapy[7,9,19,29]						X	Promising					Level 1/ Effective	Level 1		EBP	B	X
Interpersonal-Social Rhythm Therapy[7]						X						Effective				A	
Iowa's Elderly Outreach Project (IOP)[19]						X	Promising									A	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Jail Diversion Programs (e.g., Illinois MH Juvenile Justice Initiative)[7]						X						Model				B	
Job-Loss Recovery Program[22]						X					Promising					A	
K' E' Project[19]						X	Promising									C	
Kaiser Permanente Social Health Maintenance Organization[19]						X	Promising									A	
Kids Intervention with Kids in School[22]						X					Promising					C	
Kimihqitahasultipon Program[19]						X	Promising									C	
King Co Treatment Court[7]						X						Model					
Kit Clark Senior Services[19]						X	Promising									A	
LA-Westside Infant Family Network[7]						X						Promising				C	
Leadership and Resiliency Program[22]						X					Model					C	
Lesbian, Gay, Bisexual, and Transgender - Affirmative/Feminist Therapies[19]						X	Promising									A	
Let Each One Teach One[22]						X					Promising					C	
Life Givers[19]						X	Promising									C	
Life Skills Training[9,19]						X	Promising						Level 4			C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Light Therapy for Depression[29]						X									EBP		
Linking the Interests of Families and Teachers (LIFT)[9,22]						X					Promising		Level 2			C	
Lions Quest Skills for Adolescence[22]						X					Model					C	
Listening Mothers[7]						X						Emerging				C	
Little Havana Health Program[19]						X	Promising									A	
Los Nino's Bien Educados Parenting Program[9]						X							Level 4			C	
Matrix Model[30]						X				EBP							
Medication Algorithms[7]						X						Evidence Based				A	
Medication Management[27]	X	X						EBP								B	
Medications for specific conditions[7,9,29]						X						Level 1	Level 1		EBP	B	X
Mental Health Court[7]						X						Promising				A	
Mentalization Partial-Hospitalization[7]						X						Effective				A	
Miami-Dade Infant Mental Health Court[7]						X						Promising				C	
Minimal Intervention Approach to Problem Gambling[22]						X					Promising					A	
Minneapolis American Indian Center[19]						X	Promising									C	

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	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Mno Bmaadzid Endaad[19]						X	Promising									C	
Mockingbird Family Model[7]						X						Emerging				C	
Moral Reconation Therapy (MRT)[11,28]			X		X											B	
Motivational Enhancement Therapy (MET)[7,9]	X											Evidence Based	Level 2			B	
Motivational Interviewing (co-occurring)[7,19,29]						X	Not Rated					Effective			EBP	A	X
MOVE[7]						X						Evidence Based				C	
Multidimensional Family Therapy[7,9,13,19,22]	X						Not Rated				Model	Level 2	Level 1	EBP		C	X
Multidimensional Treatment Foster Care[7,9]		X	X	X								Level 1	Level 1			C	
Multi-Family Group Treatment (MFG)[7,9,19,29]		X					Not Rated					Effective	Level 2		EBP	C	X
Multimodal Approaches (Medication & CBT & Parent Training)[7,9]						X						Level 1	Level 1			C	
Multimodal Substance Abuse Prevention[22]						X					Promising					C	
Multisystemic Therapy[7,9,19,22,27]	X	X	X	X			Best	EBP			Model	Evidence Based	Level 1			B	X
Music Therapy for Schizophrenia[29]						X									EBP		

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
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								DIG	Toolkit	NREPP (2007)	Model Programs						
National Federation of Families for Children's Mental Health[7]						X						Promising				TBD	
Native Visions-Wind River[19]						X	Promising									C	
Natural Helpers Program[19]						X	Promising									C	
Network Therapy[30]						X				EBP							
New York Community Mobile Crisis Team[7]						X						Model					
Nurse-Family Partnership[7,9]		X										Evidence Based	Level 1			C	
Nurturing Parenting Programs[9]		X											Level 2			C	
NYS PINS Diversion Program[7]						X						Model					
Older Adult Outreach and Education Service[19]						X	Promising									A	
Olweus Bullying Prevention[22]						X					Model					C	
On Lok Senior Services Program Day Health Center[19]						X	Promising									A	
OSLC Treatment Foster Care[22]						X					Effective					C	
Outcomes-Based Treatment Plan (OBTP)[19]						X	Promising									A	
Over 60 Health Center[19]						X	Promising									A	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Panic Control Treatment[19]						X	Promising									A	
Parent & Teacher Behavior Management (e.g., Barkley curriculum)[9]						X						Level 1				C	
Parent-Child Assistance Program[22]						X					Promising					C	
Parent-Child Interaction Therapy[7,9]		X										Level 1	Level 1			C	
Parent-Infant Psychotherapy[19]						X	Promising									C	
Parenting Partnership[22]						X					Promising					C	
Parenting Through Change[30]						X				EBP							
Parenting Wisely[9,19]						X	Best						Level 1			C	
Parents Anonymous Adult Group[19]						X	Best									A	
Parents as Teachers[7,9]						X						Evidence Based	Level 1			C	
Pathways[7]						X						Evidence Based				C	
PeaceBuilders[22]						X					Promising					C	
Peacemakers[22]						X					Promising					C	
Peer Assistance and Leadership[22]						X					Promising					C	
Peer Coping Skills Training[9]						X							Level 4			C	
Peer Support[7]		X										Promising				A	
Peers Making Peace[22]						X					Promising					C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Perinatal Care Program[22]						X					Promising					C	
Personal Assistance Services (PAS)[7]						X						Emerging				A	
Pharmacotherapy for Anxiety Disorder[29]						X									EBP		
Pharmacotherapy for Depression[29]						X									EBP		
Pharmacotherapy for Post Traumatic Stress Disorder[29]						X									EBP		
Pharmacotherapy for schizophrenia[29]						X									EBP		
Pivotal Response Intervention[9]						X							Level 4			TBD	
Positive Behavioral Interventions and Supports (PBIS)[7]						X						Evidence Based				C	
Positive Parenting Program (PPP)[9]						X							Level 1			C	
Pre-admission Screening and Resident Review (PASRR)[19]						X	Promising									C	
Preparing for the Drug Free Years[19]						X	Best										
Prevention and Relationship Enhancement Program (PREP)[30]						X				EBP							

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Prevention of Suicide in Primary Care Elderly-Collaborative Trial (PROSPECT)[7,19]						X	Promising					Evidence Based				A	
Preventive Treatment Program[9]						X							Level 4				
PRIDE Program[19]						X	Promising									C	
Primary Care Research in Substance Abuse And Mental Health for Elders (PRISME)[19]						X	Promising									A	
Program for All-Inclusive Care of Elderly[19]						X	Promising									A	
Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)[7,19]						X	Promising					Evidence Based				A	
Project 12-Ways[9]						X							Level 2			C	
Project Achieve[7,22]						X					Model	Level 2				C	
Project Alert[19,22]						X	Best				Model					C	
Project Eagle[19]						X	Promising									C	
Project Link[22]						X					Promising					C	
Project Making Medicine[19]						X	Promising									C	
Project PACE[22]						X					Promising					C	
Project Venture: The National Indian Youth Leadership Project[19,22]						X	Best				Model					C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Prolonged Exposure Therapy[9,22]						X					Model		Level 2			B	
Promoting Alternative Thinking Strategies (PATH)[7,19]		X					Best					Level 2				C	
Promoting First Relationships (PFR)[7]						X						Promising				TBD	
Promoting Maternal Mental Health in Pregnancy[7]						X						Promising				A	
Protecting You, Protecting Me[22]						X					Model					C	
Psychogeriatric Assessment and Treatment in City Housing (PATCH)[19]						X	Best									A	
Psychological Treatment of Post-Traumatic Stress Disorder[29]						X									EBP		
PTSD Stress-Management Therapy[29]						X									EBP		
Pueblo Zuni Recovery Center[19]						X	Promising									C	
Purdue Brief Family Therapy[7,9]						X						Level 2	Level 2			C	
Reconnecting Youth[22]						X					Model					C	
Residential Student Assistance Program (RSAP)[22]						X					Model					C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Resolving Conflict Creatively Program (RCCP)[22]						X					Effective					C	
Resources for Enhancing Alzheimer's Caregiver Health (REACH)[19]						X	Best									A	
Respite Care[7]						X						Promising				TBD	
Responding in Peaceful and Positive Ways[22]						X					Model					C	
Rural Educational Achievement Project[22]						X					Effective					C	
Rural Elderly Outreach Project (REOP)[19]						X	Promising									A	
Sacred Child Project[19]						X	Promising									C	
Safe Children: Schools and Families Educating Children[22]						X					Model					C	
Safe Dates[22,30]						X				EBP	Model						
San Franscisco General Hospital: Consultation/Laison Program[19]						X	Not Rated									A	
Santa Clara, CA Court for the Individualized Treatment of Adolescents[7]						X						Model					
Say It Straight[22]						X					Promising					C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
School Transitional Environmental Program (STEP)[9]						X							Level 2			C	
School Violence Prevention Demonstration Program[22]						X					Effective					C	
Second Step[9,22,30]						X				EBP	Model		Level 2			C	X
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse[13,19,30]						X	Promising			EBP				EBP		A	X
Sembrando Salud[22]						X					Effective					C	
Senior Companion Program[19]						X	Best									A	
Senior Services' Caregiver Outreach and Support Program[19]						X	Promising									A	
Sequenced Treatment Alternatives to Reduce Depression[7]						X						Evidence Based				A	
SISTERS[22]						X					Promising					C	
Skills Training/Social Skills Training[7,9]						X						Level 1/ Effective	Level 1			B	
Skills, Opportunities, and Recognition (SOAR)[22]						X					Effective					C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Social Adjustment Program for Southeast Asians[19]						X	Not Rated									A	
Social Competence Promotion Program for Young Adolescents (SCPP-YA)[22]						X					Effective					C	
Sons of Tradition[19]						X	Promising									C	
SOS: Signs of Suicide[22]						X					Promising					C	
Southeast Alaska Regional Health Consortium[19]						X	Promising									B	
Southern Ute Spirit Youth Services Program [19]						X	Promising									C	
Speak Up When You're Down[7]						X						Promising				TBD	
Specialized Help for Alzheimer's in a Residential Environment (SHARE)[19]						X	Promising									A	
STEEP model[7]						X						Evidence Based				C	
Storytelling for Empowerment[19,22]						X	Promising									C	
Strengthening Families Program (SFP)[9,19,22]		X					Best				Model		Level 1			C	X
Strengthening Hawaii Families[19,22]						X	Not Rated				Promising					C	
Strengthening Multiethnic Families and Communities (SMFC)[19]						X	Best									B	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Strengthening the Bonds of Chicano Youth & Families[22]						X					Promising					C	
Stress Inoculation Training[7]						X						Effective				TBD	
Students Managing Anger & Resolution Together (SMARTteam) [22,30]						X				EBP	Model					C	
Supported Education[7]						X						Promising				A	
Supported Employment[3,7,27,29]		X						EBP	EBP			Effective			EBP	A	X
Supported Housing[7,27]		X						EBP				Emerging				A	
Supportive Expressive Psychotherapy[13]						X								EBP		A	
Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD)[19]						X	Not Rated									A	
Talk Safe[19]						X	Promising									A	
Targeted Parent Assistance[7]						X						Emerging				C	
TARGET-T[7]						X						Evidence Based				C	
Teaching Students To Be Peacemakes [22]						X					Model					C	
Teenage Health Teaching Modules[22]						X					Promising					C	
Texas Special Needs Diversionary Program[7]						X						Model				C	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
The Eden Alternative[19]						X	Promising									A	
The Historical Trauma & Unresolved Grief Intervention (HTUG)[9]						X							Level 4			B	
The Multi-faceted primary Care Intervention[19]						X	Promising									A	
The SHARE Model[19]						X	Promising									A	
The TAMAR Project[7,19]						X	Not Rated					Evidence Based				A	
The Village[19]						X	Not Rated									TBD	
Therapeutic Foster Care[7,27]		X						EBP				Level 1				C	
Tinkham Alternative High School[22]						X					Promising					C	
Token Economies[7]						X						Effective				TBD	
Tool Good For Violence[22]						X					Model					C	
Transcend[19]						X	Not Rated									A	
Trauma Focused Integrative Eclectic Therapy[7,9]						X						Level 3	Level 4			TBD	
Trauma Focused Play Therapy[7,9,22]						X					Model	Level 3	Level 4			C	X
Trauma Recovery and Empowerment Model (TREM)[30]						X				EBP							
Treating Tobacco Use and Dependence[13]						X								EBP		A	

Practices	MH/COD Practices Currently Implemented or Planning to be Implemented in Washington						Rating Systems/Level of Support									Child or Adult	Endorsed by 3 or more sources
	DASA[12]	MHD[10,18,23,25]	JRA[23,24]	CA[23,26]	DOC[28]	Don't Know	WIMIRT	SAMHSA				T-Grant EBPEP Task Group	Children's EBP Expert Panel	Alcohol and Drug Abuse Institute (ADAI)	WSIPP	C= Child A= Adult B= Both	
								DIG	Toolkit	NREPP (2007)	Model Programs						
Turtle Mountain Safe Communities Program[19]						X	Promising									C	
Twelve Feathers Program[19]						X	Promising									C	
UCLA Family Development Project[7]						X						Emerging				C	
United American Indian Involvement[19]						X	Promising									A	
United States Air Force Suicide Prevention Program[30]						X				EBP							
Urban Women Against Substance Abuse (UWASA)[22]						X					Promising					A	
Welcome Baby[7]						X						Emerging				C	
Wellness Recovery Action Plan (WRAP)[7]		X										Promising				A	
With Eagle's Wings[19]						X	Best									C	
Woodrock Youth Development Program[22]						X					Promising					C	
Wraparound Services/Wraparound Process[7,19]		X					Promising					Promising				B	
Yale Child Study Center Parents First Program[7]						X						Promising				C	
Young Parents Project[7]						X						Evidence Based				C	
Youth Care Model[7]						X						Emerging				C	
Youth Relationships Project[9]						X							Level 2			C	
Zuni Life Skills Curriculum[19]						X	Promising									C	

Part 1b: Rating Systems Definition

WIMIRT[19]

The WIMIRT Best and Promising Practices Report included two definitions*

1. Best Practices are strategies and programs that are deemed research-based by scientists and researchers through a number of organizations including NIMH, NIDA, American Psychological Association, National Association of Social Workers, CSAP, NCAP, OJJDP, and DOE.

2. Promising Practices are programs that seem effective, but do not have enough outcome data or have not been sufficiently evaluated to be deemed a best practice. Ideally, these programs or strategies have some quantitative data showing positive outcomes over a period, but do not have enough research or replication to support generalized outcomes.

*Note: If a rating was not specified for a particular practice, "Not Rated" was entered.

SAMHSA[3,22,27,30]

SAMHSA has at least 4 initiatives to disseminate and/or collect information about EBP utilization:

1. DIG - Every State has to report data on 10 practices as a requirement of the SAMHSA Data Infrastructure Grant (DIG). They are ACT, Supported Employment,Supported Housing, Family Psychoeducation, Medication Management, Therapeutic Foster Care, MST, FFT, Integrated Dual Disorders Treatment & Illness Management & Recovery. The DIG identifies all of these practices as EBPs.

2. Toolkits- SAMHSA has created toolkits for five mental health practices, all of which are identified as EBPs: Illness Management & recovery, Family Psychoeducation, Integrated Dual Disorder, Treatment, ACT, & Supported Employment.

3.Model Programs- the National Registry of Evidence Based Programs and Practices (NREPP) has three definitions of evidence based programs*:

A. Promising = Programs in this category have been implemented and sufficiently evaluated. The programs have shown positive outcomes, but do not have the consistently positive findings required for an Effective Program status.

B. Effective = Programs in this category have been implemented, evaluated, and show consistently positive outcomes. The developers of these programs have not yet agreed to work with SAMHSA to disseminate their programs on an extensive basis.

C. Model = Programs in this category are well-implemented and well-evaluated. These programs have been reviewed by the National Registry of Evidence-based Programs and Practices (NREPP) and have agreed to provide quality materials, training, and technical assistance for nationwide implementation.

4. NREPP - SAMHSA revised NREPP in 2007 (formerly called Model Programs). To be considered, the practice had to meet the following conditions:

A. demonstrate one or more positive outcomes ($p \leq .05$) in mental health and/or substance use behavior among individuals, communities, or populations;

B. Intervention results have been published in a peer-reviewed publication or documented in a comprehensive evaluation report; AND

C. documentation (e.g., manuals, process guides, tools, training materials) of the intervention and its proper implementation is available to the public to facilitate dissemination.

*Note: Practices that were judged to be exclusively Alcohol and/or Drug treaments were excluded.

TG ECBPEP Task Group[7]

The Evidence/Consensus-Based/Promising/Emerging Practices (ECPEP) Task Group report presented 4 different rating systems.*

1. Evidence-Based=Most support; Promising=less support; Emerging=Least Support
2. Level 1=Best Support; Level 2=Good/Moderate Support; Level 3=Promising Practice
3. The Juvenile Justice section presented Model programs (e.g., Texas Special Needs Diversionary Program)
4. Effective= Most Support; Promising=less support; Emerging= Least Support

*Note: When possible, the highest rating was chosen.

Children's EBP Expert Panel[9]

The Children's EBP Expert Panel rated each practice from 1 to 5, depending on the problem area: Level 1= best empirical support, Level 2= good or moderate support, Level 3= moderate support for other populations or conditions, level 4= innovative practices, and Level 5= practices having known risks.

Only practices between 1-4 were included in this document (a rating of 5 was a practice with known risks). If the practice was given more than one level assignment, the highest was entered.

Alcohol and Drug Abuse Institute (ADAI)[13]

All the practices on the ADAI database are identified as Evidence-Based Practices (EBPs) and meet the following criteria:

1. they are supported by research, often through randomized controlled trials and quasi-experimental studies.
2. they result in meaningful outcomes
3. they are standardized (e.g., thorough instructions).
4. they have been studied in more than one setting (i.e. replicated).
5. they can be monitored with fidelity.

Only practices that were applicable to co-occurring MH/SA populations were included in the current document.

Washington State Institute for Public Policy (WSIPP)[29]

Practices that met the following criteria were included in the meta-analyses; 1) studies had to have a control or comparison group; 2) enough information to calculate effect sizes; 3) the analysis had to include treatment drop-outs, not just treatment completers

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Part 2: Evidence Based Practices Inclusion Criteria

	Score3 Number of EBP (3) Selections	Score2 Number of "Promising" (2) Selections	Score1 Number of "Emerging" (1) Selections	Total_Count Total Number of Endorsements	Numeric_Score Total Score	Washington Currently offered in Washington State
Aggression Replacement Training7,9	2.00	.00	.00	2.00	6.00	1
Assertive Community Treatment(ACT/PACT)3,7,19,27,29	5.00	.00	1.00	6.00	16.00	1
Behavioral Treatment for Substance Abuse in Schizophrenia7,19,29	2.00	.00	1.00	3.00	7.00	0
Brief Strategic Family Therapy9,13,19,22	3.00	.00	1.00	4.00	10.00	0
Cognitive Behavior Therapies7,9,19,22,29,30	3.00	1.00	.00	4.00	11.00	1
Contingency Management (co-occurring)7,9,13	2.00	.00	1.00	3.00	7.00	1
Dare to Be You19,22,30	3.00	.00	.00	3.00	9.00	0
Dialectical Behavioral Therapy7,9,13,19,30	4.00	1.00	1.00	6.00	15.00	1
Eye Movement Desensitization & Reprocessing (EMDR)7,9	1.00	1.00	.00	2.00	5.00	1
Family Integrated Transitions7,9	1.00	1.00	.00	2.00	5.00	1
Family Psychoeducation3,7,27	3.00	.00	.00	3.00	9.00	1
Functional Family Therapy7,9,19,27	4.00	.00	.00	4.00	12.00	1
Gatekeeper program7,19,22	1.00	2.00	.00	3.00	7.00	0
Illness Self-Management/Illness Management & Recovery3,7,,27	3.00	.00	.00	3.00	9.00	1
Incredible Years7,9	2.00	.00	.00	2.00	6.00	1
Integrated Dual Disorders Treatment3,9,13,19,27,29	5.00	.00	1.00	6.00	16.00	1
Interpersonal Therapy7,9,19,29	3.00	1.00	.00	4.00	11.00	0

	Score3 Number of EBP (3) Selections	Score2 Number of "Promising" (2) Selections	Score1 Number of "Emerging" (1) Selections	Total_Count Total Number of Endorsements	Numeric_Score Total Score	Washington Currently offered in Washington State
Medications for specific conditions7,9,29	3.00	.00	.00	3.00	9.00	0
Motivational Enhancement Therapy (MET)7,9	1.00	1.00	.00	2.00	5.00	1
Motivational Interviewing (co-occurring)7,19,29	2.00	.00	1.00	3.00	7.00	0
Multi-Family Group Treatment (MFG)7,9,19,29	2.00	1.00	1.00	4.00	9.00	1
Multidimensional Family Therapy7,9,13,19,22	3.00	1.00	1.00	5.00	12.00	1
Multidimensional Treatment Foster Care7,9	2.00	.00	.00	2.00	6.00	1
Multisystemic Therapy7,9,19,22,27	5.00	.00	.00	5.00	15.00	1
Nurse-Family Partnership7,9	2.00	.00	.00	2.00	6.00	1
Parent-Child Interaction Therapy7,9	2.00	.00	.00	2.00	6.00	1
Promoting Alternative Thinking Strategies (PATH)7,19	1.00	1.00	.00	2.00	5.00	1
Second Step9,22,30	2.00	1.00	.00	3.00	8.00	0
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse13,19,30	2.00	1.00	.00	3.00	8.00	0
Strengthening Families Program (SFP)9,19,22	3.00	.00	.00	3.00	9.00	1
Supported Employment3,7,27,29	4.00	.00	.00	4.00	12.00	1
Therapeutic Foster Care7,27	2.00	.00	.00	2.00	6.00	1

Part 3: Evidence Based Practices Definitions

Aggression Replacement Training[1]
An intervention designed for aggressive adolescents and children. Its component procedures are: 1) Skill Streaming- which teaches a curriculum of prosocial, interpersonal skills (i.e. what to do instead of aggression); 2) Anger Control Training - to teach youth what not to do if provoked; and 3) Moral Reasoning Training - to promote values that respect the rights of others, and help youths want to use the interpersonal and anger management skills taught.

Assertive Community Treatment (ACT or PACT)[2,9]
A multi-disciplinary team based approach to the provision of treatment, rehabilitation and support services. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads, 24 hour service availability, and the availability of the services in a range of settings.

Brief Strategic Family Therapy[3,4]
A family-based intervention aimed at preventing and treating child and adolescent (ages 8-17) behavior problems, particularly substance use and its associated problems such as antisocial/aggressive behavior. BSFT uses the therapeutic techniques of: 1) Joining – forming a therapeutic alliance with all family members; 2) Diagnosis – identifying interactional patterns that encourage problematic youth behavior; and 3) Restructuring – changing family interactions that are related to the problematic behavior.

Cognitive Behavior Therapy (CBT) [5]
A form of psychotherapy focusing on decreasing symptoms and improving quality of life by changing a person's thoughts and behaviors. The treatment involves a collaborative agreement on treatment goals which the patient tracks each week, learning and practicing new skills and ways of thinking in the treatment session and practicing via homework assignments throughout the week. Many EBP's on this list are based on CBT. For this survey, only rate this if CBT is used in your site separate from another EBP in this list.

Contingency Management (CM) [5]
A broad group of behavioral interventions that structure the client's environment in such a way as to encourage change. CM includes setting specific, objective goals, the systematic reinforcement of desired behaviors, and specific, objective consequences for not meeting these goals.

Dare to Be You[6] **Error! Bookmark not defined.**
DARE To Be You (DTBY) is a multilevel prevention program that serves high-risk families with children 2 to 5 years old. Program objectives focus on children's developmental attainments and aspects of parenting that contribute to youth resilience to later substance abuse, including parental self-efficacy, effective child rearing, social support, and problem-solving skills.

Dialectical Behavioral Therapy (DBT) [7]
DBT is cognitive-behavioral therapy for individuals exhibiting self-injurious behaviors, such as self-cutting, suicidal thoughts, urges to suicide, and suicide attempts. Standard DBT is provided via four modes of treatment: weekly individual therapy, weekly skills training, phone coaching as needed, and a weekly therapist consultation team.

Eye Movement Desensitization & Reprocessing (EMDR)[8]**Error! Bookmark not defined.**
Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. EMDR uses a three pronged protocol: (1) the past events that have laid the groundwork for dysfunction are processed, forging new associative links with adaptive information; (2) the current circumstances that elicit distress are targeted, and internal and external triggers are desensitized; (3) imaginal templates of future events are incorporated, to assist the client in acquiring the skills needed for adaptive functioning.

Family Integrated Transitions[9]
The Family Integrated Transitions (FIT) program provides integrated individual and family services to juvenile offenders who have mental health and chemical dependency disorders during their transition from incarceration back into the community. FIT is based on components of three programs: multisystemic therapy (MST), dialectical behavior therapy (DBT), and motivational enhancement therapy (MET).

Family Psychoeducation[Error! Bookmark not defined.10]
Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Core characteristics of family Psycho Education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

Functional Family Therapy (FFT)[10]
Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

Gatekeeper Program[3]
The Gatekeeper Program is a community-wide system of proactive case finding to identify at-risk older adults who remain invisible to the service delivery systems created to serve them. Gatekeepers are non-traditional referral sources that come into contact with older adults through their everyday work activities.

Illness Self-Management/Illness Management & Recovery[10]
Illness Self-Management is a broad set of rehabilitation methods aimed at teaching individuals with a mental illness, strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Services include a specific curriculum that can include mental illness facts, recovery strategies, using medications, stress management and coping skills. It is critical that a specific curriculum is being used for these components to be counted for reporting.

Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) [3]
With this model primary care patients have up to 12 months of access to a depression care manager who is supervised by a psychiatrist and primary care liaison. The care manager provides medication support and/or counseling and depression management in collaboration with the primary care physician.

Incredible Years[11]

Incredible Years features three comprehensive, multifaceted, developmentally based curricula for parents, teachers, and children. The program is designed to promote emotional and social competence and to prevent, reduce, and treat aggressive, defiant, oppositional, and impulsive behaviors in young children 2 to 8 years old.

Integrated Dual Diagnosis Treatment[10]
Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion.

Interpersonal Therapy[3,12]
Interpersonal therapy (IPT) is a time-limited (12-16 weeks) treatment that suggests that a client's interpersonal relationships may play a significant role in the onset and maintenance of depressive symptoms. Problem areas addressed in IPT are the client's difficulty in interpersonal functioning, unresolved grief, role transitions, and interpersonal deficits.

Medications for specific conditions
Pharmacotherapy for a variety of psychiatric conditions including depression, bipolar disorder, anxiety, and schizophrenia.

Motivational Enhancement Therapy (MET)[13]
MET is based on principles of cognitive and social psychology whereby the counselor seeks to develop a discrepancy in the client's perceptions between current behavior and significant personal goals. As applied to drug abuse, MET seeks to alter the harmful use of drugs. The intervention is typically brief, limited to two to four sessions that each last 1 hour. MET differs from Motivational Interviewing (see below).

Motivational Interviewing[14]
Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Motivational Interviewing differs MET (see above).

Multidimensional Family Therapy (MDFT)[15]**Error! Bookmark not defined.**
MDFT is a comprehensive and flexible, family-based program designed for substance-abusing adolescents or those at high risk for substance us and other problem behaviors. MDFT interventions target research-derived risk factors and processes that have created and perpetuate substance use and related problems such as conduct disorder and delinquency.

Multidimensional Treatment Foster Care[16]
The goal of the MTFC program is to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems.

Multisystemic Therapy (MST)[10]
Multisystem Therapy is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior. The Multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. The goal is to facilitate change in this natural environment to promote individual change.

Nurse-Family Partnership[17]
The program provides first-time, low income mothers with home visitation services from public health nurses. NFP nurses work intensively with mothers to improve maternal, prenatal, and early childhood health and well-being, focusing on therapeutic relationships with the family that are designed to improve family functioning in areas of health, home and neighborhood environment, family and friend support, parental roles and major life events. The nurse remains with the mother through the first 2 years of the target child's life.

Parent-Child Interaction Therapy[18]
Parent-Child Interaction Therapy (PCIT) is a treatment for conduct-disordered young children that places an emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior.

Promoting Alternative Thinking Strategies (PATHS)[19]
PATHS is comprehensive program for educators and counselors working with elementary school aged children (5 – 12 years old) to facilitate the development of self-control, emotional awareness, and interpersonal problem-solving skills. PATHS seeks to reduce aggression and behavior problems while simultaneously enhancing emotional development and the educational process in the classroom.

Second Step[20]
Second Step is a classroom-based social-skills program for children 4 to 14 years of age that teaches socioemotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. It consists of in-school curricula, parent training, and skill development.

Seeking Safety: A Psychotherapy for Trauma/PTSD and Substance Abuse[3]
Seeking Safety is a present-focused therapy designed to help people attain safety from PTSD and substance abuse. Key principles include: Safety as the larger goal; working on PTSD and substance at the same time; a focus on ideals to counteract the loss of ideals from the experience of having PTSD and a substance use disorder; and addressing cognitive, behavioral, interpersonal, and case management for client functioning.

Strengthening Families Program (SFP)[21]
The Strengthening Families Program (SFP) involves elementary school children, 6 to 12 years of age, and their families in 14 family training sessions using family systems and cognitive behavioral approaches to increase resilience and reduce risk factors. It seeks to improve family relationships, parenting skills, and youth's social and life skills.

Supported Employment[10]
Supported Employment is designed to help consumers with mental illness find and keep competitive employment within their communities. Supported Employment programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along, and everyone who desires to work is offered employment services. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), occur in normalized settings, and utilize multiple employers, and that the search for competitive jobs occurs rapidly after program entry.

Therapeutic Foster Care[10]

Children in Therapeutic Foster Care are placed with parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed.

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APPENDIX C

Evidence-Based Practices Survey Instrument

Department of Social and Health Services (DSHS)

Inventory of Evidence Based Practices (I-EBP)

June, 2007

Mental Health Transformation Project
Mental Health Division (MHD)
Division of Alcohol and Substance Abuse (DASA)
Juvenile Rehabilitation Administration (JRA)
Children's Administration (CA)

Provider Agency
--ATTENTION-- **PLEASE PROVIDE THE AGENCY NAME AND ADDRESS OF THE AGENCY THAT YOU ARE REPRESENTING**
Agency Name:
Address:
City:
State: **Zip:**

PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE

INSTRUCTIONS

- The questions in this survey ask about "this agency". By "this agency" we mean the specific agency name and location that you have provided on the front cover. If you have any questions about how the term "this agency" applies to your program, please call 1-253-761-7590.
- Please answer ONLY for the specific agency whose name and location are provided on the front cover.
- Although we prefer that you complete the questionnaire online, you may choose to return it in any one of following three ways:
  1. Enter your responses online. To access the survey, enter your agency's unique Login ID at the following web address:

     http://survey4.spss-asp.com/Survey?I.Project=P4840002A

  2. Email survey as an attached document to mertzh@u.washington.edu

  3. Mail or fax completed survey to:

     The Washington Institute for Mental Illness Research & Training
     ATTN: EBP PROJECT
     9601 Steilacoom Blvd. SW
     Tacoma, WA 98498-7213
     FAX: 253-756-3987

- Please keep a copy for your records.
- If you have any questions, contact:

THE WASHINGTON INSTITUTE FOR MENTAL ILLNESS RESEARCH AND TRAINING (WIMIRT)
1-253-761-7590

SECTION A: AGENCY CHARACTERISTICS

Section A asks about characteristics of individual agencies and should be completed for this agency only.

1. SERVICES PROVIDED: Which of the following services are offered by this agency?

MARK ALL THAT APPLY

Intake, assessment, or referral	Chemical Dependency Treatment	Mental Health Treatment	Co-occurring Disorders Treatment	Other (please specify)
☐	☐	☐	☐	

2. SOLO PRACTICE: Is this a solo practice, meaning an office with a single practitioner or therapist?

MARK ONE ONLY

No	Yes
☐	☐

3. POPULATION: What is the population of the service area for your agency?

	MARK ONE ONLY
1. Population less than 5,000	☐
2. Population between 5,001 and 50,000	☐
3. Population between 50,001 and 500,000	☐
4. Population greater than 500,000	☐

SECTION B: Utilization

In this next section, there are questions about specific practices being offered by this agency only, that is, the treatment agency or program listed on the front cover.

4. UTILIZATION OF EBPS: In the list below, please indicate which of following evidence based practices* (EBPs) your agency currently provides. Also indicate whether program fidelity is assessed or monitored (i.e., the practice is being implemented as intended according to established guidelines and/or manuals) for those practices you are currently providing and if so, what fidelity measure or method you are using?

*** Descriptions for the following EBPs are provided in the respective email as an attachment labeled "EBP Definitions"**

Check All That Apply	List of Practices	Assess Program Fidelity Yes	Fidelity Measure/Method Used (please specify)
☐	Aggression Replacement Training	☐	
☐	Assertive Community Treatment (ACT/PACT)	☐	
☐	Behavioral Treatment for Substance Abuse in Schizophrenia	☐	
☐	Brief Strategic Family Therapy	☐	
☐	Cognitive Behavior Therapies (CBT)	☐	
☐	Contingency Management (co-occurring)	☐	
☐	Dare to Be You	☐	
☐	Dialectical Behavioral Therapy (DBT)	☐	
☐	Eye Movement Desensitization & Reprocessing (EMDR)	☐	
☐	Family Integrated Transitions	☐	
☐	Family Psychoeducation	☐	
☐	Functional Family Therapy	☐	
☐	Gatekeeper program	☐	
☐	Illness Self-Management/Illness Management & Recovery	☐	
☐	Incredible Years	☐	
☐	Integrated Dual Disorders Treatment	☐	
☐	Interpersonal Therapy	☐	
☐	Medication Management	☐	
☐	Motivational Enhancement Therapy (MET)	☐	
☐	Motivational Interviewing	☐	
☐	Multi-Family Group Treatment (MFG)	☐	
☐	Multidimensional Family Therapy	☐	
☐	Multidimensional Treatment Foster Care	☐	
☐	Multisystemic Therapy	☐	
☐	Nurse-Family Partnership	☐	
☐	Parent-Child Interaction Therapy	☐	
☐	Peer Support	☐	
☐	Promoting Alternative Thinking Strategies (PATH)	☐	
☐	Second Step	☐	
☐	Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	☐	
☐	Strengthening Families Program (SFP)	☐	
☐	Supported Employment	☐	
☐	Supported Housing	☐	
☐	Therapeutic Foster Care	☐	
☐	Other (Specify:)	☐	
☐	Other (Specify:)	☐	
☐	Not applicable, we do not provide any EBPs-Skip to Q.9	☐	

If your agency does not provide any EBPs, please skip to Question 9.

5. TRAINING: For the practices your agency currently provides (see question #4), please indicate which mechanisms are used to provide training.

List of Practices	MARK ALL THAT APPLY				
	Internal Staff	**Collaboration with Universities**	**Provider-to-Provider Training**	**Outside Accreditation**	**Other (please specify)**
Aggression Replacement Training	☐	☐	☐	☐	
Assertive Community Treatment (ACT/PACT)	☐	☐	☐	☐	
Behavioral Treatment for Substance Abuse in Schizophrenia	☐	☐	☐	☐	
Brief Strategic Family Therapy	☐	☐	☐	☐	
Cognitive Behavior Therapies (CBT)	☐	☐	☐	☐	
Contingency Management (co-occurring)	☐	☐	☐	☐	
Dare to Be You	☐	☐	☐	☐	
Dialectical Behavioral Therapy (DBT)	☐	☐	☐	☐	
Eye Movement Desensitization & Reprocessing (EMDR)	☐	☐	☐	☐	
Family Integrated Transitions	☐	☐	☐	☐	
Family Psychoeducation	☐	☐	☐	☐	
Functional Family Therapy	☐	☐	☐	☐	
Gatekeeper program	☐	☐	☐	☐	
Illness Self-Management/Illness Management & Recovery	☐	☐	☐	☐	
Incredible Years	☐	☐	☐	☐	
Integrated Dual Disorders Treatment	☐	☐	☐	☐	
Interpersonal Therapy	☐	☐	☐	☐	
Medication Management	☐	☐	☐	☐	
Motivational Enhancement Therapy (MET)	☐	☐	☐	☐	
Motivational Interviewing	☐	☐	☐	☐	
Multi-Family Group Treatment (MFG)	☐	☐	☐	☐	
Multidimensional Family Therapy	☐	☐	☐	☐	
Multidimensional Treatment Foster Care	☐	☐	☐	☐	
Multisystemic Therapy	☐	☐	☐	☐	
Nurse-Family Partnership	☐	☐	☐	☐	
Parent-Child Interaction Therapy	☐	☐	☐	☐	
Peer Support	☐	☐	☐	☐	
Promoting Alternative Thinking Strategies (PATH)	☐	☐	☐	☐	
Second Step	☐	☐	☐	☐	
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	☐	☐	☐	☐	
Strengthening Families Program (SFP)	☐	☐	☐	☐	
Supported Employment	☐	☐	☐	☐	
Supported Housing	☐	☐	☐	☐	
Therapeutic Foster Care	☐	☐	☐	☐	
Other (Specify:)	☐	☐	☐	☐	
Other (Specify:)	☐	☐	☐	☐	

6. TARGET POPULATIONS: For the practices your agency currently provides (see question #4), please indicate which target populations you are providing the EBP for.

List of practices	MARK ALL THAT APPLY					
	Children	Adolescents	Adults	Elderly	Co-occurring Disorders	Other (Specify)
Aggression Replacement Training	☐	☐	☐	☐	☐	
Assertive Community Treatment (ACT/PACT)	☐	☐	☐	☐	☐	
Behavioral Treatment for Substance Abuse in Schizophrenia	☐	☐	☐	☐	☐	
Brief Strategic Family Therapy	☐	☐	☐	☐	☐	
Cognitive Behavior Therapies (CBT)	☐	☐	☐	☐	☐	
Contingency Management (co-occurring)	☐	☐	☐	☐	☐	
Dare to Be You	☐	☐	☐	☐	☐	
Dialectical Behavioral Therapy (DBT)	☐	☐	☐	☐	☐	
Eye Movement Desensitization & Reprocessing (EMDR)	☐	☐	☐	☐	☐	
Family Integrated Transitions	☐	☐	☐	☐	☐	
Family Psychoeducation	☐	☐	☐	☐	☐	
Functional Family Therapy	☐	☐	☐	☐	☐	
Gatekeeper program	☐	☐	☐	☐	☐	
Illness Self-Management/Illness Management & Recovery	☐	☐	☐	☐	☐	
Incredible Years	☐	☐	☐	☐	☐	
Integrated Dual Disorders Treatment	☐	☐	☐	☐	☐	
Interpersonal Therapy	☐	☐	☐	☐	☐	
Medication Management	☐	☐	☐	☐	☐	
Motivational Enhancement Therapy (MET)	☐	☐	☐	☐	☐	
Motivational Interviewing	☐	☐	☐	☐	☐	
Multi-Family Group Treatment (MFG)	☐	☐	☐	☐	☐	
Multidimensional Family Therapy	☐	☐	☐	☐	☐	
Multidimensional Treatment Foster Care	☐	☐	☐	☐	☐	
Multisystemic Therapy	☐	☐	☐	☐	☐	
Nurse-Family Partnership	☐	☐	☐	☐	☐	
Parent-Child Interaction Therapy	☐	☐	☐	☐	☐	
Peer Support	☐	☐	☐	☐	☐	
Promoting Alternative Thinking Strategies (PATH)	☐	☐	☐	☐	☐	
Second Step	☐	☐	☐	☐	☐	
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	☐	☐	☐	☐	☐	
Strengthening Families Program (SFP)	☐	☐	☐	☐	☐	
Supported Employment	☐	☐	☐	☐	☐	
Supported Housing	☐	☐	☐	☐	☐	
Therapeutic Foster Care	☐	☐	☐	☐	☐	
Other (Specify:)	☐	☐	☐	☐	☐	
Other (Specify:)	☐	☐	☐	☐	☐	

7. IMPLEMENTATION SUCCESS: For the practices your agency currently provides (see question #4), please indicate how successful your agency has been in implementing the EBP(s) listed below.

List of Practices	Not at All	A little	Somewhat	Very	Extremely
Aggression Replacement Training	☐	☐	☐	☐	☐
Assertive Community Treatment (ACT/PACT)	☐	☐	☐	☐	☐
Behavioral Treatment for Substance Abuse in Schizophrenia	☐	☐	☐	☐	☐
Brief Strategic Family Therapy	☐	☐	☐	☐	☐
Cognitive Behavior Therapies (CBT)	☐	☐	☐	☐	☐
Contingency Management (co-occurring)	☐	☐	☐	☐	☐
Dare to Be You	☐	☐	☐	☐	☐
Dialectical Behavioral Therapy (DBT)	☐	☐	☐	☐	☐
Eye Movement Desensitization & Reprocessing (EMDR)	☐	☐	☐	☐	☐
Family Integrated Transitions	☐	☐	☐	☐	☐
Family Psychoeducation	☐	☐	☐	☐	☐
Functional Family Therapy	☐	☐	☐	☐	☐
Gatekeeper program	☐	☐	☐	☐	☐
Illness Self-Management/Illness Management & Recovery	☐	☐	☐	☐	☐
Incredible Years	☐	☐	☐	☐	☐
Integrated Dual Disorders Treatment	☐	☐	☐	☐	☐
Interpersonal Therapy	☐	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐	☐
Motivational Enhancement Therapy (MET)	☐	☐	☐	☐	☐
Motivational Interviewing	☐	☐	☐	☐	☐
Multi-Family Group Treatment (MFG)	☐	☐	☐	☐	☐
Multidimensional Family Therapy	☐	☐	☐	☐	☐
Multidimensional Treatment Foster Care	☐	☐	☐	☐	☐
Multisystemic Therapy	☐	☐	☐	☐	☐
Nurse-Family Partnership	☐	☐	☐	☐	☐
Parent-Child Interaction Therapy	☐	☐	☐	☐	☐
Peer Support	☐	☐	☐	☐	☐
Promoting Alternative Thinking Strategies (PATH)	☐	☐	☐	☐	☐
Second Step	☐	☐	☐	☐	☐
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	☐	☐	☐	☐	☐
Strengthening Families Program (SFP)	☐	☐	☐	☐	☐
Supported Employment	☐	☐	☐	☐	☐
Supported Housing	☐	☐	☐	☐	☐
Therapeutic Foster Care	☐	☐	☐	☐	☐
Other (Specify:)	☐	☐	☐	☐	☐
Other (Specify:)	☐	☐	☐	☐	☐

8. EFFECT ON OUTCOMES: For the practices your agency currently provides (see question #4), how effective do you think the EBP is at producing positive client outcomes.

List of Practices	Not at All	A little	Somewhat	Very	Extremely
Aggression Replacement Training	☐	☐	☐	☐	☐
Assertive Community Treatment (ACT/PACT)	☐	☐	☐	☐	☐
Behavioral Treatment for Substance Abuse in Schizophrenia	☐	☐	☐	☐	☐
Brief Strategic Family Therapy	☐	☐	☐	☐	☐
Cognitive Behavior Therapies (CBT)	☐	☐	☐	☐	☐
Contingency Management (co-occurring)	☐	☐	☐	☐	☐
Dare to Be You	☐	☐	☐	☐	☐
Dialectical Behavioral Therapy (DBT)	☐	☐	☐	☐	☐
Eye Movement Desensitization & Reprocessing (EMDR)	☐	☐	☐	☐	☐
Family Integrated Transitions	☐	☐	☐	☐	☐
Family Psychoeducation	☐	☐	☐	☐	☐
Functional Family Therapy	☐	☐	☐	☐	☐
Gatekeeper program	☐	☐	☐	☐	☐
Illness Self-Management/Illness Management & Recovery	☐	☐	☐	☐	☐
Incredible Years	☐	☐	☐	☐	☐
Integrated Dual Disorders Treatment	☐	☐	☐	☐	☐
Interpersonal Therapy	☐	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐	☐
Motivational Enhancement Therapy (MET)	☐	☐	☐	☐	☐
Motivational Interviewing	☐	☐	☐	☐	☐
Multi-Family Group Treatment (MFG)	☐	☐	☐	☐	☐
Multidimensional Family Therapy	☐	☐	☐	☐	☐
Multidimensional Treatment Foster Care	☐	☐	☐	☐	☐
Multisystemic Therapy	☐	☐	☐	☐	☐
Nurse-Family Partnership	☐	☐	☐	☐	☐
Parent-Child Interaction Therapy	☐	☐	☐	☐	☐
Peer Support	☐	☐	☐	☐	☐
Promoting Alternative Thinking Strategies (PATH)	☐	☐	☐	☐	☐
Second Step	☐	☐	☐	☐	☐
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	☐	☐	☐	☐	☐
Strengthening Families Program (SFP)	☐	☐	☐	☐	☐
Supported Employment	☐	☐	☐	☐	☐
Supported Housing	☐	☐	☐	☐	☐
Therapeutic Foster Care	☐	☐	☐	☐	☐
Other (Specify:)	☐	☐	☐	☐	☐
Other (Specify:)	☐	☐	☐	☐	☐

9. FUTURE USE: Are there any EBP's* that you are NOT currently using but want to use in the future?
*** Descriptions of the following EBPs are provided in the respective email as an attachment labeled "EBP Definitions"**

MARK ALL THAT APPLY	List of practices
☐	Aggression Replacement Training
☐	Assertive Community Treatment (ACT/PACT)
☐	Behavioral Treatment for Substance Abuse in Schizophrenia
☐	Brief Strategic Family Therapy
☐	Cognitive Behavior Therapies (CBT)
☐	Contingency Management (co-occurring)
☐	Dare to Be You
☐	Dialectical Behavioral Therapy (DBT)
☐	Eye Movement Desensitization & Reprocessing (EMDR)
☐	Family Integrated Transitions
☐	Family Psychoeducation
☐	Functional Family Therapy
☐	Gatekeeper program
☐	Illness Self-Management/Illness Management & Recovery
☐	Incredible Years
☐	Integrated Dual Disorders Treatment
☐	Interpersonal Therapy
☐	Medication Management
☐	Motivational Enhancement Therapy (MET)
☐	Motivational Interviewing
☐	Multi-Family Group Treatment (MFG)
☐	Multidimensional Family Therapy
☐	Multidimensional Treatment Foster Care
☐	Multisystemic Therapy
☐	Nurse-Family Partnership
☐	Parent-Child Interaction Therapy
☐	Peer Support
☐	Promoting Alternative Thinking Strategies (PATH)
☐	Second Step
☐	Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse
☐	Strengthening Families Program (SFP)
☐	Supported Employment
☐	Supported Housing
☐	Therapeutic Foster Care
☐	Other (Specify:)
☐	Other (Specify:)
☐	Other (Specify:)
☐	No, there are not any EBPs that I want to use in the future.

10. BARRIERS: Please indicate whether any of the barriers listed below interfere with your agency in providing EBPs you are using or want to use?

LIST OF PRACTICES	MARK ALL THAT APPLY							
	Shortage of appropriately trained workforce	**Financing issues in paying for EBPs**	**EBP needs modification to fit local needs**	**Attaining or maintaining fidelity to EBP model standards**	**Resistance to implementing EBPs from practitioners or others**	**Rules & Regulations**	**None**	**Other (Specify)**
Aggression Replacement Training	☐	☐	☐	☐	☐	☐	☐	
Assertive Community Treatment (ACT/PACT)	☐	☐	☐	☐	☐	☐	☐	
Behavioral Treatment for Substance Abuse in Schizophrenia	☐	☐	☐	☐	☐	☐	☐	
Brief Strategic Family Therapy	☐	☐	☐	☐	☐	☐	☐	
Cognitive Behavior Therapies (CBT)	☐	☐	☐	☐	☐	☐	☐	
Contingency Management (co-occurring)	☐	☐	☐	☐	☐	☐	☐	
Dare to Be You	☐	☐	☐	☐	☐	☐	☐	
Dialectical Behavioral Therapy (DBT)	☐	☐	☐	☐	☐	☐	☐	
Eye Movement Desensitization & Reprocessing (EMDR)	☐	☐	☐	☐	☐	☐	☐	
Family Integrated Transitions	☐	☐	☐	☐	☐	☐	☐	
Family Psychoeducation	☐	☐	☐	☐	☐	☐	☐	
Functional Family Therapy	☐	☐	☐	☐	☐	☐	☐	
Gatekeeper program	☐	☐	☐	☐	☐	☐	☐	
Illness Self-Management/Illness Management & Recovery	☐	☐	☐	☐	☐	☐	☐	
Incredible Years	☐	☐	☐	☐	☐	☐	☐	
Integrated Dual Disorders Treatment	☐	☐	☐	☐	☐	☐	☐	
Interpersonal Therapy	☐	☐	☐	☐	☐	☐	☐	
Medication Management	☐	☐	☐	☐	☐	☐	☐	
Motivational Enhancement Therapy (MET)	☐	☐	☐	☐	☐	☐	☐	
Motivational Interviewing	☐	☐	☐	☐	☐	☐	☐	
Multi-Family Group Treatment (MFG)	☐	☐	☐	☐	☐	☐	☐	
Multidimensional Family Therapy	☐	☐	☐	☐	☐	☐	☐	
Multidimensional Treatment Foster Care	☐	☐	☐	☐	☐	☐	☐	
Multisystemic Therapy	☐	☐	☐	☐	☐	☐	☐	
Nurse-Family Partnership	☐	☐	☐	☐	☐	☐	☐	
Parent-Child Interaction Therapy	☐	☐	☐	☐	☐	☐	☐	
Peer Support	☐	☐	☐	☐	☐	☐	☐	
Promoting Alternative Thinking Strategies (PATH)	☐	☐	☐	☐	☐	☐	☐	
Second Step	☐	☐	☐	☐	☐	☐	☐	
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	☐	☐	☐	☐	☐	☐	☐	
Strengthening Families Program (SFP)	☐	☐	☐	☐	☐	☐	☐	
Supported Employment	☐	☐	☐	☐	☐	☐	☐	
Supported Housing	☐	☐	☐	☐	☐	☐	☐	
Therapeutic Foster Care	☐	☐	☐	☐	☐	☐	☐	
Other (Specify:)	☐	☐	☐	☐	☐	☐	☐	
Other (Specify:)	☐	☐	☐	☐	☐	☐	☐	

11. FACILITATING EBPS: What type of assistance is most needed by your agency to help facilitate the adoption and implementation of evidence based practices?	
	MARK ONE ONLY
None	☐
Appropriately trained workforce	☐
Financing issues in paying for EBPs	☐
Modification of EBP to fit local needs	☐
Attaining or maintaining fidelity to EBP model standards	☐
Resistance to implementing EBPs from practitioners	☐
Other: _____	☐

12. OTHER CLIENT NEEDS: Does your agency serve populations or address specific client needs for which there are no known or available evidence-based practices?		
No	☐	**If "No", go to Q.13**
Yes	☐	**If "Yes", what are these populations or client needs? Specify:**

13. INTEREST IN EBP IMPLEMENTATION: Please rate your agency's interest in continuing/beginning to implement EBPs into your treatment program?					
	Not at All	**A little**	**Somewhat**	**Very**	**Extremely**
	☐	☐	☐	☐	☐

14. EBP INITIATIVES: What initiatives, if any, is your agency implementing to promote the adoption of evidence-based practices (EBPs)?	
	MARK ALL THAT APPLY
1. Increase awareness about EBPs	☐
2. Training	☐
3. Incorporation of EBPs in contracts	☐
4. Monitoring of fidelity	☐
5. Modification of information systems/data reports	☐
6. Modification of paperwork/documentation forms/guidelines to fit EBPs so as to accurately reflect the work done.	☐
7. Financial incentives	☐
8. Other (specify:_____)	☐
9. None	☐

15. EBP EFFECTS: Is your agency conducting any systematic assessment of the effects of the evidence-based interventions that you are using?	
1. No **(Skip to Q.16)**	☐
2. Yes	☐

If "Yes" what method(s) are you using?	**MARK ALL THAT APPLY**
Benchmarking	☐
Outcome monitoring	☐
Program Evaluation	☐
Other	☐

SECTION C: CLIENT COUNT INFORMATION

Section C asks about client count information for specific EBPs and for this agency.

16. ANNUAL CLIENT COUNT: How many unduplicated clients did your agency serve in Fiscal Year 2007 (July 1, 2006 – June 30, 2007)?

___ ___ ___ ___ ___ ___ ___

Continue on to the next page.

17. CLIENT COUNTS FOR EACH EBP: For each EBP that you are currently providing (see question #4), please provide the total number of unduplicated clients served in FY 2007 (July 1, 2006 – June 30, 2007). Also provide the number of adults and number of children who received each practice.

List of Practices	# of persons served	# of adults	# of children
Aggression Replacement Training			
Assertive Community Treatment(ACT/PACT)			
Behavioral Treatment for Substance Abuse in Schizophrenia			
Brief Strategic Family Therapy			
Cognitive Behavior Therapies (CBT)			
Contingency Management (co-occurring)			
Dare to Be You			
Dialectical Behavioral Therapy (DBT)			
Eye Movement Desensitization & Reprocessing (EMDR)			
Family Integrated Transitions			
Family Psychoeducation			
Functional Family Therapy			
Gatekeeper program			
Illness Self-Management/Illness Management & Recovery			
Incredible Years			
Integrated Dual Disorders Treatment			
Interpersonal Therapy			
Medication Management			
Motivational Enhancement Therapy (MET)			
Motivational Interviewing			
Multi-Family Group Treatment (MFG)			
Multidimensional Family Therapy			
Multidimensional Treatment Foster Care			
Multisystemic Therapy			
Nurse-Family Partnership			
Parent-Child Interaction Therapy			
Peer Support			
Promoting Alternative Thinking Strategies (PATH)			
Second Step			
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse			
Strengthening Families Program (SFP)			
Supported Employment			
Supported Housing			
Therapeutic Foster Care			
Other (specify:)			
Other (specify:)			

18. RESPONDENT PROVIDING CLIENT COUNT INFORMATION: Whom should we contact if we have questions about client count information?	
Name	
Agency Name	
Phone Number	**( ) _____ - _____**
E-mail address	

SECTION D: RESPONDENT CHARACTERISTICS

Section D asks about the person who had primary responsibility for filling out this form. We will contact you only if we have further questions about your responses.

19. CHARACTERISTICS OF THE PRIMARY RESPONDENT	
Name	
What is your current job title?	
How long have you been working at this agency?	**_____ years**
Phone Number	**( ) _____ - _____**
E-mail address	

Thank you for your participation! When completed you may choose to do one of the following:

1) Enter all of the above responses online at: http://survey4.spss-asp.com/Survey?I.Project=P4840002A

2) Email the survey as an attachment to mertzh@u.washington.edu

3) Mail or Fax the survey to:

The Washington Institute for Mental Illness Research and Training (WIMIRT)
ATTN: EBP Project
9601 Steilacoom Blvd. SW
Tacoma, WA 98498-7213
FAX: 253-756-3987

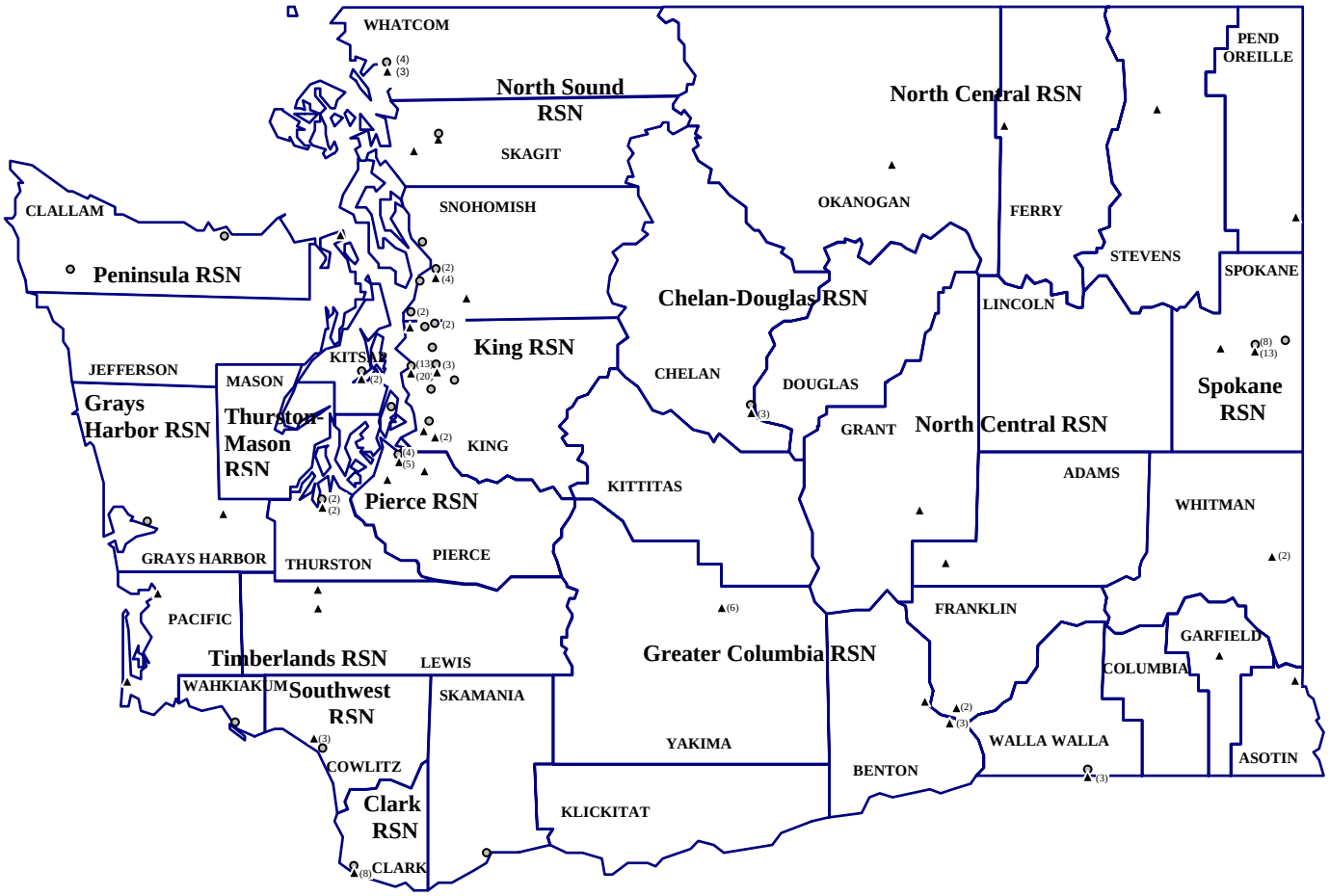
APPENDIX D

MAPS

Completions/Non-Completions By Agency Type

Appendix D Contents

MHD Map



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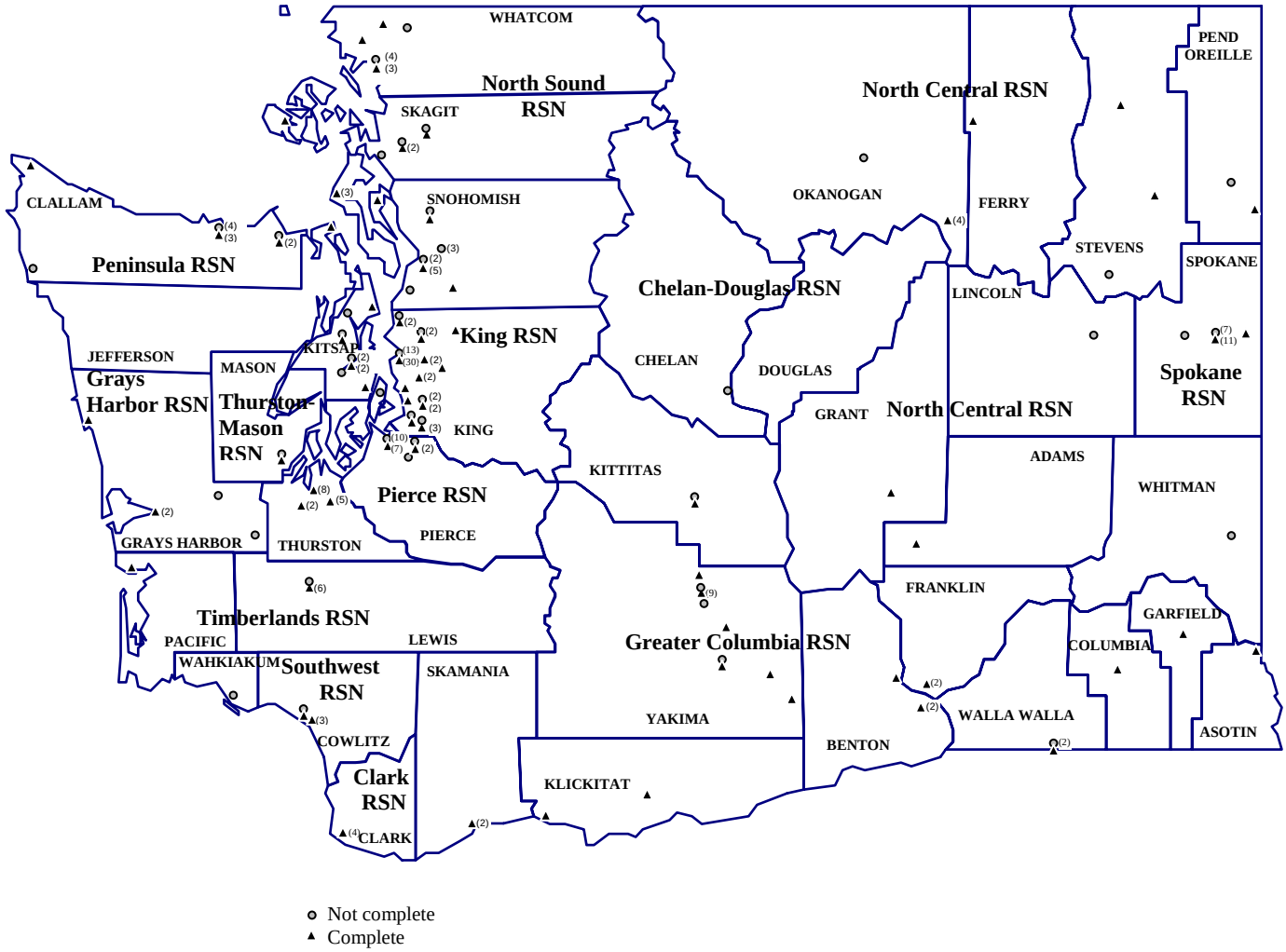
Complete

DASA Map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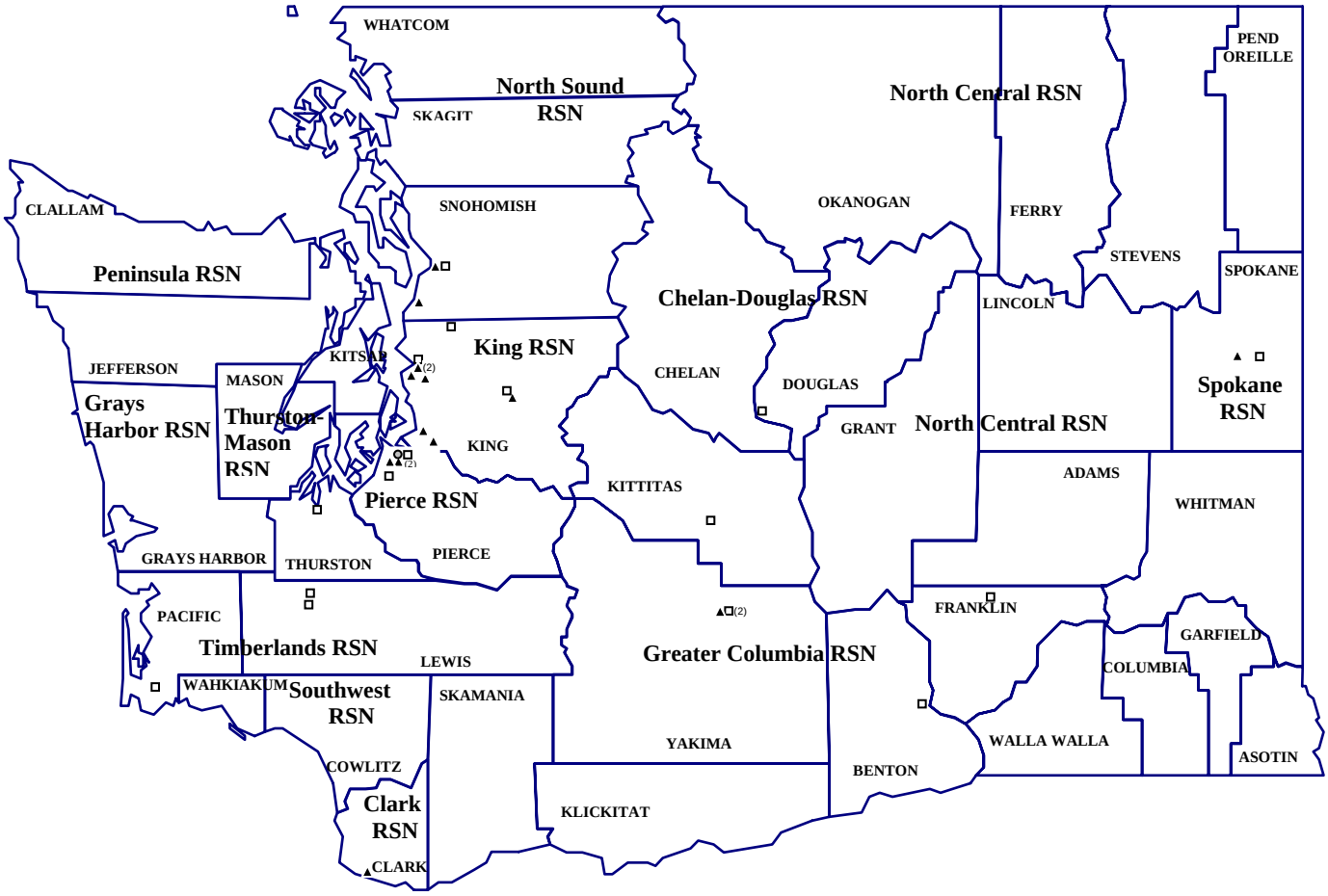
SKAGIT
North Central RSN
PEND OREILLE
SNOHOMISH
OKANOGAN
FERRY
CLALLAM
Peninsula RSN
STEVENS
SPOKANE
Chelan-Douglas RSN
LINCOLN
King RSN
JEFFERSON
KITSAP
MASON
CHELAN
DOUGLAS
Spokane RSN
Grays Harbor RSN
Thurston-Mason RSN
KING
GRANT
North Central RSN
ADAMS
KITTITAS
WHITMAN
Pierce RSN
PIERCE
GRAYS HARBOR
THURSTON
FRANKLIN
Timberlands RSN
GARFIELD
PACIFIC
LEWIS
Greater Columbia RSN
COLUMBIA
WAHKIAKUM
Southwest RSN
SKAMANIA
YAKIMA
WALLA WALLA
ASOTIN
COWLITZ
BENTON
Clark RSN
KLICKITAT
CLARK
Not complete
Complete

JRA & CA Map


WHATCOM
North Sound RSN
SKAGIT
North Central RSN
PEND OREILLE
CLALLAM
SNOHOMISH
OKANOGAN
FERRY
STEVENS
SPOKANE
Peninsula RSN
Chelan-Douglas RSN
LINCOLN
King RSN
JEFFERSON
KITSAP
MASON
CHELAN
DOUGLAS
Spokane RSN
Grays Harbor RSN
Thurston-Mason RSN
KING
GRANT
North Central RSN
ADAMS
KITTITAS
WHITMAN
Pierce RSN
PIERCE
GRAYS HARBOR
THURSTON
FRANKLIN
PACIFIC
Timberlands RSN
Greater Columbia RSN
GARFIELD
LEWIS
COLUMBIA
WAHKIAKUM
Southwest RSN
SKAMANIA
WALLA WALLA
YAKIMA
ASOTIN
COWLITZ
BENTON
Clark RSN
KLICKITAT
CLARK
Children Not complete
Children Complete
JRA Complete

MHD Agencies Not Completing the EBP Survey

RSN	MHD Agency
Chelan-Douglas	The Promise Club
Clark	Mental Health Northwest
Grays Harbor	Evergreen Counseling Center
Greater Columbia	Children's Home Society of Washington – Walla Walla
	Skamania County Counseling Center
King	Asian Counseling and Referral Services
	BHC Fairfax
	Cedar Park Counseling Network
	Children's Home Society of Washington
	Community House Mental Health
	Creative Change Counseling Center
	Downtown Emergency Services Center
	Friends of Youth
	Hero House
	Kent Youth and Family Services
	Lutheran Community Services Seattle
	Meier Clinics
	Northshore Youth and Family Services
	Olive Crest
	Pioneer Human Services
	Renton Area Youth and Family Services
	Ruth Dykeman Children's Center
	Seattle Counseling Service
	Seattle Indian Health Board
	Seattle Mental Health
	Therapeutic Health Services
	Vashon Youth and Family Services
	Wallingford House
	Youth Eastside Services
North Sound	Catholic Community Services – Snohomish County
	Compass Health
	Lake Whatcom Residential and Treatment Center
	North Sound Evaluation & Treatment Facility
	Rainbow Center
	Sea Mar Counseling and Social Services – Bellingham
	Snohomish County Evaluation and Treatment Facility
	Stevens Hospital
	The Center for Counseling & Health Resources
	Tulalip Family Counseling
	Whatcom Counseling & Psychiatric Clinic

MHD Agencies Not Completing the EBP Survey (cont)

RSN	MHD Agency
Peninsula	RMH Services
	West End Outreach Services
	Peninsula Community Mental Health Services
Pierce	Catholic Community Services – Tacoma
	Child and Family Guidance Center
	Kwawachee Counseling Center
	Social Treatment Opportunity Programs
Southwest	S.L. Start & Associates, Inc
	Children's Home Society – Spokane
	Evergreen Club
	Excelsior Youth Center
	Sacred Heart Medical Center
	SEER Supported Education Enhancing Rehabilitation
	Spokane County Juvenile Services
	Spokane County Supportive Living Program
	Spokane School District #81
	The N.A.T.I.V.E. Project
Thurston-Mason	Capitol Clubhouse
	Catholic Community Services Family Preservation System
Timberlands	Wahkiakum County Mental Health Services

MHD Agencies Completing the EBP Survey

RSN	MHD Agency
Chelan-Douglas	Catholic Family and Child Service
	Children's Home Society – Wenatchee
	Columbia Valley Community Health
Clark	Catholic Community Services – Vancouver
	Children's Center
	Children's Home Society of Washington – Vancouver
	Columbia River MH Services
	Family Solutions
	Institute for Family Development – Vancouver*
	Lifeline Connections
	Southwest Washington Medical Center
Grays Harbor	Behavioral Health Resources – Elma
Greater Columbia	Benton & Franklin Counties Crisis Unit
	Blue Mountain Counseling
	Catholic Family and Child Services – Yakima
	Central Washington Comprehensive Mental Health
	Garfield County Human Services*
	Harvest House
	Institute for Family Development*
	Lourdes Counseling Center
	Lourdes Wilson House*
	Lutheran Community Services Northwest
	Nueva Esperanza Community Counseling Services
	Palouse River Counseling Services
	Rising Sun Clubhouse
	Rogers Counseling Center
	Sunderland Family Treatment Services
	Sunrise Club
	Walla Walla Department of Human Services
	Yakima Valley Farmworkers Behavioral Health Services
	Yakima Valley Memorial Hospital
King	Atlantic Street Center
	Auburn Youth Resources
	Catholic Community Services – Seattle
	Center for Human Services
	Children's Hospital and Regional Medical Center
	Community Psychiatric Clinic
	Consejo Counseling and Referral Services
	Crisis Clinic of Seattle
	Evergreen Healthcare
	Harborview Medical Center

MHD Agencies Completing the EBP Survey (cont)

RSN	MHD Agency
King	Harborview Mental Health Services
	Highline West Seattle Mental Health Center
	Institute for Family Development – King Prime Time Projects
	Northwest Hospital
	Pathways Mental Health
	Prime Time Projects
	Ryther Child Center
	Sea Mar Community Health Center
	Sea Mar Counseling and Social Services – Tacoma
	Seattle Children's Home
	Southwest Youth and Family Services
	Transitional Resources
	Valley Cities Counseling & Consultation
	West Seattle Psychiatric Hospital
	YMCA Mental Health Services
North Central	Community Counseling Services of Adams County
	Ferry County Community Services
	Grant Mental Healthcare
	Okanogan Behavioral Healthcare
	Pend Oreille County Counseling Services
	Stevens County Counseling Services
North Sound	Bridgeways
	Catholic Community Services – Bellingham
	Northwest Youth Services
	Skagit Valley Hospital
	Snohomish County Human Services Mental Health Division
	St. Joseph Hospital Mental Health Unit
	Sunrise Services
	United General Hospital
	Valley General Hospital
	Volunteers of America Care Crisis Response Services
Peninsula	Jefferson Counseling Center
	Kitsap Mental Health Services
	Kitsap Mental Health Services Inpatient Unit*
Pierce	Comprehensive Mental Health
	Good Samaritan Behavioral Healthcare
	Greater Lakes Mental Healthcare
	Pearl Street Center*
	Pierce County Evaluation and Treatment

MHD Agencies Completing the EBP Survey (cont)

RSN	MHD Agency
Pierce	Pierce County Mobile Outreach Crisis Team & Crisis Response
	Rose House
Southwest	Lower Columbia Mental Health C. (Cowlitz Co. Guidance Assoc)
	PeaceHealth – St. John Medical C./C. for Behavioral Solutions
	Toutle River Ranch/Youth and Family Link
Spokane	Camas Institute-Behavioral Health Department
	Catholic Family Services Counseling Program – Spokane
	Community Detox Services of Spokane County
	Family Services Spokane
	Institute for Family Development Spokane*
	Lutheran Community Services Northwest – Inland Northwest Area
	Partners with Families and Children
	Saint Joseph Family Center
	SNAP – Spokane Neighborhood Action Program
	Spokane County Jail Services
	Spokane Mental Health
	Tamarack Center
	Volunteers of America – Passages
	YFA Connections
Thurston-Mason	Behavioral Health Resources
	Providence St. Peter Hospital
Timberlands	Cascade Mental Health*
	Cascade Mental Health Care – Centralia
	Willipa Counseling Center
	Willipa Counseling Center*

*Roll-up/Completes

DASA Agencies Not Completing the EBP Survey

RSN	DASA Agency
Chelan-Douglas	Center For Alcohol And Drug Treatment (The)
Grays Harbor	Northwest Indian Treatment Center - Elma
	TSAPOWUM / Chehalis Tribal Chemical Dependency Program
Greater Columbia	Alcohol Drug Dependency Service - Ellensburg ADDS
	Community Counseling Clinic LLC (Union Gap)
	Palouse River Counseling Center
	Veterans Administration - Yakima Substance Abuse Outreach
	Veterans Administration Medical Center - Walla Walla
	Yakama Indian Nation Comprehensive Alcoholism Program
	Yakima County Assessment Service
King	Alternatives - Seattle
	Avalon Center, The
	Bi-County Co-Occurring Residential Treatment Center
	Central Youth And Family Services
	Community Psychiatric Clinic - Bellevue
	Consejo Counseling And Referral - Seattle
	Genesis House
	Intercept Associates
	Kent Youth And Family Services
	Korean Community Counseling Center
	Lakeside-Milam Recovery Center (Kirkland Inpatient)
	Muckleshoot Behavioral Health Program
	Ryther Child Center - West Seattle Outpatient Branch
	Seattle Counseling Service for Sexual Minorities
	Sound Mental Health-NCI Renton
	Therapeutic Health Services - Seneca Branch
	Therapeutic Health Services - Shoreline
	Therapeutic Health Services - Summit Branch
	Thunderbird Treatment Center
	Washington Asian/Pacific Islander Families
	Youth Eastside Services - Lake Washington Branch

DASA Agencies Not Completing the EBP Survey (cont)

RSN	DASA Agency
North Central	Kalispel Social Services - Usk
	Lincoln County Alcohol & Drug Center
	Okanogan Behavioral Healthcare, Inc.
	Spokane Tribe Of Indians Substance Abuse Program
North Sound	Catholic Community Services - Recovery Center - Bellingham
	Catholic Community Services - Recovery Center - Everett
	Catholic Community Services - Recovery Center - Marysville
	Island Crossing Counseling Services
	La Esperanza Health Counseling Services
	Lummi Counseling Services
	Nooksack Tribe`s Genesis II
	Phoenix Recovery Services, LLC
	Sea Mar Substance Abuse Outpatient Services -- Main Facility
	Swinomish Alcohol Program
	Therapeutic Health Services - Everett Branch
	Tulalip Tribal Family Services Chemical Dependency Program
	Tulalip Tribes Family Services CD Youth Program
	Upper Skagit Tribe Chemical Dependency Treatment Program
	Westcoast Counseling and Treatment Center
Peninsula	Cascade Recovery Center - Silverdale
	Highland Courte
	Kitsap Mental Health Services
	Kitsap Recovery Center
	Klallam Counseling Services
	Peninsula Community Mental Health Center
	Quileute Addictions Program
	Safe Harbor Recovery Center - Sequim, Inc.
	Suquamish Tribe Wellness Program
	Trillium Treatment Center
	West Sound Treatment Center - Fuller Wise Bldg

DASA Agencies Not Completing the EBP Survey (cont)

RSN	DASA Agency
Pierce	Chief Leschi School
	Foundation for Multicultural Solutions
	Madigan Army Medical Center (MAMC)
	Moms & Women`s Recovery Center - East Puyallup Branch
	Moms & Women`s Recovery Center - South (Parkland) Branch
	Moms & Women`s Recovery Center - Tacoma Branch
	Prosperity Counseling & Treatment Services, Inc.
	Puyallup Tribal Treatment Center
	Remann Hall Alcohol/Drug Development Program (RHADD)
	Sea Mar Outpatient Substance Abuse Services - Tacoma
	Tacoma/Pierce County Treatment Services - Unit 1
	Tacoma/Pierce County Treatment Services - Unit 2
Southwest	Cowlitz Tribal Treatment Program - Vancouver
Spokane	Alcohol/Drug Network (CHIPS)
	Camas Institute Behavioral Health Services
	Daybreak Of Spokane (Intensive Inpatient Program)
	N.A.T.I.V.E. Project
	Northeast Washington Treatment Alternatives
	SPARC -- Spokane Addiction Recovery Centers
	SPARC Intensive Inpatient Services (Christoph House/Delaney)
	SPARC Outpatient Services
Thurston-Mason	Northwest Indian Treatment Center - Shelton Outpatient Servi
Timberlands	Eugenia Center
	Wahkiakum Chemical Dependency Services

DASA Agencies Completing the EBP Survey

RSN	DASA Agency
Clark	Columbia River Mental Health
	Daybreak - Vancouver (Male-Youth Inpatient)
	Lifeline Connections
	Northwest Recovery Center
Grays Harbor	HarborCrest Behavioral Health
	Quinault Indian Nation
	True North- Grays Harbor
Greater Columbia	Advocates for Wellness
	Benton And Franklin Counties Assessment Center
	Blue Mountain Counseling of Columbia County
	Casa de Esperanza -- Behavioral Health Services
	Casa de Esperanza - Grandview
	Cascade Recovery Resource Center
	Casita del Rio - Unit I
	Casita Del Rio - Unit II
	Central Washington Comprehensive Mental Health
	Crossroads Behavioral Health - Stevenson
	Dependency Health Services
	Dependency Health Services - Goldendale
	Dependency Health Services - Yakima Outpatient
	Garfield County Human Services - Pomeroy Office*
	Lourdes Counseling Center - Pasco
	Merit Resource Services - Sunnyside
	Merit Resource Services - Toppenish Branch
	Merit Resource Services - Wapato Branch
	Merit Resource Services - Yakima
	Quality Behavioral Health -- Clarkston Main Facility
	Serenity Point Counseling Services, LLC
	Skamania County Counseling Center
	Somerset Counseling Center
	Sundown M Ranch
	Triumph Treatment Services
	Triumph Treatment Services - James Oldham Treatment Center
	Triumph Treatment Services - Riel House
	Unity Counseling Services
King	Asian Counseling and Referral Service (ACRS)
	Auburn Youth Resources
	Catholic Community Services - South King County
	Center For Human Services
	Community Psychiatric Clinic - Belltown
	Community Psychiatric Clinic - Bridgeway

DASA Agencies Completing the EBP Survey (cont)

RSN	DASA Agency
King	Community Psychiatric Clinic - Northgate Branch
	Community Psychiatric Clinic - Wallingford House
	Community Psychiatric Clinic- Seattle
	Consejo Counseling and Referral - Eastside Branch
	Downtown Emergency Service Center (Seattle)
	Evergreen Treatment Services - Unit 1
	Evergreen Treatment Services - Unit 2*
	Evergreen Treatment Services - Unit 3*
	Friends Of Youth
	Harborview Medical Center Addictions Program
	Highline - West Seattle Mental Health Center (Burien)
	Northshore STARS Program
	Perinatal Treatment Services -- Seattle
	Pioneer Counseling Services
	Pioneer DOSA West
	Raging River Recovery Center
	Recovery Centers of King County - Kent Branch
	Recovery Centers of King County - Main Facility
	Recovery Centers of King County - Seattle Detox/Inpatient Ce
	Renton Area Youth And Family Services
	Residence XII - Kirkland (formerly Kenmore/Bothell)
	Ruth Dykeman Youth & Family Services
	Ryther Child Center - Main Facility
	Safeco Safehouse Branch (Girls Adolescent Program)
	Sea mar Community Health
	Seadrunar - Forest Park
	Sea Mar Renacer Youth Treatment Center*
	Seattle Indian Health Board
	Sound Mental Health-Bellevue
	Sound Mental Health-Capitol Hill
	Sound Mental Health-NCI Auburn
	Sound Mental Health-NCI Kent/SCS Kent
	Sound Mental Health-NCI Northgate
	Sound Mental Health-Service Center Auburn
	Sound Mental Health-Service Center Tukwila

DASA Agencies Completing the EBP Survey (cont)

RSN	DASA Agency
King	Therapeutic Health Services - Rainier Branch (South)
	Valley Cities Counseling & Consultation – Auburn*
	Valley Cities Counseling & Consultation – Federal Way Comprehensive Services
	Valley Cities Counseling & Consultation – Kent*
	Veterans Administration Puget Sound Health Care System-Seatt
	Youth Eastside Services
North Central	Adams County Community Counseling Services
	Change Point of Ferry County Counseling Services
	Colville Tribal Alcohol/Drug Program - Omak
	Colville Tribal Alcohol/Drug Program - Inchelium
	Colville Tribal Alcohol/Drug Program - Keller
	Colville Tribal Alcohol/Drug Program - Nespelem
	Grant County Prevention and Recovery Center (PARC)
	Pend Oreille County Counseling Services
	Stevens County Counseling Services
	Stevens County Counseling Services (Colville)
North Sound	Compass Health - Camano Island*
	Compass Health - Coupeville
	Compass Health – Langley*
	Compass Health - Oak Harbor*
	Compass Health – San Juan
	Evergreen Manor Outpatient Services - Main Campus*
	Evergreen Manor Outpatient Services- Wall Street Campus
	Evergreen Manor Residential Services-Unit 1 (Bldg B)
	Evergreen Residential Services -Unit 2 (Bldg C)
	Pioneer Center North
	Sea Mar - Visions
	Sea Mar Community Health Care Centers - Monroe
	Sea Mar Substance Abuse Outpatient Services - Mt Vernon
	Sea Mar Substance Abuse Services - Everett
	Skagit Recovery Center - John King Recovery House
	St. Joseph Hospital - Bellingham
	St. Joseph Hospital - Ferndale Branch
	Stillaguamish Tribe of Indians
	The Center - Lynden
	Westcoast Counseling and Treatment Center

DASA Agencies Completing the EBP Survey (cont)

RSN	DASA Agency
Peninsula	Agape
	Jamestown S`Klallam Chemical Dependency Program
	Makah Chemical Dependency Program
	Naval Hospital
	Olalla Guest Lodge
	Olympic ESD 114 Youth Recovery Program
	Olympic Personal Growth Center
	Port Gamble S'Klallam Recovery Center
	Safe Harbor Recovery Center, Inc. FPC (Pt Townsend) AND
	True Star Recovery Program (Clallam County Youth Services)
	WEOS – Oak Street Center
	West End Outreach Services - Oak Street Center (Port Angeles
Pierce	Perinatal Treatment Services - Pierce County Branch
	Perinatal Treatment Svcs - Pierce County Adolescent Fresh St
	Pierce County Alliance
	Prosperity Wellness Center
	Sea Mar Residential Alcohol/Drug Treatment - Tacoma Adult
	The Center East (Sumner)*
	The Center for Substance Abuse and Recovery
	The Center South (Gravelly Lake -- Lakewood)*
	Veterans Administration Medical Center/American Lake
Southwest	Cowlitz Tribal Treatment Program - Longview
	Drug Abuse Prevention Center (Castle Rock)
	Drug Abuse Prevention Center (Drug Court)
	Drug Abuse Prevention Center (Longview Inpatient & OP)
Spokane	American Behavioral Health Systems – Cozza Branch*
	American Behavioral Health Systems - Mission Branch
	Daybreak Of Spokane (Outpatient Program)
	Excelsior Youth Centers, Inc. - Spokane
	Isabella House
	New Horizon Counseling Services
	Partners with Families and Children: Spokane
	Pioneer Center East - Spokane
	SATP/USVAMC
	STEPPS - Youth Family Adult (YFA) Connections
	Sun Ray Court (Adult Male Branch)
	The Healing Lodge of the Seven Nations

DASA Agencies Completing the EBP Survey (cont)

RSN	DASA Agency
Thurston-Mason	Alternatives Professional Counseling, Inc. (Olympia)
	BHR Recovery Services-Olympia
	BHR Recovery Services-Shelton*
	Nisqually Tribal Substance Abuse & Prevention Program
	Sea Mar Outpatient Substance Abuse Services-Olympia
	Skokomish H.O.P.E. Alcohol & Drug Program
	St. Peter Chemical Dependency Center - Aberdeen ADATSA*
	St. Peter Chemical Dependency Center – Belfair*
	St. Peter Chemical Dependency Center – Hoquiam*
	St. Peter Chemical Dependency Center - Main Facility
	St. Peter Chemical Dependency Center – Shelton*
	South Sound Clinic of Evergreen Treatment Services
	True North-ESD 113 - Lewis (Student Assistance Program)
	True North-ESD 113 - Mason (Student Assistance Program)
	True North-ESD 113 - Thurston (Student Assistance Program)
	True North-ESD 113 - Yelm (Student Assistance Program)
Timberlands	Addictions Recovery Center - Chehalis
	Addictions Recovery Center - Long Beach Branch
	Addictions Recovery Center - Longview Branch
	Addictions Recovery Center - Morton Branch
	Addictions Recovery Center - South Bend
	Lewis County Social Services (Jail Treatment Program)
	Shoalwater Bay Indian Tribe

JRA Agencies Completing the EBP Survey

RSN	JRA Agency
Chelan-Douglas	Canyon View Community Facility
Greater Columbia	Camp Outlook
	Parke Creek Treatment Center
	Ridgeview Community Facility
	Twin Rivers Community Facility
	DSHS/ JRA Region 2
King	Echo Glen Children's Center
	Woodinville Treatment Center
	DSHS/ JRA Region 4
North Sound	DSHS/ JRA Region 3
Pierce	Oakridge Community Facility
	DSHS/ JRA Region 5
Spokane	DSHS/ JRA Region 1
Timberlands	Green Hill School
	Maple Lane School
	Naselle Youth Camp
	DSHS/ JRA Region 6

Children's Administration Agencies Not Completing the EBP Survey

RSN	CA Agency
Pierce	Catholic Community Services – Pierce County

Children's Administration Agencies Completing the EBP Survey

RSN	CA Agency
Clark	Children's Home Society
Greater Columbia	Yakima Valley Farmworkers
King	Auburn Youth Resources
	Children's Hospital and Regional Medical Center/Harborview
	Encompass
	Institute for Family Development
	King County Sexual Assault Resource Center
	Odessa Brown*
	Ruth Dykeman
North Sound	Deaconess Children's Services
	Grayson and Associates
Pierce	Advantages Plus Counseling
	Comprehensive Mental Health
	Tacoma Pierce County Health Department
Spokane	Lutheran Community Services

*Roll-up/Complete

EBP Completions by County and Agency Type

	MHD*		DASA		JRA		CA		TOTAL	
	N	% Complete	N	% Complete	N	% Complete	N	% Complete	N	% Complete
Adams	1	100.0%	1	100.0%	—	—	—	—	2	100.0%
Asotin	1	100.0%	1	100.0%	—	—	—	—	2	100.0%
Benton	4	100.0%	3	100.0%	1	100.0%	—	—	8	100.0%
Chelan	4	75.0%	1	0.0%	—	—	—	—	5	60.0%
Clallam	2	0.0%	12	50.0%	—	—	—	—	14	42.9%
Clark	9	88.9%	4	100.0%	—	—	1	100.0%	14	92.9%
Columbia	—	—	1	100.0%	—	—	—	—	1	100.0%
Cowlitz	4	75.0%	5	80.0%	—	—	—	—	9	77.8%
Douglas	—	—	—	—	1	100.0%	—	—	1	100.0%
Ferry	1	100.0%	1	100.0%	—	—	—	—	2	100.0%
Franklin	2	100.0%	2	100.0%	1	100.0%	—	—	5	100.0%
Garfield	1	100.0%	1	100.0%	—	—	—	—	2	100.0%
Grant	1	100.0%	1	100.0%	—	—	—	—	2	100.0%
Grays Harbor	2	50.0%	5	60.0%	—	—	—	—	7	57.1%
Island	—	—	4	100.0%	—	—	—	—	4	100.0%
Jefferson	1	100.0%	1	100.0%	—	—	—	—	2	100.0%
King	49	51.0%	68	69.1%	3	100.0%	7	100.0%	127	64.6%
Kitsap	3	66.7%	10	50.0%	—	—	—	—	13	53.8%
Kittitas	—	—	2	50.0%	1	100.0%	—	—	3	66.7%
Klickitat	—	—	2	100.0%	—	—	—	—	2	100.0%
Lewis	2	100.0%	7	85.7%	2	100.0%	—	—	11	90.9%
Lincoln	—	—	1	0.0%	—	—	—	—	1	0.0%
Mason	—	—	2	50.0%	—	—	—	—	2	50.0%
Okanogan	1	100.0%	5	80.0%	—	—	—	—	6	83.3%
Pacific	2	100.0%	1	100.0%	1	100.0%	—	—	4	100.0%
Pend Oreille	1	100.0%	2	50.0%	—	—	—	—	3	66.7%
Pierce	11	63.6%	21	42.9%	2	100.0%	4	75.0%	38	55.3%
San Juan	—	—	1	100.0%	—	—	—	—	1	100.0%
Skagit	3	66.7%	6	50.0%	—	—	—	—	9	55.6%
Skamania	1	0.0%	2	100.0%	—	—	—	—	3	66.7%
Snohomish	11	45.5%	14	50.0%	1	100.0%	2	100.0%	28	53.6%
Spokane	23	60.9%	20	60.0%	1	100.0%	1	100.0%	45	62.2%
Stevens	1	100.0%	3	66.7%	—	—	—	—	4	75.0%
Thurston	4	50.0%	15	100.0%	1	100.0%	—	—	20	90.0%
Wahkiakum	1	0.0%	1	0.0%	—	—	—	—	2	0.0%
Walla Walla	4	75.0%	3	33.3%	—	—	—	—	7	57.1%
Whatcom	7	42.9%	10	50.0%	—	—	—	—	17	47.1%
Whitman	2	100.0%	1	0.0%	—	—	—	—	3	66.7%
Yakima	6	100.0%	17	82.4%	2	100.0%	1	100.0%	26	88.5%
OVERALL	165	63.6%	257	66.90%	17	100.0%	16	93.75%	455	67.9%

* Some sites completed a survey for multiple agencies. Each agency is represented in this table.

APPENDIX E

Tables

Appendix E Contents

Q1. Which of the following services are offered by this agency?

	MHD (n = 96)	DASA (n = 154)	JRA (n = 17)	CA (n = 14)	Total (n = 281)
Intake, Assessment, or Referral	89.6%	92.2%	100.0%	7.1%	87.5%
Chemical Dependency Treatment	35.4%	98.1%	29.4%	—	67.6%
Mental Health Treatment	91.7%	41.6%	29.4%	14.3%	56.6%
Co-Occurring Disorders Treatment	51.0%	52.6%	23.5%	—	47.7%
Other	44.8%	28.6%	76.5%	100.0%	40.6%

*Question allowed multiple responses

Q2. Is this a solo practice, meaning an office with a single practitioner or therapist?

	MHD (n = 96)	DASA (n = 154)	JRA (n = 17)	CA (n = 14)	Total (n = 281)
Yes	—	4.5%	—	—	2.5%
No	100.0%	95.5%	100.0%	100.0%	97.5%

Q3. What is the population of the service area for your agency?

	MHD (n = 96)	DASA (n = 154)	JRA (n = 17)	CA (n = 14)	Total (n = 281)
Population less than 5,000	6.3%	15.6%	5.9%	—	11.0%
Population between 5,001 and 50,000	17.7%	23.4%	—	—	18.9%
Population between 50,001 and 500,000	47.9%	39.0%	—	71.4%	41.3%
Population greater than 500,000	28.1%	22.1%	94.1%	28.6%	28.8%

Q4a. In the list below, please indicate which of the following evidence based practices (EBPs) your agency currently provides.

	MHD (n = 96)	DASA (n = 154)	JRA (n = 17)	CA (n = 14)	Total (n = 281)
Aggression Replacement Training	12.5%	9.7%	29.4%	—	11.4%
Assertive Community Treatment (ACT/PACT)	17.7%	3.9%	—	—	8.2%
Behavioral Treatment for Substance Abuse in Schizophrenia	4.2%	3.9%	—	—	3.6%
Brief Strategic Family Therapy	21.9%	9.7%	—	—	12.8%
Cognitive Behavior Therapies (CBT)	72.9%	53.2%	5.9%	—	54.4%
Contingency Management (Co-occurring)	10.4%	8.4%	—	—	8.2%
Dare to be you	1.0%	—	—	—	0.4%
Dialectical Behavioral Therapy (DBT)	43.8%	30.5%	58.8%	—	35.2%
Eye Movement Desensitization & Reprocessing (EMDR)	14.6%	3.2%	—	—	6.8%
Family Integrated Transitions	6.3%	1.9%	23.5%	—	4.6%
Family Psychoeducation	37.5%	14.3%	—	—	20.6%
Functional Family Therapy	15.6%	5.8%	35.3%	7.1%	11.0%
Gatekeeper Program	7.3%	—	—	—	2.5%
Illness Self-Management/Illness Management & Recovery	18.8%	1.9%	—	—	7.5%
Incredible Years	3.1%	—	—	7.1%	1.4%
Integrated Dual Disorders	30.2%	20.8%	—	—	21.7%
Interpersonal Therapy	12.5%	7.8%	—	—	8.5%
Medication Management	46.9%	20.1%	—	—	27.0%
Motivational Enhancement Therapy (MET)	12.5%	18.8%	—	—	14.6%
Motivational Interviewing	46.9%	64.3%	—	—	51.2%
Multi-Family Group Treatment (MFG)	7.3%	5.2%	—	—	5.3%
Multidimensional Family Therapy	6.3%	1.3%	—	—	2.8%
Multidimensional Treatment Foster Care	5.2%	0.6%	5.9%	21.4%	3.6%
Multisystematic Therapy	18.8%	5.8%	—	—	9.6%
Nurse-Family Partnership	—	0.6%	—	7.1%	0.7%
Parent-Child Interaction Therapy	15.6%	6.5%	—	71.4%	12.5%
Peer Support	34.4%	19.5%	—	—	22.4%
Promoting Alternative Thinking Strategies (PATH)	1.0%	2.6%	—	—	1.8%
Second Step	5.2%	3.2%	—	—	3.6%
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	6.3%	12.3%	—	—	8.9%
Strengthening Families Program (SFP)	10.4%	9.1%	—	—	8.5%
Supported Employment	27.1%	6.5%	—	—	12.8%
Supported Housing	17.7%	7.1%	—	—	10.0%
Therapeutic Foster Care	10.4%	1.3%	—	—	4.3%
Other (Specify:)	39.6%	26.6%	58.8%	—	31.7%
Other (Specify:)	17.7%	7.8%	—	—	10.3%
Not applicable, we do not provide any evidence-based practices (EBPs)	5.2%	6.5%	—	7.1%	5.7%

Q4b. Also indicate whether program fidelity is assessed or monitored for those practices you are currently providing.

	MHD		DASA		JRA		CA		Total	
	%	N	%	N	%	N	%	N	%	N
Aggression Replacement Training	58.3%	12	60.0%	15	0.0%	5	—	—	50.0%	32
Assertive Community Treatment (ACT/PACT)	76.5%	17	50.0%	6	—	—	—	—	69.6%	23
Behavioral Treatment for Substance Abuse in Schizophrenia	25.0%	4	16.7%	6	—	—	—	—	20.0%	10
Brief Strategic Family Therapy	23.8%	21	20.0%	15	—	—	—	—	22.2%	36
Cognitive Behavior Therapies (CBT)	28.6%	70	42.7%	82	0.0%	1	—	—	35.9%	153
Contingency Management (Co-occurring)	10.0%	10	46.2%	13	—	—	—	—	30.4%	23
Dare to be you	0.0%	1	—	—	—	—	—	—	0.0%	1
Dialectical Behavioral Therapy (DBT)	42.9%	42	40.4%	47	0.0%	10	—	—	37.4%	99
Eye Movement Desensitization & Reprocessing (EMDR)	28.6%	14	20.0%	5	—	—	—	—	26.3%	19
Family Integrated Transitions	50.0%	6	100.0%	3	100.0%	4	—	—	76.9%	13
Family Psychoeducation	22.2%	36	31.8%	22	—	—	—	—	25.9%	58
Functional Family Therapy	73.3%	15	44.4%	9	100.0%	6	100.0%	1	71.0%	31
Gatekeeper Program	28.6%	7	—	—	—	—	—	—	28.6%	7
Illness Self-Management/Illness Management & Recovery	50.0%	18	0.0%	3	—	—	—	—	42.9%	21
Incredible Years	0.0%	3	—	—	—	—	100.0%	1	25.0%	4
Integrated Dual Disorders	48.3%	29	53.1%	32	—	—	—	—	50.8%	61
Interpersonal Therapy	25.0%	12	33.3%	12	—	—	—	—	29.2%	24
Medication Management	33.3%	45	48.4%	31	—	—	—	—	39.5%	76
Motivational Enhancement Therapy (MET)	33.3%	12	62.1%	29	—	—	—	—	53.7%	41
Motivational Interviewing	26.7%	45	46.5%	99	—	—	—	—	40.3%	144
Multi-Family Group Treatment (MFG)	71.4%	7	37.5%	8	—	—	—	—	53.3%	15
Multidimensional Family Therapy	16.7%	6	50.0%	2	—	—	—	—	25.0%	8
Multidimensional Treatment Foster Care	80.0%	5	100.0%	1	100.0%	1	100.0%	3	90.0%	10
Multisystematic Therapy	72.2%	18	44.4%	9	—	—	—	—	63.0%	27
Nurse-Family Partnership	—	—	0.0%	1	—	—	100.0%	1	50.0%	2
Parent-Child Interaction Therapy	53.3%	15	60.0%	10	—	—	100.0%	10	68.6%	35
Peer Support	24.2%	33	56.7%	30	—	—	—	—	39.7%	63
Promoting Alternative Thinking Strategies (PATH)	100.0%	1	75.0%	4	—	—	—	—	80.0%	5
Second Step	40.0%	5	80.0%	5	—	—	—	—	60.0%	10
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	66.7%	6	15.8%	19	—	—	—	—	28.0%	25
Strengthening Families Program (SFP)	50.0%	10	71.4%	14	—	—	—	—	62.5%	24
Supported Employment	57.7%	26	40.0%	10	—	—	—	—	52.8%	36
Supported Housing	17.6%	17	36.4%	11	—	—	—	—	25.0%	28
Therapeutic Foster Care	30.0%	10	100.0%	2	—	—	—	—	41.7%	12
Other (Specify:)	71.1%	38	58.5%	41	60.0%	10	—	—	64.0%	89
Other (Specify:)	76.5%	17	41.7%	12	—	—	—	—	41.7%	29
Overall*	**38.4%**	**578**	**45.6%**	**555**	**40.7%**	**27**	**100%**	**16**	**42.7%**	**1176**

*Note: Overall totals include the first 34 EBPs only. The "Other" EBP categories have not been included in this overall analysis. Overall sample size reflects number of EBPs included within analysis, not the number of agencies selected within each organization.

Q5. For the practices your agency currently provides, please indicate which mechanisms are used to provide training. Select all that apply.

		Internal Staff	Collaboration With Universities	Provider-to-Provider Training	Outside Accreditation	Other	Total N
Aggression Replacement Training	MHD	50.0%	8.3%	33.3%	58.3%	25.0%	12
	DASA	66.7%	—	20.0%	40.0%	6.7%	15
	JRA	100%	—	40.0%	—	—	5
	CA	—	—	—	—	—	—
	TOTAL	**65.6%**	**3.1%**	**28.1%**	**40.6%**	**12.5**	**32**
Assertive Community Treatment (ACT/PACT)	MHD	82.4%	41.2%	41.2%	41.2%	11.8%	17
	DASA	50.0%	—	57.1%	42.9%	—	6
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**73.9%**	**30.4%**	**43.5%**	**39.1%**	**8.7%**	**23**
Behavioral Treatment for Substance Abuse in Schizophrenia	MHD	50.0%	50.0%	50.0%	—	50.0%	4
	DASA	83.3%	—	33.3%	33.3%	16.7%	6
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**70.0%**	**20.0%**	**40.0%**	**20.0%**	**30.0**	**10**
Brief Strategic Family Therapy	MHD	66.7%	23.8%	42.9%	14.3%	—	21
	DASA	73.3%	6.7%	20.0%	33.3%	13.3%	15
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**69.4%**	**16.7%**	**33.3%**	**22.2%**	**5.6%**	**36**
Cognitive Behavior Therapies (CBT)	MHD	75.7%	20.0%	35.7%	27.1%	11.4%	70
	DASA	73.2%	23.2%	37.8%	35.4%	6.1%	82
	JRA	100%	—	—	—	—	1
	CA	—	—	—	—	—	—
	TOTAL	**74.5%**	**21.6%**	**36.6%**	**31.4%**	**8.5%**	**153**
Contingency Management (co-occurring)	MHD	70.0%	20.0%	60.0%	30.0%	—	10
	DASA	76.9%	7.7%	46.2%	46.2%	23.1%	13
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**73.9%**	**13.0%**	**52.2%**	**39.1%**	**13%**	**23**
Dare to Be You	MHD	100.0%	100.0%	100.0%	—	—	1
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**100.0%**	**100.0%**	**100.0%**	**—**	**—**	**1**
Dialectical Behavioral Therapy (DBT)	MHD	81.0%	26.2%	52.4%	50.0%	7.1%	42
	DASA	74.5%	34.0%	40.4%	57.4%	4.3%	47
	JRA	100%	10.0%	80.0%	—	20.0%	10
	CA	—	—	—	—	—	—
	TOTAL	**79.8%**	**28.3%**	**49.5%**	**48.5%**	**7.1%**	**99**

		Internal Staff	Collaboration With Universities	Provider-to-Provider Training	Outside Accreditation	Other	Total N
Eye Movement Desensitization & Reprocessing (EMDR)	MHD	57.1%	—	35.7%	78.6%	—	14
	DASA	60.0%	20.0%	40.0%	20.0%	20.0%	5
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**57.9%**	**5.3%**	**36.8%**	**63.2%**	**5.3%**	**19**
Family Integrated Transitions	MHD	50.0%	33.3%	—	16.7%	33.3%	6
	DASA	100%	—	66.7%	—	—	3
	JRA	100%	100%	100%	—	—	4
	CA	—	—	—	—	—	—
	TOTAL	**76.9%**	**46.2%**	**46.2%**	**7.7%**	**15.4%**	**13**
Family Psychoeducation	MHD	83.3%	8.3%	44.4%	27.8%	11.1%	36
	DASA	90.9%	13.6%	27.3%	18.2%	4.5%	22
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**86.2%**	**10.3%**	**37.9%**	**24.1%**	**8.6%**	**58**
Functional Family Therapy	MHD	53.3%	13.3%	46.7%	66.7%	6.7%	15
	DASA	77.8%	11.1%	11.1%	33.3%	11.1%	9
	JRA	100%	66.7%	100%	—	—	6
	CA	—	—	—	—	100%	1
	TOTAL	**67.7%**	**22.6%**	**45.2%**	**41.9%**	**9.7%**	**31**
Gatekeeper program	MHD	85.7%	14.3%	71.4%	28.6%	14.3%	7
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**85.7%**	**14.3%**	**71.4%**	**28.6%**	**14.3%**	**7**
Illness Self-Management/Illness Management & Recovery	MHD	83.3%	16.7%	44.4%	22.2%	11.1%	18
	DASA	100%	33.3%	33.3%	66.7%	—	3
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**85.7%**	**19.0%**	**42.9%**	**28.6%**	**9.5%**	**21**
Incredible Years	MHD	66.7%	33.3%	33.3%	100%	—	3
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	100%	1
	TOTAL	**50.0%**	**25.0%**	**25.0%**	**75.0%**	**25.0%**	**4**
Integrated Dual Disorders Treatment	MHD	75.9%	10.3%	44.8%	44.8%	17.2%	29
	DASA	84.4%	15.6%	40.6%	37.5%	12.5%	32
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**80.3%**	**13.1%**	**42.6%**	**41.0%**	**14.8%**	**61**

		Internal Staff	Collaboration With Universities	Provider-to-Provider Training	Outside Accreditation	Other	Total N
Interpersonal Therapy	MHD	75.0%	25.0%	41.7%	50.0%	8.3%	12
	DASA	83.3%	—	16.7%	41.7%	—	12
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**79.2%**	**12.5%**	**29.2%**	**45.8%**	**4.2%**	**24**
Medication Management	MHD	64.4%	15.6%	40.0%	33.3%	11.1%	45
	DASA	48.4%	12.9%	32.3%	48.4%	12.9%	31
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**57.9%**	**14.5%**	**6.8%**	**39.5%**	**11.8%**	**76**
Motivational Enhancement Therapy (MET)	MHD	58.3%	33.3%	50.0%	25.0%	33.3%	12
	DASA	82.8%	17.2%	34.5%	44.8%	6.9%	29
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**75.6%**	**22.0%**	**39.0%**	**39.0%**	**14.6%**	**41**
Motivational Interviewing	MHD	71.1%	13.3%	37.8%	35.6%	20.0%	45
	DASA	78.8%	33.3%	29.3%	29.3%	10.1%	99
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**76.4%**	**27.1%**	**31.9%**	**31.3%**	**13.2%**	**144**
Multi-Family Group Treatment (MFG)	MHD	57.1%	28.6%	28.6%	14.3%	14.3%	7
	DASA	87.5%	12.5%	12.5%	12.5%	37.5%	8
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**73.3%**	**20.0%**	**20.0%**	**13.3%**	**26.7%**	**15**
Multidimensional Family Therapy	MHD	83.3%	16.7%	33.3%	33.3%	—	6
	DASA	100%	—	—	—	—	2
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**87.5%**	**12.5%**	**25.0%**	**25.0%**	—	**8**
Multidimensional Treatment Foster Care	MHD	60.0%	—	60.0%	60.0%	—	5
	DASA	100%	—	100%	100%	—	1
	JRA	100%	—	—	100%	—	1
	CA	—	—	—	—	100%	3
	TOTAL	**50.0%**	—	**40.0%**	**50.0%**	**30.0%**	**10**
Multisystemic Therapy	MHD	66.7%	44.4%	27.8%	33.3%	16.7%	18
	DASA	66.7%	11.1%	11.1%	55.6%	—	9
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**66.7%**	**33.3%**	**22.2%**	**40.7%**	**11.1%**	**27**

		Internal Staff	Collaboration With Universities	Provider-to-Provider Training	Outside Accreditation	Other	Total N
Nurse-Family Partnership	MHD	—	—	—	—	—	—
	DASA	100%	—	—	—	—	1
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	100%	1
	TOTAL	**50.0%**	**—**	**—**	**—**	**50.0%**	**2**
Parent-Child Interaction Therapy	MHD	53.3%	13.3%	33.3%	46.7%	13.3%	15
	DASA	90.0%	20.0%	30.0%	30.0%	10.0%	10
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	100%	10
	TOTAL	**48.6%**	**11.4%**	**22.9%**	**28.6%**	**37.1%**	**35**
Peer Support	MHD	69.7%	15.2%	42.4%	39.4%	21.2%	33
	DASA	86.7%	13.3%	33.3%	36.7%	3.3%	30
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**77.8%**	**14.3%**	**38.1%**	**38.1%**	**12.7%**	**63**
Promoting Alternative Thinking Strategies (PATH)	MHD	100.0%	—	100.0%	100.0%	—	1
	DASA	100%	25.0%	75.0%	50.0%	25.0%	4
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**100%**	**20.0%**	**80.0%**	**60.0%**	**20.0%**	**5**
Second Step	MHD	100.0%	20.0%	40.0%	20.0%	—	5
	DASA	100%	20.0%	—	20.0%	20.0%	5
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**100%**	**20.0%**	**20.0%**	**20.0%**	**10.0%**	**10**
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	MHD	66.7%	—	16.7%	16.7%	50.0%	6
	DASA	78.9%	31.6%	47.4%	42.1%	—	19
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**76.0%**	**24.0%**	**40.0%**	**36.0%**	**12.0%**	**25**
Strengthening Families Program (SFP)	MHD	80.0%	10.0%	60.0%	30.0%	10.0%	10
	DASA	85.7%	7.1%	50.0%	21.4%	—	14
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**83.3%**	**8.3%**	**54.2%**	**25.0%**	**4.2%**	**24**
Supported Employment	MHD	84.6%	7.7%	23.1%	38.5%	15.4%	26
	DASA	60.0%	20.0%	30.0%	40.0%	20.0%	10
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**77.8%**	**11.1%**	**25.0%**	**38.9%**	**16.7%**	**36**

		Internal Staff	Collaboration With Universities	Provider-to-Provider Training	Outside Accreditation	Other	Total N
Supported Housing	MHD	100.0%	5.9%	35.3%	11.8%	—	17
	DASA	81.8%	9.1%	36.4%	27.3%	9.1%	11
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**92.9%**	**7.1%**	**35.7%**	**17.9%**	**3.6%**	**28**
Therapeutic Foster Care	MHD	90.0%	—	50.0%	10.0%	—	10
	DASA	100%	—	50.0%	50.0%	—	2
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**91.7%**	**—**	**50.0%**	**16.7%**	**—**	**12**
Other (Specify:)	MHD	57.9%	18.4%	28.9%	52.6%	13.2%	38
	DASA	56.1%	7.3%	19.5%	58.5%	9.8%	41
	JRA	90.0%	60.0%	80.0%	10.0%	10.0%	10
	CA	—	—	—	—	—	—
	TOTAL	**60.7%**	**18.0%**	**30.3%**	**50.6%**	**11.2%**	**89**
Other (Specify:)	MHD	70.6%	29.4%	29.4%	41.2%	11.8%	17
	DASA	75.0%	8.3%	41.7%	58.3%	8.3%	12
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**72.4%**	**20.7%**	**34.5%**	**48.3%**	**10.3%**	**29**
OVERALL*	MHD	73.2%	17.5%	40.7%	35.5%	12.6%	578
	DASA	77.3%	19.8%	33.5%	36.8%	8.5%	555
	JRA	100%	33.3%	74.1%	3.7%	7.4%	27
	CA	—	—	—	—	100%	16
	TOTAL	**74.7%**	**18.7%**	**37.5%**	**34.9%**	**11.7%**	**1176**

*Note: Overall totals include the first 34 EBPs only. The "Other" EBP categories have not been included in this overall analysis. Overall sample size reflects number of EBPs included within analysis, not the number of selected within each organization.

Q6. For the practices your agency currently provides, please indicate which target populations you are providing the EBP for.

		Children	Adolescents	Adults	Elderly	Co-Occurring Disorders	Other	Total N
Aggression Replacement Training	MHD	50.0%	91.7%	25.0%	—	8.3%	—	12
	DASA	6.7%	100.0%	6.7%	—	13.3%	—	15
	JRA	—	100.0%	60.0%	—	—	20.0%	5
	CA	—	—	—	—	—	—	—
	TOTAL	**21.9%**	**96.9%**	**21.9%**	—	**9.4%**	**3.1%**	**32**
Assertive Community Treatment (ACT/PACT)	MHD	5.9%	5.9%	94.1%	17.6%	70.6%	5.9%	17
	DASA	16.7%	33.3%	100.0%	33.3%	66.7%	—	6
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**8.7%**	**13.0%**	**95.7%**	**21.7%**	**69.6%**	**4.3%**	**23**
Behavioral Treatment for Substance Abuse in Schizophrenia	MHD	25.0%	25.0%	50.0%	25.0%	75.0%	25.0%	4
	DASA	—	—	83.3%	16.7%	83.3%	—	6
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**10.0%**	**10.0%**	**70.0%**	**20.0%**	**80.0%**	**10.0%**	**10**
Brief Strategic Family Therapy	MHD	71.4%	66.7%	38.1%	4.8%	9.5%	9.5%	21
	DASA	20.0%	60.0%	60.0%	20.0%	46.7%	6.7%	15
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**50.0%**	**63.9%**	**47.2%**	**11.1%**	**25.0%**	**8.3%**	**36**
Cognitive Behavior Therapies (CBT)	MHD	58.6%	72.9%	75.7%	48.6%	42.9%	2.9%	70
	DASA	9.8%	52.4%	75.6%	28.0%	53.7%	4.9%	82
	JRA	—	100.0%	—	—	—	—	1
	CA	—	—	—	—	—	—	—
	TOTAL	**32.0%**	**62.1%**	**75.2%**	**37.3%**	**48.4%**	**3.9%**	**153**
Contingency Management (Co-occurring)	MHD	20.0%	30.0%	70.0%	20.0%	60.0%	—	10
	DASA	—	38.5%	76.9%	23.1%	76.9%	—	13
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**8.7%**	**34.8%**	**73.9%**	**21.7%**	**69.6%**	—	**23**
Dare to be you	MHD	100.0%	—	—	—	—	—	1
	DASA	—	—	—	—	—	—	—
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**100.0%**	—	—	—	—	—	**1**
Dialectical Behavioral Therapy (DBT)	MHD	14.3%	50.0%	76.2%	21.4%	38.1%	4.8%	42
	DASA	—	46.8%	68.1%	8.5%	48.9%	8.5%	47
	JRA	40.0%	100.0%	80.0%	—	60.0%	10.0%	10
	CA	—	—	—	—	—	—	—
	TOTAL	**10.1%**	**53.5%**	**72.7%**	**13.1%**	**45.5%**	**7.1%**	**99**

		Children	Adolescents	Adults	Elderly	Co-Occurring Disorders	Other	Total N
Eye Movement Desensitization & Reprocessing (EMDR)	MHD	42.9%	57.1%	85.7%	28.6%	14.3%	—	14
	DASA	20.0%	40.0%	100.0%	20.0%	20.0%	—	5
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**36.8%**	**52.6%**	**89.5%**	**26.3%**	**15.8%**	—	**19**
Family Integrated Transitions	MHD	33.3%	83.3%	66.7%	—	16.7%	16.7%	6
	DASA	—	100.0%	33.3%	33.3%	66.7%	—	3
	JRA	—	100.0%	—	—	100.0%	—	4
	CA	—	—	—	—	—	—	—
	TOTAL	**15.4%**	**92.3%**	**38.5%**	**7.7%**	**53.8%**	**7.7%**	**13**
Family Psychoeducation	MHD	69.4%	77.8%	77.8%	33.3%	41.7%	2.8%	36
	DASA	27.3%	72.7%	68.2%	27.3%	45.5%	9.1%	22
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**53.4%**	**75.9%**	**74.1%**	**31.0%**	**43.1%**	**5.2%**	**58**
Functional Family Therapy	MHD	46.7%	93.3%	40.0%	6.7%	6.7%	6.7%	15
	DASA	33.3%	88.9%	33.3%	11.1%	11.1%	—	9
	JRA	83.3%	100.0%	100.0%	—	100.0%	—	6
	CA	—	100.0%	100.0%	—	—	—	1
	TOTAL	**48.4%**	**93.5%**	**51.6%**	**6.5%**	**25.8%**	**3.2%**	**31**
Gatekeeper Program	MHD	—	—	—	100.0%	—	—	7
	DASA	—	—	—	—	—	—	—
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	—	—	—	**100.0%**	—	—	**7**
Illness Self-Management/Illness Management & Recovery	MHD	11.1%	22.2%	94.4%	44.4%	50.0%	5.6%	18
	DASA	—	—	66.7%	—	66.7%	—	3
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**9.5%**	**19.0%**	**90.5%**	**38.1%**	**52.4%**	**4.8%**	**21**
Incredible Years	MHD	66.7%	—	33.3%	—	—	33.3%	3
	DASA	—	—	—	—	—	—	—
	JRA	—	—	—	—	—	—	—
	CA	100.0%	—	100.0%	—	—	—	1
	TOTAL	**75.0%**	—	**50.0%**	—	—	**25.0%**	**4**
Integrated Dual Disorders	MHD	3.4%	13.8%	65.5%	20.7%	75.9%	6.9%	29
	DASA	—	37.5%	59.4%	15.6%	87.5%	—	32
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**1.6%**	**26.2%**	**62.3%**	**18.0%**	**82.0%**	**3.3%**	**61**

		Children	Adolescents	Adults	Elderly	Co-Occurring Disorders	Other	Total N
Interpersonal Therapy	MHD	58.3%	58.3%	75.0%	58.3%	41.7%	8.3%	12
	DASA	16.7%	58.3%	75.0%	25.0%	66.7%	—	12
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**37.5%**	**58.3%**	**75.0%**	**41.7%**	**54.2%**	**4.2%**	**24**
Medication Management	MHD	57.8%	68.9%	77.8%	62.2%	51.1%	—	45
	DASA	12.9%	45.2%	87.1%	51.6%	83.9%	—	31
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**39.5%**	**59.2%**	**81.6%**	**57.9%**	**64.5%**	—	**76**
Motivational Enhancement Therapy (MET)	MHD	8.3%	33.3%	100.0%	41.7%	66.7%	—	12
	DASA	3.4%	58.6%	58.6%	34.5%	51.7%	—	29
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**4.9%**	**51.2%**	**70.7%**	**36.6%**	**56.1%**	—	**41**
Motivational Interviewing	MHD	28.9%	55.6%	84.4%	28.9%	60.0%	2.2%	45
	DASA	5.1%	51.5%	83.8%	32.3%	54.5%	4.0%	99
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**12.5%**	**52.8%**	**84.0%**	**31.3%**	**56.3%**	**3.5%**	**144**
Multi-Family Group Treatment (MFG)	MHD	28.6%	28.6%	85.7%	—	14.3%	28.6%	7
	DASA	12.5%	75.0%	62.5%	25.0%	37.5%	12.5%	8
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**20.0%**	**53.3%**	**73.3%**	**13.3%**	**26.7%**	**20.0%**	**15**
Multidimensional Family Therapy	MHD	33.3%	100.0%	83.3%	—	16.7%	—	6
	DASA	50.0%	50.0%	50.0%	—	100.0%	—	2
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**37.5%**	**87.5%**	**75.0%**	—	**37.5%**	—	**8**
Multidimensional Treatment Foster Care	MHD	60.0%	80.0%	—	—	—	—	5
	DASA	—	100.0%	—	—	—	—	1
	JRA	—	100.0%	—	—	100.0%	—	1
	CA	100.0%	33.3%	—	—	—	—	3
	TOTAL	**60.0%**	**70.0%**	—	—	**10.0%**	—	**10**
Multisystematic Therapy	MHD	61.1%	94.4%	50.0%	11.1%	22.2%	5.6%	18
	DASA	33.3%	88.9%	33.3%	—	55.6%	—	9
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**51.9%**	**92.6%**	**44.4%**	**7.4%**	**33.3%**	**3.7%**	**27**

		Children	Adolescents	Adults	Elderly	Co-Occurring Disorders	Other	Total N
Nurse-Family Partnership	MHD	—	—	—	—	—	—	—
	DASA	—	—	100.0%	100.0%	—	—	1
	JRA	—	—	—	—	—	—	—
	CA	100.0%	—	100.0%		—	—	1
	TOTAL	**50.0%**	—	**100.0%**	**50.0%**	—	—	**2**
Parent-Child Interaction Therapy	MHD	86.7%	20.0%	66.7%	6.7%	—	13.3%	15
	DASA	70.0%	30.0%	60.0%	—	30.0%	10.0%	10
	JRA	—	—	—	—	—	—	—
	CA	90.0%	—	100.0%	—	—	—	10
	TOTAL	**82.9%**	**17.1%**	**74.3%**	**2.9%**	**8.6%**	**8.6%**	**35**
Peer Support	MHD	12.1%	15.2%	87.9%	30.3%	36.4%	3.0%	33
	DASA	3.3%	50.0%	76.7%	26.7%	33.3%	3.3%	30
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**7.9%**	**31.7%**	**82.5%**	**28.6%**	**34.9%**	**3.2%**	**63**
Promoting Alternative Thinking Strategies (PATH)	MHD	—	—	100.0%	100.0%	100.0%	—	1
	DASA	—	25.0%	100.0%	75.0%	75.0%		4
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	—	**20.0%**	**100.0%**	**80.0%**	**80.0%**	—	**5**
Second Step	MHD	100.0%	20.0%	—	—	—	—	5
	DASA	40.0%	100.0%	—	—	—	—	5
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**70.0%**	**60.0%**	—	—	—	—	**10**
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	MHD	—	—	100.0%	16.7%	83.3%	—	6
	DASA	—	21.1%	73.7%	15.8%	63.2%	15.8%	19
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	—	**16.0%**	**80.0%**	**16.0%**	**68.0%**	**12.0%**	**25**
Strengthening Families Program (SFP)	MHD	70.0%	70.0%	80.0%	10.0%	10.0%	—	10
	DASA	42.9%	71.4%	64.3%	—	14.3%	—	14
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**54.2%**	**70.8%**	**70.8%**	**4.2%**	**12.5%**	—	**24**
Supported Employment	MHD	—	11.5%	100.0%	23.1%	76.9%	3.8%	26
	DASA	—	—	90.0%	20.0%	60.0%	—	10
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	—	**8.3%**	**97.2%**	**22.2%**	**72.2%**	**2.8%**	**36**

		Children	Adolescents	Adults	Elderly	Co-Occurring Disorders	Other	Total N
Supported Housing	MHD	11.8%	23.5%	100.0%	47.1%	64.7%	—	17
	DASA	—	9.1%	81.8%	27.3%	72.7%	—	11
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**7.1%**	**17.9%**	**92.9%**	**39.3%**	**67.9%**	—	**28**
Therapeutic Foster Care	MHD	100.0%	80.0%	10.0%	—	—	—	10
	DASA	—	100.0%	—	—	—	—	2
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**83.3%**	**83.3%**	**8.3%**	—	—	—	**12**
Other (Specify:)	MHD	63.2%	60.5%	55.3%	23.7%	28.9%	5.3%	38
	DASA	9.8%	43.9%	70.7%	31.7%	46.3%	2.4%	41
	JRA	80.0%	100.0%	90.0%	—	90.0%	10.0%	10
	CA	—	—	—	—	—	—	—
	TOTAL	**40.4%**	**57.3%**	**66.3%**	**24.7%**	**43.8%**	**4.5%**	**89**
Other (Specify:)	MHD	58.8%	47.1%	64.7%	17.6%	41.2%	5.9%	17
	DASA	—	75.0%	33.3%	25.0%	50.0%	—	12
	JRA	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—
	TOTAL	**34.5%**	**58.6%**	**51.7%**	**20.7%**	**44.8%**	**3.4%**	**29**
OVERALL*	MHD	**38.8%**	**50.5%**	**72.7%**	**29.6%**	**41.3%**	**4.2%**	**578**
	DASA	**10.1%**	**51.0%**	**70.3%**	**24.0%**	**53.3%**	**3.8%**	**555**
	JRA	**33.3%**	**100%**	**63.0%**	—	**63.0%**	**7.4%**	**27**
	CA	**87.5%**	**12.5%**	**81.3%**	—	—	—	**16**
	TOTAL	**25.8%**	**51.4%**	**71.4%**	**25.9%**	**46.9%**	**4.0%**	**1176**

*Note: Overall totals include the first 34 EBPs only. The "Other" EBP categories have not been included in this overall analysis. Overall sample size reflects number of EBPs included within analysis, not the number of agencies within each organization.

Q7. For the practices your agency currently provides, please indicate how successful your agency has been in implementing the EBPs listed below.

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Aggression Replacement Training	MHD	—	8.3%	50.0%	33.3%	8.3%	12
	DASA	—	6.7%	66.7%	20.0%	6.7%	15
	JRA	—	—	80.0%	20.0%	—	5
	CA	—	—	—	—	—	—
	TOTAL	—	**6.3%**	**62.5%**	**25.0%**	**6.3%**	**32**
Assertive Community Treatment (ACT/PACT)	MHD	—	5.9%	29.4%	52.9%	11.8%	17
	DASA	—	—	33.3%	66.7%	—	6
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**4.3%**	**30.4%**	**56.5%**	**8.7%**	**23**
Behavioral Treatment for Substance Abuse in Schizophrenia	MHD	—	—	75.0%	25.0%	—	4
	DASA	—	16.7%	—	83.3%	—	6
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**10.0%**	**30.0%**	**60.0%**	—	**10**
Brief Strategic Family Therapy	MHD	4.8%	14.3%	38.1%	42.9%	—	21
	DASA	6.7%	13.3%	46.7%	33.3%	—	15
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**5.6%**	**13.9%**	**41.7%**	**38.9%**	—	**36**
Cognitive Behavior Therapies (CBT)	MHD	1.4%	2.9%	31.4%	54.3%	10.0%	70
	DASA	1.2%	3.7%	36.6%	48.8%	9.8%	82
	JRA	—	—	100.0%	—	—	1
	CA	—	—	—	—	—	—
	TOTAL	**1.3%**	**3.3%**	**34.6%**	**51.0%**	**9.8%**	**153**
Contingency Management (Co-occurring)	MHD	10.0%	10.0%	40.0%	30.0%	10.0%	10
	DASA	—	7.7%	30.8%	61.5%	—	13
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**4.3%**	**8.7%**	**34.8%**	**47.8%**	**4.3%**	**23**
Dare to be you	MHD	—	—	100.0%	—	—	1
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	—	**100.0%**	—	—	**1**
Dialectical Behavioral Therapy (DBT)	MHD	—	7.1%	38.1%	38.1%	16.7%	42
	DASA	—	12.8%	36.2%	36.2%	14.9%	47
	JRA	—	—	90.0%	10.0%	—	10
	CA	—	—	—	—	—	—
	TOTAL	—	**9.1%**	**42.4%**	**34.3%**	**14.1%**	**99**

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Eye Movement Desensitization & Reprocessing (EMDR)	MHD	—	21.4%	57.1%	7.1%	14.3%	14
	DASA	—	20.0%	60.0%	20.0%	—	5
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**21.1%**	**57.9%**	**10.5%**	**10.5%**	**19**
Family Integrated Transitions	MHD	—	—	—	50.0%	50.0%	6
	DASA	—	—	—	66.7%	33.3%	3
	JRA	—	25.0%	—	25.0%	50.0%	4
	CA	—	—	—	—	—	—
	TOTAL	—	**7.7%**	—	**46.2%**	**46.2%**	**13**
Family Psychoeducation	MHD	—	11.1%	19.4%	47.2%	22.2%	36
	DASA	—	9.1%	31.8%	54.5%	4.5%	22
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**10.3%**	**24.1%**	**50.0%**	**15.5%**	**58**
Functional Family Therapy	MHD	6.7%	6.7%	46.7%	20.0%	20.0%	15
	DASA	—	33.3%	44.4%	22.2%	—	1
	JRA	—	—	16.7%	83.3%	—	6
	CA	—	—	100.0%	—	—	9
	TOTAL	**3.2%**	**12.9%**	**41.9%**	**32.3%**	**9.7%**	**31**
Gatekeeper Program	MHD	—	—	42.9%	14.3%	42.9%	7
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	—	**42.9%**	**14.3%**	**42.9%**	**7**
Illness Self-Management/Illness Management & Recovery	MHD	5.6%	5.6%	22.2%	66.7%	—	18
	DASA	—	—	66.7%	33.3%	—	3
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**4.8%**	**4.8%**	**28.6%**	**61.9%**	—	**21**
Incredible Years	MHD	—	—	66.7%	33.3%	—	3
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	100.0%	—	1
	TOTAL	—	—	**50.0%**	**50.0%**	—	**4**
Integrated Dual Disorders	MHD	—	10.3%	27.6%	44.8%	17.2%	29
	DASA	—	6.3%	34.4%	46.9%	12.5%	32
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**8.2%**	**31.1%**	**45.9%**	**14.8%**	**61**
Interpersonal Therapy	MHD	8.3%	—	8.3%	50.0%	33.3%	12
	DASA	—	16.7%	41.7%	25.0%	16.7%	12
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**4.2%**	**8.3%**	**25.0%**	**37.5%**	**25.0%**	**24**

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Medication Management	MHD	—	—	11.1%	55.6%	33.3%	45
	DASA	—	3.2%	38.7%	32.3%	25.8%	31
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**1.3%**	**22.4%**	**46.1%**	**30.3%**	**76**
Motivational Enhancement Therapy (MET)	MHD	8.3%	—	25.0%	58.3%	8.3%	12
	DASA	—	3.4%	24.1%	58.6%	13.8%	29
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**2.4%**	**2.4%**	**24.4%**	**58.5%**	**12.2%**	**41**
Motivational Interviewing	MHD	—	4.4%	35.6%	48.9%	11.1%	45
	DASA	1.0%	3.0%	28.3%	52.5%	15.2%	99
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**0.7%**	**3.5%**	**30.6%**	**51.4%**	**13.9%**	**144**
Multi-Family Group Treatment (MFG)	MHD	14.3%	28.6%	14.3%	28.6%	14.3%	7
	DASA	12.5%	25.0%	37.5%	25.0%	—	8
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**13.3%**	**26.7%**	**26.7%**	**26.7%**	**6.7%**	**15**
Multidimensional Family Therapy	MHD	16.7%	33.3%	16.7%	33.3%	—	6
	DASA	—	—	—	100.0%	—	2
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**12.5%**	**25.0%**	**12.5%**	**50.0%**	—	**8**
Multidimensional Treatment Foster Care	MHD	—	—	20.0%	60.0%	20.0%	5
	DASA	—	—	100%	—	—	1
	JRA	—	—	—	100.0%	—	1
	CA	—	66.7%	—	33.3%	—	3
	TOTAL	—	**20.0%**	**20.0%**	**50.0%**	**10.0%**	**10**
Multisystematic Therapy	MHD	—	—	38.9%	33.3%	27.8%	18
	DASA	—	22.2%	11.1%	55.6%	11.1%	9
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**7.4%**	**29.6%**	**40.7%**	**22.2%**	**27**
Nurse-Family Partnership	MHD	—	—	—	—	—	—
	DASA	—	—	100.0%	—	—	1
	JRA	—	—	—	—	—	
	CA	—	—	—	100.0%	—	1
	TOTAL	—	—	**50.0%**	**50.0%**	—	**2**
Parent-Child Interaction Therapy	MHD	—	—	40.0%	46.7%	13.3%	15
	DASA	—	10.0%	30.0%	40.0%	20.0%	10
	JRA	—	—	—	—	—	—
	CA	—	—	30.0%	40.0%	30.0%	10
	TOTAL	—	**2.9%**	**34.3%**	**42.9%**	**20.0%**	**35**

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Peer Support	MHD	—	15.2%	33.3%	45.5%	6.1%	33
	DASA	—	3.3%	23.3%	50.0%	23.3%	30
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**9.5%**	**28.6%**	**47.6%**	**14.3%**	**63**
Promoting Alternative Thinking Strategies (PATH)	MHD	—	—	—	100.0%	—	1
	DASA	—	—	50.0%	50.0%	—	4
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	—	**40.0%**	**60.0%**	—	**5**
Second Step	MHD	—	20.0%	20.0%	60.0%	—	5
	DASA	—	20.0%	40.0%	20.0%	20.0%	5
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**20.0%**	**30.0%**	**40.0%**	**10.0%**	**10**
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	MHD	—	16.7%	50.0%	33.3%	—	6
	DASA	—	5.3%	52.6%	26.3%	15.8%	19
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**8.0%**	**52.0%**	**28.0%**	**12.0%**	**25**
Strengthening Families Program (SFP)	MHD	—	10.0%	30.0%	40.0%	20.0%	10
	DASA	—	7.1%	7.1%	64.3%	21.4%	14
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**8.3%**	**16.7%**	**54.2%**	**20.8%**	**24**
Supported Employment	MHD	—	7.7%	23.1%	50.0%	19.2%	26
	DASA	—	10.0%	50.0%	20.0%	20.0%	10
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**8.3%**	**30.6%**	**41.7%**	**19.4%**	**36**
Supported Housing	MHD	—	—	17.6%	52.9%	29.4%	17
	DASA	—	9.1%	36.4%	9.1%	45.5%	11
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**3.6%**	**25.0%**	**35.7%**	**35.7%**	**28**
Therapeutic Foster Care	MHD	—	—	10.0%	40.0%	50.0%	10
	DASA	—	—	50.0%	50.0%	—	2
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	—	**16.7%**	**41.7%**	**41.7%**	**12**
Other (Specify:)	MHD	—	—	21.1%	57.9%	21.1%	38
	DASA	—	7.3%	14.6%	46.3%	31.7%	41
	JRA	—	—	30.0%	70.0%	—	10
	CA	—	—	—	—	—	—
	TOTAL	—	**3.4%**	**19.1%**	**53.9%**	**23.6%**	**89**

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Other (Specify:)	MHD	—	—	29.4%	41.2%	29.4%	17
	DASA	—	16.7%	16.7%	41.7%	25.0%	12
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**6.9%**	**24.1%**	**41.4%**	**27.6%**	**29**
OVERALL*	MHD	1.6%	6.7%	29.9%	45.3%	16.4%	**578**
	DASA	0.7%	7.2%	34.2%	44.3%	13.5%	**555**
	JRA	—	3.7%	55.6%	33.3%	7.4%	**27**
	CA	—	12.5%	25.0%	43.8%	18.8%	**16**
	TOTAL	**1.1%**	**7.0%**	**32.5%**	**44.6%**	**14.9%**	**1176**

*Note: Overall totals include the first 34 EBPs only. The "Other" EBP categories have not been included in this overall analysis. Overall sample size reflects number of EBPs included within analysis, not the number of agencies within each organization.

Q8. For the practices your agency currently provides, how effective do you think the EBP is at producing positive client outcomes?

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Aggression Replacement Training	MHD	—	—	58.3%	33.3%	8.3%	12
	DASA	6.7%	13.3%	53.3%	26.7%	—	15
	JRA	—	20.0%	60.0%	20.0%	—	5
	CA	—	—	—	—	—	—
	TOTAL	**3.1%**	**9.4%**	**56.3%**	**28.1%**	**3.1%**	**32**
Assertive Community Treatment (ACT/PACT)	MHD	—	—	23.5%	64.7%	11.8%	17
	DASA	—	16.7%	50.0%	33.3%	—	6
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**4.3%**	**30.4%**	**56.5%**	**8.7%**	**23**
Behavioral Treatment for Substance Abuse in Schizophrenia	MHD	—	—	50.0%	50.0%	—	4
	DASA	—	33.3%	16.7%	50.0%	—	6
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**20.0%**	**30.0%**	**50.0%**	—	**10**
Brief Strategic Family Therapy	MHD	—	14.3%	19.0%	61.9%	4.8%	21
	DASA	6.7%		66.7%	26.7%		15
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**2.8%**	**8.3%**	**38.9%**	**47.2%**	**2.8%**	**36**
Cognitive Behavior Therapies (CBT)	MHD	1.4%	—	27.1%	57.1%	14.3%	70
	DASA	1.2%	1.2%	43.9%	47.6%	6.1%	82
	JRA	—	—	—	100.0%	—	1
	CA	—	—	—	—	—	—
	TOTAL	**1.3%**	**0.7%**	**35.9%**	**52.3%**	**9.8%**	**153**
Contingency Management (Co-occurring)	MHD	—	20.0%	40.0%	20.0%	20.0%	10
	DASA	—	—	61.5%	38.5%	—	13
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**8.7%**	**52.2%**	**30.4%**	**8.7%**	**23**
Dare to be you	MHD	—	—	100.0%	—	—	1
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	—	**100.0%**	—	—	**1**
Dialectical Behavioral Therapy (DBT)	MHD	—	2.4%	28.6%	42.9%	26.2%	42
	DASA	—	8.5%	29.8%	44.7%	17.0%	47
	JRA	—	—	80.0%	20.0%	—	10
	CA	—	—	—	—	—	—
	TOTAL	—	**5.1%**	**34.3%**	**41.4%**	**19.2%**	**99**
Eye Movement Desensitization & Reprocessing (EMDR)	MHD	—	14.3%	57.1%	7.1%	21.4%	14
	DASA	—	—	80.0%	20.0%	—	5
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**10.5%**	**63.2%**	**10.5%**	**15.8%**	**19**

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Family Integrated Transitions	MHD	—	—	16.7%	50.0%	33.3%	6
	DASA	—	—	—	66.7%	33.3%	3
	JRA	—	—	25.0%	75.0%	—	4
	CA	—	—	—	—	—	—
	TOTAL	—	—	**15.4%**	**61.5%**	**23.1%**	**13**
Family Psychoeducation	MHD	—	8.3%	38.9%	36.1%	16.7%	36
	DASA	—	4.5%	59.1%	36.4%	—	22
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**6.9%**	**46.6%**	**36.2%**	**10.3%**	**58**
Functional Family Therapy	MHD	—	6.7%	20.0%	60.0%	13.3%	15
	DASA	11.1%	11.1%	55.6%	22.2%	—	9
	JRA	—	—	33.3%	66.7%	—	6
	CA	—	—	—	100.0%		1
	TOTAL	**3.2%**	**6.5%**	**32.3%**	**51.6%**	**6.5%**	**31**
Gatekeeper Program	MHD	—	—	42.9%	14.3%	42.9%	7
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	—	**42.9%**	**14.3%**	**42.9%**	**7**
Illness Self-Management/Illness Management & Recovery	MHD	5.6%	5.6%	22.2%	50.0%	16.7%	18
	DASA	—	—	66.7%	33.3%		3
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**4.8%**	**4.8%**	**28.6%**	**47.6%**	**14.3%**	**21**
Incredible Years	MHD	—	—	33.3%	66.7%	—	3
	DASA	—	—	—	—	—	—
	JRA	—	—	—	—	—	—
	CA	—	—	—	100.0%	—	1
	TOTAL	—	—	**25.0%**	**75.0%**	—	**4**
Integrated Dual Disorders	MHD	—	3.4%	27.6%	51.7%	17.2%	29
	DASA	3.1%	—	28.1%	59.4%	9.4%	32
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**1.6%**	**1.6%**	**27.9%**	**55.7%**	**13.1%**	**61**
Interpersonal Therapy	MHD	8.3%	—	25.0%	41.7%	25.0%	12
	DASA	8.3%	8.3%	50.0%	25.0%	8.3%	12
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**8.3%**	**4.2%**	**37.5%**	**33.3%**	**16.7%**	**24**
Medication Management	MHD	—	—	13.3%	55.6%	31.1%	45
	DASA	—	6.5%	35.5%	41.9%	16.1%	31
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**2.6%**	**22.4%**	**50.0%**	**25.0%**	**76**
Motivational Enhancement Therapy (MET)	MHD	—	8.3%	25.0%	50.0%	16.7%	12
	DASA	3.4%	—	17.2%	55.2%	24.1%	29
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**2.4%**	**2.4%**	**19.5%**	**53.7%**	**22.0%**	**41**

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Motivational Interviewing	MHD	2.2%	4.4%	26.7%	57.8%	8.9%	45
	DASA	3.0%	1.0%	34.3%	42.4%	19.2%	99
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**2.8%**	**2.1%**	**31.9%**	**47.2%**	**16.0%**	**144**
Multi-Family Group Treatment (MFG)	MHD	14.3%	14.3%	14.3%	42.9%	14.3%	7
	DASA	12.5%	—	62.5%	25.0%	—	8
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**13.3%**	**6.7%**	**40.0%**	**33.3%**	**6.7%**	**15**
Multidimensional Family Therapy	MHD	—	16.7%	33.3%	50.0%	—	6
	DASA	—	—	—	100.0%	—	2
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**12.5%**	**25.0%**	**62.5%**	—	**8**
Multidimensional Treatment Foster Care	MHD	—	—	40.0%	40.0%	20.0%	5
	DASA	—	—	—	100.0%	—	1
	JRA	—	—	—	100.0%	—	1
	CA	—	33.3%	33.3%	—	33.3%	3
	TOTAL	—	**10.0%**	**30.0%**	**40.0%**	**20.0%**	**10**
Multisystematic Therapy	MHD	—	—	38.9%	44.4%	16.7%	18
	DASA	—	11.1%	22.2%	55.6%	11.1%	9
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**3.7%**	**33.3%**	**48.1%**	**14.8%**	**27**
Nurse-Family Partnership	MHD	—	—	—	—	—	—
	DASA	100.0%	—	—	—	—	1
	JRA	—	—	—	—	—	—
	CA	—	—	100.0%	—	—	1
	TOTAL	**50.0%**	—	**50.0%**	—	—	**2**
Parent-Child Interaction Therapy	MHD	—	—	33.3%	53.3%	13.3%	15
	DASA	—	—	30.0%	50.0%	20.0%	10
	JRA	—	—	—	—	—	—
	CA	—	—	20.0%	70.0%	10.0%	10
	TOTAL	—	—	**28.6%**	**57.1%**	**14.3%**	**35**
Peer Support	MHD	—	12.1%	36.4%	42.4%	9.1%	33
	DASA	3.3%	13.3%	20.0%	33.3%	30.0%	30
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**1.6%**	**12.7%**	**28.6%**	**38.1%**	**19.0%**	**63**
Promoting Alternative Thinking Strategies (PATH)	MHD	—	—	—	100.0%	—	1
	DASA	—	—	75.0%	25.0%	—	4
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	—	**60.0%**	**40.0%**	—	**5**
Second Step	MHD	—	20.0%	40.0%	40.0%	—	5
	DASA	—	—	60.0%	—	40.0%	5
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**10.0%**	**50.0%**	**20.0%**	**20.0%**	**10**

		Not at All	A Little	Somewhat	Very	Extremely	Total N
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	MHD	—	—	50.0%	50.0%	—	6
	DASA	—	5.3%	57.9%	26.3%	10.5%	19
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	**4.0%**	**56.0%**	**32.0%**	**8.0%**	**25**
Strengthening Families Program (SFP)	MHD	—	10.0%	30.0%	50.0%	10.0%	10
	DASA	7.1%	—	14.3%	57.1%	21.4%	14
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**4.2%**	**4.2%**	**20.8%**	**54.2%**	**16.7%**	**24**
Supported Employment	MHD	—	3.8%	26.9%	42.3%	26.9%	26
	DASA	10.0%	—	50.0%	10.0%	30.0%	10
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**2.8%**	**2.8%**	**33.3%**	**33.3%**	**27.8%**	**36**
Supported Housing	MHD	—	—	17.6%	52.9%	29.4%	17
	DASA	9.1%	9.1%	18.2%	36.4%	27.3%	11
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**3.6%**	**3.6%**	**17.9%**	**46.4%**	**28.6%**	**28**
Therapeutic Foster Care	MHD	—	—	10.0%	70.0%	20.0%	10
	DASA	—	—	—	100.0%	—	2
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	—	—	**8.3%**	**75.0%**	**16.7%**	**12**
Other (Specify:)	MHD	—	5.3%	18.4%	42.1%	34.2%	38
	DASA	2.4%	2.4%	26.8%	41.5%	26.8%	41
	JRA	—	—	70.0%	30.0%	—	10
	CA	—	—	—	—	—	—
	TOTAL	**1.1%**	**3.4%**	**28.1%**	**40.4%**	**27.0%**	**89**
Other (Specify:)	MHD	—	—	35.3%	35.3%	29.4%	17
	DASA	8.3%	—	41.7%	16.7%	33.3%	12
	JRA	—	—	—	—	—	—
	CA	—	—	—	—	—	—
	TOTAL	**3.4%**	—	**37.9%**	**27.6%**	**31.0%**	**29**
OVERALL*	MHD	0.9%	4.5%	28.9%	48.6%	17.1%	578
	DASA	2.9%	4.1%	38.0%	41.6%	13.3%	555
	JRA	—	3.7%	51.9%	44.4%	—	27
	CA	—	6.3%	25.0%	56.3%	12.5%	16
	TOTAL	**1.8%**	**4.3%**	**33.7%**	**45.3%**	**14.9%**	**1176**

*Note: Overall totals include the first 34 EBPs only. The "Other" EBP categories have not been included in this overall analysis. Overall sample size reflects number of EBPs included within analysis, not the number of agencies within each organization.

Q9. Are there any EBPs that you are NOT currently using but want to use in the future?

	MHD (n = 96)	DASA (n = 154)	JRA (n = 17)	CA (n = 14)	Total (n = 281)
Aggression Replacement Training	15.6%	3.2%	41.2%	—	9.6%
Assertive Community Treatment (ACT/PACT)	5.2%	3.9%	—	—	3.9%
Behavioral Treatment for Substance Abuse in Schizophrenia	10.4%	7.8%	—	—	7.8%
Brief Strategic Family Therapy	13.5%	13.6%	—	—	12.1%
Cognitive Behavior Therapies (CBT)	9.4%	9.1%	23.5%	—	9.6%
Contingency Management (Co-occurring)	8.3%	13.0%	11.8%	—	10.7%
Dare to be you	3.1%	3.2%	—	—	2.8%
Dialectical Behavioral Therapy (DBT)	16.7%	13.0%	35.3%	—	14.9%
Eye Movement Desensitization & Reprocessing (EMDR)	9.4%	7.1%	—	—	7.1%
Family Integrated Transitions	8.3%	5.2%	23.5%	—	7.1%
Family Psychoeducation	9.4%	7.1%	—	—	7.1%
Functional Family Therapy	11.5%	11.7%	—	—	10.3%
Gatekeeper Program	5.2%	—	—	—	1.8%
Illness Self-Management/Illness Management & Recovery	19.8%	5.2%	—	—	9.6%
Incredible Years	9.4%	1.3%	—	—	3.9%
Integrated Dual Disorders	11.5%	6.5%	—	—	7.5%
Interpersonal Therapy	9.4%	3.9%	—	—	5.3%
Medication Management	4.2%	2.6%	—	—	2.8%
Motivational Enhancement Therapy (MET)	13.5%	11.0%	—	—	10.7%
Motivational Interviewing	19.8%	5.8%	29.4%	—	11.7%
Multi-Family Group Treatment (MFG)	7.3%	5.2%	—	—	5.3%
Multidimensional Family Therapy	7.3%	7.8%	—	—	6.8%
Multidimensional Treatment Foster Care	3.1%	.6%	11.8%	—	2.1%
Multisystematic Therapy	5.2%	3.9%	11.8%	—	4.6%
Nurse-Family Partnership	2.1%	1.3%	—	—	1.4%
Parent-Child Interaction Therapy	15.6%	4.5%	—	7.1%	8.2%
Peer Support	14.6%	6.5%	—	—	8.5%
Promoting Alternative Thinking Strategies (PATH)	3.1%	4.5%	—	—	3.6%
Second Step	3.1%	1.3%	—	—	1.8%
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	13.5%	13.6%	—	—	12.1%
Strengthening Families Program (SFP)	7.3%	10.4%	—	—	8.2%
Supported Employment	8.3%	4.5%	5.9%	—	5.7%
Supported Housing	12.5%	4.5%	5.9%	—	7.1%
Therapeutic Foster Care	3.1%	2.6%	—	—	2.5%
Other (Specify:)	12.5%	3.9%	11.8%	7.1%	7.5%
Other (Specify:)	4.2%	—	—	—	1.4%
Other (Specify:)	—	—	—	—	—
None	15.6%	18.8%	23.5%	85.7%	21.4%

Q10. Please indicate whether any of the barriers listed below interfere with your agency in providing EBPs you are using or want to use?

		Shortage of Appropriately Trained Workforce	Financing Issues in Paying for EBPs	EBP Needs Modification to Fit Local Needs	Attaining or Maintaining Fidelity to EBP Model Standards	Resistance to Implementing EBPs from Practitioners or Others	Rules & Regulations	None	Other	Total N
Aggression Replacement Training	MHD	51.9%	70.4%	33.3%	18.5%	7.4%	3.7%	3.7%	3.7%	27
	DASA	55.0%	55.0%	35.0%	10.0%	5.0%	5.0%	20.0%	—	20
	JRA	100%	41.7%	25.0%	58.3%	8.3%	8.3%	—	16.7%	12
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**62.7%**	**59.3%**	**32.2%**	**23.7%**	**6.8%**	**5.1%**	**8.5%**	**5.1%**	**59**
Assertive Community Treatment (ACT/PACT)	MHD	40.9%	50.0%	27.3%	36.4%	18.2%	22.7%	13.6%	13.6%	22
	DASA	50.0%	66.7%	16.7%	16.7%	8.3%	8.3%	8.3%	8.3%	12
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**44.1%**	**55.9%**	**23.5%**	**29.4%**	**14.7%**	**17.6%**	**11.8%**	**11.8%**	**34**
Behavioral Treatment for Substance Abuse in Schizophrenia	MHD	57.1%	42.9%	21.4%	21.4%	7.1%	7.1%	7.1%	7.1%	14
	DASA	72.2%	61.1%	33.3%	33.3%	22.2%	5.6%	16.7%	—	18
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**65.6%**	**53.1%**	**28.1%**	**28.1%**	**15.6%**	**6.3%**	**12.5%**	**3.1%**	**32**
Brief Strategic Family Therapy	MHD	61.8%	61.8%	20.6%	44.1%	2.9%	17.6%	14.7%	—	34
	DASA	63.9%	58.3%	8.3%	11.1%	11.1%	5.6%	11.1%	—	36
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**62.9%**	**60.0%**	**14.3%**	**27.1%**	**7.1%**	**11.4%**	**12.9%**	—	**70**
Cognitive Behavior Therapies (CBT)	MHD	31.6%	36.7%	21.5%	24.1%	5.1%	10.1%	30.4%	6.3%	79
	DASA	43.8%	30.2%	14.6%	27.1%	8.3%	1.0%	33.3%	—	96
	JRA	100%	20.0%	40.0%	40.0%	20.0%	20.0%	—	—	5
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**40.0%**	**32.8%**	**18.3%**	**26.1%**	**7.2%**	**5.6%**	**31.1%**	**2.8%**	**180**
Contingency Management (Co-occurring)	MHD	55.6%	44.4%	—	27.8%	5.6%	—	11.1%	11.1%	18
	DASA	60.6%	54.5%	12.1%	21.2%	6.1%	6.1%	12.1%	—	33
	JRA	100%	100%	—	50.0%	—	—	—	—	2
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**60.4%**	**52.8%**	**7.5%**	**24.5%**	**5.7%**	**3.8%**	**11.3%**	**3.8%**	**53**
Dare to be you	MHD	75.0%	25.0%	—	25.0%	—	25.0%	25.0%	—	4
	DASA	60.0%	60.0%	20.0%	20.0%	20.0%	20.0%	20.0%	—	5
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**66.7%**	**44.4%**	**11.1%**	**22.2%**	**11.1%**	**22.2%**	**22.2%**	—	**9**
Dialectical Behavioral Therapy (DBT)	MHD	50.0%	55.2%	25.9%	32.8%	8.6%	6.9%	15.5%	5.2%	58
	DASA	49.3%	41.8%	14.9%	23.9%	7.5%	1.5%	26.9%	—	67
	JRA	87.5%	25.0%	56.3%	56.3%	6.3%	6.3%	—	37.5%	16
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**53.9%**	**45.4%**	**24.1%**	**31.2%**	**7.8%**	**4.3%**	**19.1%**	**6.4%**	**141**

		Shortage of Appropriately Trained Workforce	Financing Issues in Paying for EBPs	EBP Needs Modification to Fit Local Needs	Attaining or Maintaining Fidelity to EBP Model Standards	Resistance to Implementing EBPs from Practitioners or Others	Rules & Regulations	None	Other	Total N
Eye Movement Desensitization & Reprocessing (EMDR)	MHD	47.8%	39.1%	4.3%	17.4%	—	—	21.7%	13.0%	23
	DASA	56.3%	62.5%	31.3%	37.5%	12.5%	12.5%	6.3%	6.3%	16
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**51.3%**	**48.7%**	**15.4%**	**25.6%**	**5.1%**	**5.1%**	**15.4%**	**10.3%**	**39**
Family Integrated Transitions	MHD	50.0%	78.6%	21.4%	7.1%	7.1%	—	14.3%	—	14
	DASA	63.6%	63.6%	9.1%	9.1%	—	—	—	9.1%	11
	JRA	50.0%	37.5%	—	12.5%	—	—	37.5%	12.5%	8
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**54.5%**	**63.6%**	**12.1%**	**9.1%**	**3.0%**	—	**15.2%**	**6.1%**	**33**
Family Psychoeducation	MHD	22.2%	33.3%	13.3%	24.4%	8.9%	8.9%	26.7%	11.1%	45
	DASA	36.4%	33.3%	18.2%	21.2%	9.1%	—	39.4%	—	33
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**28.2%**	**33.3%**	**15.4%**	**23.1%**	**9.0%**	**5.1%**	**32.1%**	**6.4%**	**78**
Functional Family Therapy	MHD	61.5%	76.9%	19.2%	30.8%	3.8%	7.7%	7.7%	3.8%	26
	DASA	48.1%	66.7%	7.4%	7.4%	14.8%	3.7%	7.4%	—	27
	JRA	66.7%	—	—	16.7%	—	—	33.3%	—	6
	CA	100%	100%	—	—	—	—	—	—	1
	TOTAL	**56.7%**	**65.0%**	**11.7%**	**18.3%**	**8.3%**	**5.0%**	**10.0%**	**1.7%**	**60**
Gatekeeper Program	MHD	33.3%	50.0%	8.3%	8.3%	—	—	25.0%	16.7%	12
	DASA	—	—	—	—	—	—	—	—	—
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**33.3%**	**50.0%**	**8.3%**	**8.3%**	**—**	**—**	**25.0%**	**16.7%**	**12**
Illness Self-Management/ Illness Management & Recovery	MHD	48.6%	43.2%	16.2%	21.6%	10.8%	2.7%	16.2%	10.8%	37
	DASA	63.6%	63.6%	36.4%	45.5%	27.3%	9.1%	9.1%	—	11
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**52.1%**	**47.9%**	**20.8%**	**27.1%**	**14.6%**	**4.2%**	**14.6%**	**8.3%**	**48**
Incredible Years	MHD	66.7%	66.7%	—	33.3%	—	—	8.3%	8.3%	12
	DASA	100%	50.0%	—	—	—	—	—	—	2
	JRA	—	—	—	—	—	—	—	—	—
	CA	100%	100%	—	—	—	—	—	—	1
	TOTAL	**73.3%**	**66.7%**	**—**	**26.7%**	**—**	**—**	**6.7%**	**6.7%**	**15**
Integrated Dual Disorders	MHD	47.5%	42.5%	17.5%	15.0%	10.0%	22.5%	17.5%	12.5%	40
	DASA	40.5%	38.1%	16.7%	14.3%	11.9%	14.3%	35.7%	—	42
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**43.9%**	**40.2%**	**17.1%**	**14.6%**	**11.0%**	**18.3%**	**26.8%**	**6.1%**	**82**
Interpersonal Therapy	MHD	28.6%	42.9%	9.5%	9.5%	4.8%	4.8%	38.1%	4.8%	21
	DASA	61.1%	38.9%	27.8%	33.3%	22.2%	16.7%	27.8%	—	18
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**43.6%**	**41.0%**	**17.9%**	**20.5%**	**12.8%**	**10.3%**	**33.3%**	**2.6%**	**39**

		Shortage of Appropriately Trained Workforce	Financing Issues in Paying for EBPs	EBP Needs Modification to Fit Local Needs	Attaining or Maintaining Fidelity to EBP Model Standards	Resistance to Implementing EBPs from Practitioners or Others	Rules & Regulations	None	Other	Total N
Medication Management	MHD	24.5%	24.5%	12.2%	18.4%	4.1%	14.3%	49.0%	8.2%	49
	DASA	34.3%	31.4%	14.3%	11.4%	5.7%	—	45.7%	—	35
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**28.6%**	**27.4%**	**13.1%**	**15.5%**	**4.8%**	**8.3%**	**47.6%**	**4.8%**	**84**
Motivational Enhancement Therapy (MET)	MHD	52.0%	44.0%	20.0%	24.0%	8.0%	4.0%	20.0%	4.0%	25
	DASA	43.5%	30.4%	6.5%	17.4%	13.0%	8.7%	39.1%	—	46
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**46.5%**	**35.2%**	**11.3%**	**19.7%**	**11.3%**	**7.0%**	**32.4%**	**1.4%**	**71**
Motivational Interviewing	MHD	48.4%	39.1%	17.2%	17.2%	6.3%	6.3%	29.7%	6.3%	64
	DASA	28.7%	19.4%	7.4%	20.4%	2.8%	2.8%	46.3%	—	108
	JRA	100%	80.0%	—	100%	—	—	—	—	5
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**37.9%**	**28.2%**	**10.7%**	**21.5%**	**4.0%**	**4.0%**	**39.0%**	**2.3%**	**177**
Multi-Family Group Treatment (MFG)	MHD	42.9%	50.0%	28.6%	28.6%	7.1%	—	21.4%	7.1%	14
	DASA	50.0%	37.5%	25.0%	6.3%	6.3%	—	12.5%	6.3%	16
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**46.7%**	**43.3%**	**26.7%**	**16.7%**	**6.7%**	**—**	**16.7%**	**6.7%**	**30**
Multidimensional Family Therapy	MHD	69.2%	69.2%	15.4%	23.1%	7.7%	7.7%	23.1%	—	13
	DASA	71.4%	64.3%	7.1%	7.1%	—	—	14.3%	—	14
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**70.4%**	**66.7%**	**11.1%**	**14.8%**	**3.7%**	**3.7%**	**18.5%**	**—**	**27**
Multidimensional Treatment Foster Care	MHD	62.5%	75.0%	62.5%	25.0%	12.5%	25.0%	—	—	8
	DASA	50.0%	50.0%	50.0%	50.0%	50.0%	—	50.0%	—	2
	JRA	100%	—	33.3%	—	—	33.3%			3
	CA	66.7%	—	—	66.7%	66.7%	33.3%	—	—	3
	TOTAL	**64.7%**	**41.2%**	**41.2%**	**29.4%**	**23.5%**	**23.5%**	**11.8%**	**—**	**16**
Multisystematic Therapy	MHD	30.4%	69.6%	21.7%	30.4%	8.7%	13.0%	21.7%	—	23
	DASA	46.7%	46.7%	13.3%	20.0%	20.0%	—	20.0%	—	15
	JRA	100%	—	—	—	—	—	—	—	2
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**40.0%**	**57.5%**	**17.5%**	**25.0%**	**12.5%**	**7.5%**	**20.0%**	**—**	**40**
Nurse-Family Partnership	MHD	50.0%	50.0%	50.0%	—	—	—	50.0%	—	2
	DASA	66.7%	66.7%	—	—	33.3%	33.3%	—	—	3
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	100%	—	100%	—	—	—	—	1
	TOTAL	**50.0%**	**66.7%**	**16.7%**	**16.7%**	**16.7%**	**16.7%**	**16.7%**	**—**	**6**
Parent-Child Interaction Therapy	MHD	63.3%	70.0%	16.7%	30.0%	—	6.7%	6.7%	—	30
	DASA	41.2%	47.1%	11.8%	23.5%	5.9%	5.9%	17.6%	—	17
	JRA	—	—	—	—	—	—	—	—	—
	CA	81.8%	81.8%	—	—	—	—	9.1%	—	11
	TOTAL	**60.3%**	**65.5%**	**12.1%**	**22.4%**	**1.7%**	**5.2%**	**10.3%**	**—**	**58**

		Shortage of Appropriately Trained Workforce	Financing Issues in Paying for EBPs	EBP Needs Modification to Fit Local Needs	Attaining or Maintaining Fidelity to EBP Model Standards	Resistance to Implementing EBPs from Practitioners or Others	Rules & Regulations	None	Other	Total N
Peer Support	MHD	51.1%	46.8%	17.0%	23.4%	12.8%	17.0%	19.1%	4.3%	47
	DASA	35.0%	25.0%	15.0%	30.0%	12.5%	5.0%	30.0%	—	40
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**43.7%**	**36.8%**	**16.1%**	**26.4%**	**12.6%**	**11.5%**	**24.1%**	**2.3%**	**87**
Promoting Alternative Thinking Strategies (PATH)	MHD	25.0%	25.0%	25.0%	25.0%	—	—	50.0%	—	4
	DASA	72.7%	36.4%	18.2%	18.2%	18.2%	—	9.1%	9.1%	11
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**60.0%**	**33.3%**	**20.0%**	**20.0%**	**13.3%**	**—**	**20.0%**	**6.7%**	**15**
Second Step	MHD	25.0%	25.0%	—	25.0%	—	—	12.5%	25.0%	8
	DASA	71.4%	28.6%	28.6%	28.6%	57.1%	28.6%	28.6%	—	7
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**46.7%**	**26.7%**	**13.3%**	**26.7%**	**26.7%**	**13.3%**	**20.0%**	**13.3%**	**15**
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	MHD	42.1%	42.1%	21.1%	10.5%	15.8%	10.5%	26.3%	5.3%	19
	DASA	55.0%	45.0%	10.0%	20.0%	5.0%	5.0%	20.0%	—	40
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**50.8%**	**44.1%**	**13.6%**	**16.9%**	**8.5%**	**6.8%**	**22.0%**	**1.7%**	**59**
Strengthening Families Program (SFP)	MHD	47.1%	64.7%	41.2%	29.4%	—	5.9%	23.5%	5.9%	17
	DASA	66.7%	30.0%	13.3%	10.0%	13.3%	10.0%	20.0%	—	30
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**59.6%**	**42.6%**	**23.4%**	**17.0%**	**8.5%**	**8.5%**	**21.3%**	**2.1%**	**47**
Supported Employment	MHD	44.1%	58.8%	20.6%	17.6%	5.9%	14.7%	11.8%	5.9%	34
	DASA	52.9%	52.9%	11.8%	35.3%	11.8%	5.9%	17.6%	—	17
	JRA	—	100%	—	—	—	—	—	—	1
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**46.2%**	**57.7%**	**17.3%**	**23.1%**	**7.7%**	**11.5%**	**13.5%**	**3.8%**	**52**
Supported Housing	MHD	37.9%	58.6%	10.3%	10.3%	3.4%	17.2%	10.3%	13.8%	29
	DASA	44.4%	44.4%	5.6%	22.2%	11.1%	5.6%	27.8%	—	18
	JRA	—	100%	—	—	—	—	—	—	1
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**39.6%**	**54.2%**	**8.3%**	**14.6%**	**6.3%**	**12.5%**	**16.7%**	**8.3%**	**48**
Therapeutic Foster Care	MHD	30.8%	46.2%	15.4%	7.7%	—	15.4%	38.5%	15.4%	13
	DASA	16.7%	50.0%	16.7%	33.3%	16.7%	—	33.3%	—	6
	JRA	—	—	—	—	—	—	—	—	—
	CA	—	—	—	—	—	—	—	—	—
	TOTAL	**26.3%**	**47.4%**	**15.8%**	**15.8%**	**5.3%**	**10.5%**	**36.8%**	**10.5%**	**19**
Other (Specify:)	MHD			Data TBD						
	DASA									
	JRA									
	CA									
	TOTAL									

		Shortage of Appropriately Trained Workforce	Financing Issues in Paying for EBPs	EBP Needs Modification to Fit Local Needs	Attaining or Maintaining Fidelity to EBP Model Standards	Resistance to Implementing EBPs from Practitioners or Others	Rules & Regulations	None	Other	Total N
Other (Specify:)	MHD									
	DASA									
	JRA									
	CA									
	TOTAL									
Other (Specify:)	MHD									
	DASA									
	JRA									
	CA									
	TOTAL									
OVERALL*	**MHD**	**44.5%**	**48.9%**	**18.5%**	**22.8%**	**6.6%**	**9.7%**	**21.1%**	**6.9%**	**885**
	DASA	**47.5%**	**39.9%**	**14.3%**	**20.6%**	**10.0%**	**4.9%**	**27.3%**	**0.6%**	**872**
	JRA	**83.6%**	**34.4%**	**24.6%**	**42.6%**	**4.9%**	**6.6%**	**8.2%**	**14.8%**	**61**
	CA	**76.5%**	**70.6%**	**—**	**17.6%**	**11.8%**	**5.9%**	**5.9%**	**—**	**17**
	TOTAL	**47.5%**	**44.4%**	**16.6%**	**22.4%**	**8.2%**	**7.3%**	**23.5%**	**4.1%**	**1835**

*Note: Overall totals include the first 34 EBPs only. The "Other" EBP categories have not been included in this overall analysis. Overall sample size reflects number of EBPs included within analysis, not the number of agencies within each organization.

Q11. What type of assistance is most needed by your agency to help facilitate the adoption and implementation of evidence based practices?

	MHD (n = 96)	DASA (n=154)	JRA (n=17)	CA (n=14)	Total (n=281)
None	3.1%	5.8%	—	21.4%	**5.3%**
Appropriately trained workforce	18.8%	14.3%	35.3%	42.9%	**18.5%**
Financing issues in paying for EBP's	49.0%	50.6%	29.4%	28.6%	**47.7%**
Modification of EBP to fit local needs	12.5%	9.7%	5.9%	—	**10.0%**
Attaining or maintaining fidelity to EBP model standards	6.3%	11.7%	11.8%	7.1%	**9.6%**
Resistance to implementing EBPs from practitioners	1.0%	2.6%	—	—	**1.8%**
Other	9.4%	5.2%	17.6%	—	**7.1%**

Q12a. Does your agency serve populations or address specific client needs for which there are no known or available evidence-based practices?

Note: There were two missing data points in MHD, thus reducing its sample size and the overall sample size.

	MHD (n = 94)	DASA (n=154)	JRA (n=17)	CA (n=14)	Total (n=279)
Serve populations or address specific client needs which have no known/available EBPs	44.7%	22.7%	100%	28.6%	**35.1%**

Q13. Please rate your agency's interest in continuing/beginning to implement EBPs into your treatment program.

	MHD (n = 96)	DASA (n = 154)	JRA (n = 17)	CA (n = 14)	TOTAL (n = 281)
Not at All	2.1%	3.2%	—	—	**2.5%**
A little	1.0%	5.8%	—	—	**3.6%**
Somewhat	20.8%	22.7%	—	14.3%	**20.3%**
Very	42.7%	37.7%	11.8%	50.0%	**38.4%**
Extremely	33.3%	30.5%	88.2%	35.7%	**35.2%**

Q14. What initiatives, if any, is your agency implementing to promote the adoption of evidence-based practices (EBPs)?

	MHD (n = 96)	DASA (n = 154)	JRA (n = 17)	CA (n = 14)	TOTAL (n = 281)
Increase awareness about EBPs	80.2%	68.2%	100.0%	100.0%	75.8%
Training	77.1%	75.3%	100.0%	92.9%	78.3%
Incorporation of EBPs in contracts	32.3%	18.8%	47.1%	85.7%	28.5%
Monitoring of fidelity	44.8%	37.7%	88.2%	78.6%	45.2%
Modification of information systems/data reports	32.3%	23.4%	100.0%	28.6%	31.3%
Modification of paperwork/documentation forms/guidelines to fit EBPs so as to accurately reflect the work done	41.7%	35.1%	100.0%	28.6%	40.9%
Financial incentives	8.3%	13.0%	—	—	10.0%
Other	7.3%	5.8%	23.5%	—	7.1%
None	6.3%	9.7%	—	—	7.5%

Q15b. What method is your agency using?

	MHD (n = 39)	DASA (n = 59)	JRA (n = 6)	CA (n = 3)	TOTAL (n = 107)
Benchmarking	30.8%	28.8%	—	33.3%	28.0%
Outcome monitoring	79.5%	93.2%	—	100.0%	83.2%
Program Evaluation	71.8%	81.4%	100.0%	66.7%	78.5%
Other	7.7%	—	—	—	2.8%

Q16. How many unduplicated clients did your agency serve in Fiscal Year 2007 (July 1, 2006 – June 30, 2007)?

	Unduplicated Clients Served (FY 2007)	
	N	Mean
MHD	94	2188
DASA	150	532
JRA	17	205
CA	—	—
Total	**261**	**1107**

Q17a. For each EBP that you are currently providing, please provide the total number of **Adult** (18 years old and older) unduplicated clients served in FY 2007 (July 1, 2006-June 30, 2007)?

	MHD		DASA		JRA		CA		Total		
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N	Client Count
Aggression Replacement Training	63	2	5	1	—	—	—	—	43	3	130
Assertive Community Treatment (ACT/PACT)	60	10	8	1	—	—	—	—	56	11	611
Behavioral Treatment for Substance Abuse in Schizophrenia	51	3	1	1	—	—	—	—	39	4	155
Brief Strategic Family Therapy	70	6	53	1	—	—	—	—	68	7	474
Cognitive Behavior Therapies (CBT)	386	38	296	24	—	—	—	—	351	62	21784
Contingency Management (co-occurring)	63	2	50	2	—	—	—	—	56	4	225
Dare to Be You	—	—	—	—	—	—	—	—	—	—	—
Dialectical Behavioral Therapy (DBT)	120	25	88	16	—	—	—	—	107	41	4400
Eye Movement Desensitization & Reprocessing (EMDR)	69	6	—	—	—	—	—	—	69	6	413
Family Integrated Transitions	25	1	—	—	—	—	—	—	25	1	25
Family Psychoeducation	205	19	205	5	—	—	—	—	205	24	4912
Functional Family Therapy	66	4	5	1	—	—	56	1	54	6	324
Gatekeeper program	178	5	—	—	—	—	—	—	178	5	889
Illness Self-Management/Illness Management & Recovery	84	10	—	—	—	—	—	—	84	10	835
Incredible Years	—	—	—	—	—	—	15	1	15	1	15
Integrated Dual Disorders Treatment	150	19	62	7	—	—	—	—	126	26	3288
Interpersonal Therapy	1494	3	40	1	—	—	—	—	1131	4	4523
Medication Management	527	28	120	5	—	—	—	—	465	33	15358
Motivational Enhancement Therapy (MET)	243	8	98	8	—	—	—	—	171	16	2729
Motivational Interviewing	247	26	225	35	—	—	—	—	234	61	14272
Multi-Family Group Treatment (MFG)	88	5	384	1	—	—	—	—	137	6	823
Multidimensional Family Therapy	15	3	384	1	—	—	—	—	107	4	429
Multidimensional Treatment Foster Care	25	1	—	—	—	—	—	—	25	1	25
Multisystemic Therapy	63	4	—	—	—	—	—	—	63	4	250
Nurse-Family Partnership	—	—	3	1	—	—	2	1	3	2	5
Parent-Child Interaction Therapy	65	7	41	1	—	—	12	10	34	18	609
Peer Support	49	25	632	11	—	—	—	—	227	36	8171
Promoting Alternative Thinking Strategies (PATH)	800	1	—	—	—	—	—	—	800	1	800
Second Step	—	—	—	—	—	—	—	—	—	—	—
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	29	4	33	6	—	—	—	—	31	10	312
Strengthening Families Program (SFP)	66	6	4	2	—	—	—	—	51	8	405
Supported Employment	92	20	5	2	—	—	—	—	84	22	1841
Supported Housing	172	15	4	2	—	—	—	—	153	17	2593
Therapeutic Foster Care	15	1	—	—	—	—	—	—	15	1	15
Other (Specify:)	415	15	131	15	—	—	—	—	273	30	8181
Other (Specify:)	145	9	310	3	—	—	—	—	186	12	2233
OVERALL*	**209**	**307**	**203**	**135**	—	—	**14**	**13**	**201**	**455**	**91640**

Note: Only agencies who reported client counts greater than zero are included here, hence, the smaller sample sizes.
*Overall totals include the first 34 EBPs only. The "Other" EBP categories have not been included in this overall analysis. Overall sample size reflects number of EBPs included within analysis, not the number of agencies within each organization.

Q17b. For each EBP that you are currently providing, please provide the total number of **Children** (less than 18 years old) unduplicated clients served in FY 2007 (July1, 2006-June 30, 2007)?

	MHD		DASA		JRA		CA		Total		
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N	Client Count
Aggression Replacement Training	24	10	17	7	110	5	—	—	41	22	910
Assertive Community Treatment (ACT/PACT)	60	3	—	—	—	—	—	—	60	3	179
Behavioral Treatment for Substance Abuse in Schizophrenia	—	—	50	1	—	—	—	—	50	1	50
Brief Strategic Family Therapy	69	9	173	2	—	—	—	—	88	11	968
Cognitive Behavior Therapies (CBT)	166	37	71	15	621	1	—	—	148	53	7839
Contingency Management (co-occurring)	128	2	175	1	—	—	—	—	143	3	430
Dare to Be You	—	—	—	—	—	—	—	—	—	—	—
Dialectical Behavioral Therapy (DBT)	62	11	67	10	196	10	—	—	107	31	3309
Eye Movement Desensitization & Reprocessing (EMDR)	3	3	—	—	—	—	—	—	3	3	9
Family Integrated Transitions	15	4	13	2	15	4	—	—	15	10	145
Family Psychoeducation	116	18	70	3	—	—	—	—	109	21	2297
Functional Family Therapy	98	11	9	2	55	6	56	1	74	20	1484
Gatekeeper program	—	—	—	—	—	—	—	—	—	—	—
Illness Self-Management/Illness Management & Recovery	105	2	—	—	—	—	—	—	105	2	210
Incredible Years	266	1	—	—	—	—	15	1	141	2	281
Integrated Dual Disorders Treatment	34	6	135	5	—	—	—	—	80	11	878
Interpersonal Therapy	182	4	170	1	—	—	—	—	179	5	897
Medication Management	138	25	25	2	—	—	—	—	129	27	3491
Motivational Enhancement Therapy (MET)	—	—	66	6	—	—	—	—	66	6	395
Motivational Interviewing	134	15	58	16	—	—	—	—	95	31	2933
Multi-Family Group Treatment (MFG)	21	2	67	3	—	—	—	—	49	5	244
Multidimensional Family Therapy	30	1	—	—	—	—	—	—	30	1	30
Multidimensional Treatment Foster Care	17	4	—	—	8	1	11	3	14	8	109
Multisystemic Therapy	75	14	14	3	—	—	—	—	65	17	1098
Nurse-Family Partnership	—	—	1	1	—	—	—	—	1	1	1
Parent-Child Interaction Therapy	39	12	18	1	—	—	12	10	26	23	602
Peer Support	16	7	100	2	—	—	—	—	35	9	314
Promoting Alternative Thinking Strategies (PATH)	—	—	—	—	—	—	—	—	—	—	—
Second Step	326	3	30	1	—	—	—	—	252	4	1008
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	40	1	—	—	—	—	—	—	40	1	40
Strengthening Families Program (SFP)	71	4	8	5	—	—	—	—	36	9	325
Supported Employment	24	2	—	—	—	—	—	—	24	2	48
Supported Housing	26	1	—	—	—	—	—	—	26	1	26
Therapeutic Foster Care	56	9	3	1	—	—	—	—	51	10	505
Other (Specify:)	257	20	16	11	170	10	—	—	171	41	7011
Other (Specify:)	59	8	15	6	—	—	—	—	40	14	561
OVERALL*	**99**	**221**	**60**	**90**	**131**	**27**	**15**	**15**	**88**	**353**	**31055**

Note: Only agencies who reported client counts greater than zero are included here, hence, the smaller sample sizes.
*Overall totals include the first 34 EBPs only. The "Other" EBP categories have not been included in this overall analysis. Overall sample size reflects number of EBPs included within analysis, not the number of agencies within each organization.

Q17c. For each EBP that you are currently providing, please provide the **total number** of unduplicated clients served in FY 2007 (July1, 2006-June 30, 2007)?

	MHD		DASA		JRA		CA		Total		
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N	Client Count
Aggression Replacement Training	36	10	18	7	110	5	—	—	47	22	1040
Assertive Community Treatment (ACT/PACT)	78	10	8	1	—	—	—	—	72	11	790
Behavioral Treatment for Substance Abuse in Schizophrenia	51	3	26	2	—	—	—	—	41	5	205
Brief Strategic Family Therapy	62	12	133	3	—	—	—	—	76	15	1142
Cognitive Behavior Therapies (CBT)	417	50	272	30	621	1	—	—	366	81	29623
Contingency Management (co-occurring)	127	3	92	3	—	—	—	—	109	6	655
Dare to Be You	—	—	—	—	—	—	—	—	—	—	—
Dialectical Behavioral Therapy (DBT)	123	30	99	21	196	10	—	—	126	61	7709
Eye Movement Desensitization & Reprocessing (EMDR)	53	8	—	—	—	—	—	—	53	8	422
Family Integrated Transitions	21	4	13	2	15	4	—	—	17	10	170
Family Psychoeducation	272	22	206	6	—	—	—	—	257	28	7209
Functional Family Therapy	122	11	12	2	55	6	112	1	90	20	1808
Gatekeeper program	178	5	—	—	—	—	—	—	178	5	889
Illness Self-Management/Illness Management & Recovery	105	10	—	—	—	—	—	—	105	10	1045
Incredible Years	266	1	—	—	—	—	30	1	148	2	296
Integrated Dual Disorders Treatment	146	21	101	11	—	—	—	—	130	32	4166
Interpersonal Therapy	1303	4	105	2	—	—	—	—	903	6	5420
Medication Management	535	34	130	5	—	—	—	—	483	39	18849
Motivational Enhancement Therapy (MET)	243	8	91	13	—	—	—	—	149	21	3124
Motivational Interviewing	272	31	214	41	—	—	—	—	239	72	17205
Multi-Family Group Treatment (MFG)	96	5	147	4	—	—	—	—	119	9	1067
Multidimensional Family Therapy	25	3	384	1	—	—	—	—	115	4	459
Multidimensional Treatment Foster Care	19	5	—	—	8	1	11	3	15	9	134
Multisystemic Therapy	93	14	14	3	—	—	—	—	79	17	1348
Nurse-Family Partnership	—	—	4	1	—	—	2	1	3	2	6
Parent-Child Interaction Therapy	77	12	30	2	—	—	23	10	50	24	1211
Peer Support	48	28	550	13	—	—	—	—	207	41	8485
Promoting Alternative Thinking Strategies (PATH)	800	1	—	—	—	—	—	—	800	1	800
Second Step	326	3	30	1	—	—	—	—	252	4	1008
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	39	4	33	6	—	—	—	—	35	10	352
Strengthening Families Program (SFP)	97	7	10	5	—	—	—	—	61	12	730
Supported Employment	94	20	5	2	—	—	—	—	86	22	1889
Supported Housing	174	15	4	2	—	—	—	—	154	17	2619
Therapeutic Foster Care	57	9	3	1	—	—	—	—	52	10	520
Other (Specify:)	392	29	112	19	170	10	—	—	262	58	15192
Other (Specify:)	136	13	146	7	—	—	—	—	140	20	2794
OVERALL*	**212**	**403**	**173**	**190**	**131**	**27**	**25**	**16**	**192**	**636**	**122395**

Note: Only agencies who reported client counts greater than zero are included here, hence, the smaller sample sizes.
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Q19a. What is your current job title?

	MHD (n = 96)
Administrator	1.0%
Area Director	1.0%
Associate Director	2.1%
Associate Director, Clinical	2.1%
Behavioral Mental Health Director	1.0%
CEO	5.2%
Chief Clinical Officer	1.0%
Chief of Inpatient Services	1.0%
Chief Operating Officer	1.0%
Clinical Coordinator	1.0%
Clinical Director	13.5%
Clinical Director Family Services & Mental Health	1.0%
Clinical Manager/Interim Agency Director	1.0%
Clinical Program Manager	1.0%
Clinical Supervisor	1.0%
Director	1.0%
Director Child & Family Services	1.0%
Director Community Relations	1.0%
Director of Children Services	1.0%
Director of Clinical Services	3.1%
Director of Compliance	1.0%
Director of Psychiatric Services	1.0%
Director of Senior Behavioral Health	1.0%
Director, Behavioral Health Services	4.2%
Director, Outpatient Services	1.0%
Executive Director	16.7%
Director of HSD/Admin. Specialist	1.0%
Manager Outpt Psychiatry	1.0%
Manager, ARNP, DMHP	1.0%
Manager, Clinical Services	1.0%
Medical Director	1.0%
Mental Health Professional	1.0%
Mental Health Program Manager	2.1%
Pierce County Crisis and Corrections Coordinator	1.0%
Program Coordinator	2.1%
Program Director	2.1%
Program Manager	3.1%
Program Supervisor	1.0%

Q19a. What is your current job title? (cont.)

	MHD (n = 96)
Psychiatry Director	1.0%
Quality Assurance Director	1.0%
Quality Specialist	1.0%
Regional Chief of Operations	1.0%
Site Manager	1.0%
Supervisor of Adult Services	1.0%
Vice President	1.0%
Vice President Behavioral Health	1.0%
VP Clinical Services	1.0%
Youth and Family Services Director	1.0%

Q19a. What is your current job title?

	DASA (n = 155)
Administrator	3.9%
Administrator/County CD Coordinator	0.6%
Associate Director	0.6%
BH Manager	0.6%
CD Program Director	0.6%
CD Supervisor	1.3%
CEO	0.6%
Chemical Dependency Coordinator	0.6%
Chemical Dependency Counselor/Director	0.6%
Chemical Dependency Professional	3.2%
Chemical Dependency Program Director	0.6%
Chief Operations Officer	0.6%
Clinical Director	7.1%
Clinical Manager	0.6%
Clinical Program Manager	0.6%
Clinical Services Manager	0.6%
Clinical Supervisor	7.1%
Co-Director	0.6%
COD Program Coordinator	0.6%
COO/Rainier Branch Manager	0.6%
Coordinator	3.2%
Coordinator, SATP/BHS	0.6%
Deputy Director, ATC	0.6%
Director	7.1%
Director CD Services	1.3%
Director of Operations	0.6%
Director, Addiction Patient Care Line	0.6%
Director, Youth and Family Services Program	0.6%
Division Director	0.6%
Executive Clinical Director	3.2%
Executive Director	3.9%
Grant Manager/Family Counselor/CDP	0.6%
Manager	5.2%
Manager, COD Services	0.6%
Operation Administrator	0.6%
Outpatient Programs Manager	1.3%
Outpatient Treatment Director	0.6%
Owner/Administrator	1.3%

Q19a. What is your current job title? (cont.)

	DASA (n = 155)
Pgm Administrator	0.6%
Program Coordinator	0.6%
Program Director	3.9%
Program Director Outpatient Services	0.6%
Program Manager	9.7%
Program Supervisor	3.9%
Res. Services Clinical Manager	1.3%
Research Coordinator	2.6%
SA Director	0.6%
Substance Abuse Counselor/Clinical Supervisor	0.6%
Substance Abuse Prog. Coord.	0.6%
Substance Abuse Program Director	0.6%
Substance Abuse Service Program Manager	0.6%
Supervisor	0.6%
Supervisor, Outpatient Services	0.6%
Treatment Administrator	0.6%
Treatment Director	1.9%
Treatment Supervisor	1.3%
Vice President	1.3%
Vice President Behavioral Health	1.3%
Wellness Program Coordinator	0.6%

Q19a. What is your current job title?

	JRA (n = 17)
Associate Superintendent	5.9%
Clinical Director	52.9%
Juvenile Parole Administrator	41.2%

Q19a. What is your current job title?

	CA (n = 14)
EBP Manager	100.0%

Q19b. How many years have you been working at this agency?

	MHD (n = 96)	DASA (n=154)	JRA (n=17)	CA (n=14)	Total (n=281)
Mean number of years at agency	12.3	8.5	14.8	16.0	**10.5**

APPENDIX F

“Other” Responses

Appendix F Contents

Q1_other. Other services offered by agency

	MHD (n=43)
Advocacy and Therapy for Sexual Assault Victims	2.3%
Case management, family counseling, individual therapy, group therapy, medication management, community training, psychoeducational, respite	2.3%
Child Welfare Services	2.3%
Clubhouse model rehabilitation program	2.3%
Clubhouse, Inpatient Psychiatric Treatment, Children's Day School Services	2.3%
Court ordered COD but no IOP	2.3%
Crisis Intervention	2.3%
Crisis Stabilization & ITA Services	2.3%
Crisis Stabilization; RCW 71.05, RCW 71.34 and RCW 70.96B Investigations; DD crisis response 24/7	2.3%
Crisis telephone intervention	2.3%
Crisis, E& T Services	2.3%
Deaf addictions residential, recovery and drug court programs, diversion programs	2.3%
Developmental Disabilities	4.7%
Domestic Violence Treatment/Victim Advocacy,Housing	2.3%
Employment and peer support	2.3%
Family Counseling	2.3%
Family Support; Research	2.3%
Foster Care (BRS), therapeutic, CHAP)	2.3%
Governmental Agency	2.3%
HIV/AIDS, Domestic Violence, and Housing Services	2.3%
Hospital Alternative-intensive community based services	2.3%
Hospital utilization management	2.3%
ICCD Clubhouse	2.3%
Medical Care	4.7%
Medication Management, Supported Employment	2.3%
PACT	2.3%
Peer Support Services	2.3%
Post-Adoption Resource Center offers supportive services to adoptive, kinship, and guardianship families including a parent support/training group using a state of the art curriculum on parenting children who are drug/alcohol effected.	2.3%
Problem Gambling, Employee Assistance Program, Faith Based Advocacy, ADIS	2.3%
Psychiatry Consultation for medical/surgical inpatients and for primary and specialty outpatients	2.3%
Psychosocial Rehabilitation	2.3%
Readiness to Learn, Therapeutic Foster Care	2.3%
Residential	2.3%
Residential Treatment and Vocational Services	2.3%
Rural Outreach, Supported Housing-landlord	2.3%
SMART Recovery	2.3%
Stabilization	2.3%
Supportive Housing	2.3%
Therapeutic Foster Care	2.3%
Wraparound Services; Pregnancy Prevention; Divorce Parenting Seminar; Youth Crisis Stabilization	2.3%
Youth Short Term Residential	2.3%

Q1_other. Other services offered by agency

	DASA (n=44)
Abus Programs in both Adult and Youth	2.3%
Alcohol/drug free housing for eligible individuals	2.3%
AOD Prevention	2.3%
Behavior modification work training	2.3%
Case Management	4.5%
Community Sexual Assault Victim Services	2.3%
Crisis Outreach - DSHS Liaison	2.3%
DD, voc rehab	2.3%
dv, vr, ecs	2.3%
DVR	2.3%
Elderly Outreach & A/DIS	2.3%
family group, drug testing, case management	2.3%
Family Support	2.3%
Gambling	2.3%
Gambling Addiction Tx Also: Contracted Methadone Treatment Referrals to Healthcare for Homeless Veterans Participation in a variety of other clinical pursuits to include Pain Management	2.3%
Gambling treatment; prevention activities	2.3%
HIV case management	2.3%
Housing	2.3%
Interventions	2.3%
Medical	2.3%
Other behavioral health programs, domestic violence perp. treatment, parenting, anger management.	2.3%
Outpatient Treatments Only	2.3%
outreach	2.3%
Parent Child Interaction Therapy	2.3%
Parenting Classes	2.3%
Pathologic Gambling	2.3%
PPPW Priority Population COD Treatment	2.3%
PPW	4.5%
Prevention/Intervention	4.5%
Primary Care	2.3%
Problem Gambling and Domestic Violence	2.3%
Prometa	2.3%
Relapse Prevention	2.3%
Residential/outreach	2.3%
Shelter, supportive housing	2.3%
Suboxone	2.3%
Transitional housing	2.3%
Yakima County Drug Court and Family Court	9.1%

Q1_other. Other services offered by agency

	JRA (n=13)
Dialectical behavior therapy	38.5%
Functional Family Parole Services	46.2%
Medical	7.7%
Tx. for youth with cognitive deficits, who have committed sex offenses, and "juvenile justice youth"	7.7%

Q1_other. Other services offered by agency

	CA (n=14)
Child Welfare focused therapy services	7.1%
MTFC	14.3%
Nurse Family Partnership	7.1%
PCIT	57.1%
PCIT and MTFC	7.1%
PCIT, Incredible Years	28.6%

Q4a_other35. Other EBPs Used by Agencies

	MHD (n=38)	DASA (n=41)	JRA (n=10)	CA (n=0)	Inclusion Score
Brief Solution-Focused Therapy	—	2.4%	—	—	—
Change Companies workbooks	—	2.4%		—	—
Child Play Therapy	2.6%	—		—	—
Client-Directed Outcome-Informed Therapy	2.6%	—		—	—
Comprehensive, Continuous, Integrated System of Care	—	2.4%		—	—
Cultural Specific Approach for Asian Pacific American/Asian Pacific Asian	—	2.4%		—	—
DBT-SUD	—	—	20.0%	—	—
Disulfrum Treatment	—	2.4%	—	—	—
Experiential/Recreational Component	—	2.4%	—	—	—
Family Preservation	2.6%	—	—	—	4
Functional Family Parole Services	—	—	60.0%	—	2
GAIN I	—	2.4%	—	—	—
GAIN/GAIN SS	—	2.4%	—	—	—
Gender-specific groups for co-occurring disorders	2.6%	—	—	—	—
Growth Groups	—	2.4%	—	—	—
Guiding Good Choices Parenting Classes	2.6%	—	—	—	1
HOMEBUILDERS	2.6%	—	—	—	—
ICCD Clubhouse	5.3%	—	—	—	—
Individual treatment plans (ITP)	2.6%	—	—	—	—
Infant Mental Health	2.6%	—	—	—	—
Intensive Outpatient Adult/Youth	—	2.4%	—	—	—
Living in Balance	—	4.9%	—	—	—
Matrix Model	2.6%	2.4%	—	—	3
Minckoff's Co-occurring Therapy	—	2.4%	—	—	—
Moral Recognition Therapy	2.6%	—	—	—	—
Moral Reconation Therapy	2.6%	36.6%	10.0%	—	0
Motivation for Change	—	2.4%	—	—	—
Parent-Child Mutual Competence	—	2.4%	—	—	—
PCAP	—	2.4%	—	—	2
PEARL Depression Treatment	2.6%	—	—	—	—
Post-traumatic Stress Disorder EBP	2.6%	—	—	—	—
Promoting First Relationships	2.6%	—	—	—	2
QPRT	2.6%	—	—	—	—
Relapse Prevention		—	10.0%	—	—
Seven Challenges	2.6%	14.6%	—	—	—
Solution Focused Therapy	2.6%	—	—	—	—
Starting WA PACT Service	2.6%	—	—	—	—
Strengthening Families (Iowa)	2.6%	—	—	—	—
Suicide prevention EBPs	2.6%	—	—	—	—
TeenPEACE	2.6%	—	—	—	—
Theraplay	2.6%	—	—	—	—
Transitional Support Services for PPPW		2.4%	—	—	—
Trauma-Specific CBT	2.6%	—	—	—	—
Trauma-Based CBT	2.6%	—	—	—	—
Trauma-Focused CBT (TF-CBT)	13.2%	—	—	—	—
Triple P	2.6%	—	—	—	—
Work-ordered day	5.3%	—	—	—	—
WRAP	2.6%	—	—	—	—
WrapAround	7.9%	—	—	—	4

Q4a_other36. Other EBPs Used by Agencies

	MHD (N=17)	DASA (n=12)	JRA (n=0)	CA (n=0)	Inclusion Score
Adolescent Community Reinforcement Approach (ACRA)	—	16.7%	—	—	—
Behavioral Activation	5.6%	—	—	—	3
Bernstein/Goldberg Mutual Competence P-C Interaction	5.6%	—	—	—	—
Breakthrough Parenting	5.6%	—	—	—	—
Change Companies Journals	—	8.3%	—	—	—
Commitment to Change	—	8.3%	—	—	—
Complete range of medications for MH disorders via referral to the BHS Psychiatric Team	—	8.3%	—	—	—
Day Support	5.6%	—	—	—	—
Diagnostics	5.6%	—	—	—	—
Level I AB/CD Outpatient Adult/Youth	—	8.3%	—	—	—
Lifeskills Training	—	8.3%	—	—	3
Living in Balance Model	5.6%	—	—	—	—
Matrix (for stimulant abuse)	—	8.3%	—	—	—
Nurturing Parenting	5.6%	—	—	—	2
Psychosocial Rehabilitation/Milieu Therapy	5.6%	—	—	—	—
Rational Emotive Behavioral Therapy	—	8.3%	—	—	—
Recovery Model	5.6%	—	—	—	—
Regional Intervention Program	5.6%	—	—	—	—
Seven Challenges	—	16.7%	—	—	—
Solution Focused Sexual Abuse Treatment	5.6%	—	—	—	—
Therapeutic Community	—	8.3%	—	—	—
Trauma Focused CBT	29.4%	—	—	—	—
Unofficial peer support (consumers are not trained or paid, but supportive peer relationships develop naturally	5.6%	—	—	—	—

Q5_other. Unlisted Mechanisms Used for EBP Training (73 others)

	MHD
Career Paths	1
Codiak, COCE	1
Community training	1
Conferences	3
DASA training	2
DSHS Trainers	2
DVR	1
Harborview Plus Center for Disease Control	1
In process	1
ICCD Standards	1
JRA Consultants	6
Juvenile Court	1
LNP consultation	1
Matrix conference	1
MHD	2
MHD/RSNs	1
META Model training	1
Motivational Enhancement certified consultant	1
Motivational Interviewing certified consultant	1
Multisystemic Therapy therapist in North Carolina	1
NAMI	1
National Association Training	1
(We are a) National Training Site	1
National education	1
Not applicable	3
Outside evaluator who uses OHIO SAMI CCOE materials	1
Outside training	11
Private consultant	1
Professional trainers	3
Psychiatrist on his own	1
Psychiatrist utilize and then provide consultation to staff	1
RSN	1
RSN/WIMIRT	1
Some consultation and external training	2
State training	2
SAMHSA	1
SAMHSA manual	1
Unknown	1
WIMIRT	4
missing data	5

Note: This table includes data for the original 34 EBPs only.

Q5_other. Unlisted Mechanisms Used for EBP Training (47 others)

	DASA
ARNP provides	1
Committee for Children	1
Community based organizations	1
Continuing Education	1
Contracted Trainers	1
Credentialed Trainers	9
Hired Consultants	2
King County Training	1
Local Training	4
None	2
na	4
MATRIX	1
Medical Director CDC IP	1
Medical/Psychiatric Contract Doctors	1
MHD Training for Peer Counselors	1
Outside Community Employers	1
Outside Consultation	1
Self Study by staff	1
SAMSHA Best Practices	1
Trainings	1
Training by WA Institute or Eastern WA U. certificate program	1
VA Training	2
VA Training/U. of WA Training, DASA sponsored Training	1
WA Institute Training	1
WIMIRT Training through RSN	1
Washington State Training	1
Workfirst Emp Security	1
Workshops	2
Workshops, training, continuing education	1

Note: This table includes data for the original 34 EBPs only.

Q5_other. Unlisted Mechanisms Used for EBP Training (2 others)

	JRA
Behavioral Tech, LLC.	2

Note: This table includes data for the original 34 EBPs only.

Q5_other. Unlisted Mechanisms Used for EBP Training (16 others)

	CA
FFT Inc. Training	1
Model developer consultation	1
Monitoring by model developer	1
State contracted PCIT consultants	10
TFC Consultants	3

Note: This table includes data for the original 34 EBPs only.

Q6_other. Other target populations for each EBP

	MHD (n = 96)
Aggression Replacement Training	—
Assertive Community Treatment (ACT/PACT)	Missing = 1
Behavioral Treatment for Substance Abuse in Schizophrenia	Missing = 1
Brief Strategic Family Therapy	Family = 1 None = 1
Cognitive Behavior Therapies (CBT)	Family = 1 N/A = 1
Contingency Management (Co-occurring)	—
Dare to be you	—
Dialectical Behavioral Therapy (DBT)	Missing = 2
Eye Movement Desensitization & Reprocessing (EMDR)	—
Family Integrated Transitions	Adjudicated youth = 1
Family Psychoeducation	In process = 1
Functional Family Therapy	Family = 1
Gatekeeper Program	—
Illness Self-Management/Illness Management & Recovery	N/A = 1
Incredible Years	Unsure = 1
Integrated Dual Disorders	Missing = 2
Interpersonal Therapy	N/A = 1
Medication Management	—
Motivational Enhancement Therapy (MET)	—
Motivational Interviewing	Family = 1
Multi-Family Group Treatment (MFG)	Could not get going = 1 In process = 1
Multidimensional Family Therapy	—
Multidimensional Treatment Foster Care	—
Multisystematic Therapy	Family = 1
Nurse-Family Partnership	—
Parent-Child Interaction Therapy	Family = 1 Unsure = 1
Peer Support	Family = 1
Promoting Alternative Thinking Strategies (PATH)	—
Second Step	—
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	—
Strengthening Families Program (SFP)	—
Supported Employment	In planning phase = 1
Supported Housing	—
Therapeutic Foster Care	—
Other (Specify:)	Family = 1 Persons with Epilepsy = 1
Other (Specify:)	Family = 1

Q6_other. Other target populations for each EBP

	DASA (n = 154)
Aggression Replacement Training	—
Assertive Community Treatment (ACT/PACT)	—
Behavioral Treatment for Substance Abuse in Schizophrenia	—
Brief Strategic Family Therapy	N/A = 1
Cognitive Behavior Therapies (CBT)	N/A = 1 Pregnant/parenting women = 2 Women = 1
Contingency Management (Co-occurring)	—
Dare to be you	—
Dialectical Behavioral Therapy (DBT)	Pregnant/parenting women = 2 Women = 2
Eye Movement Desensitization & Reprocessing (EMDR)	—
Family Integrated Transitions	—
Family Psychoeducation	Pregnant/parenting women = 2
Functional Family Therapy	—
Gatekeeper Program	—
Illness Self-Management/Illness Management & Recovery	—
Incredible Years	—
Integrated Dual Disorders	—
Interpersonal Therapy	—
Medication Management	—
Motivational Enhancement Therapy (MET)	—
Motivational Interviewing	N/A = 1 Pregnant/parenting women = 2 Women = 1
Multi-Family Group Treatment (MFG)	N/A = 1
Multidimensional Family Therapy	—
Multidimensional Treatment Foster Care	—
Multisystematic Therapy	—
Nurse-Family Partnership	—
Parent-Child Interaction Therapy	Adult PPPW clients & children = 1
Peer Support	Women = 1
Promoting Alternative Thinking Strategies (PATH)	—
Second Step	—
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	Pregnant/Parenting Women = 2 Women = 1
Strengthening Families Program (SFP)	—
Supported Employment	—
Supported Housing	—
Therapeutic Foster Care	—
Other (Specify:)	Adult PPPW Clients only = 1
Other (Specify:)	—

Q6_other. Other target populations for each EBP

	JRA (n = 17)
Aggression Replacement Training	Juvenile offenders = 1
Assertive Community Treatment (ACT/PACT)	—
Behavioral Treatment for Substance Abuse in Schizophrenia	—
Brief Strategic Family Therapy	—
Cognitive Behavior Therapies (CBT)	—
Contingency Management (Co-occurring)	—
Dare to be you	—
Dialectical Behavioral Therapy (DBT)	Juvenile offenders = 1
Eye Movement Desensitization & Reprocessing (EMDR)	—
Family Integrated Transitions	—
Family Psychoeducation	—
Functional Family Therapy	—
Gatekeeper Program	—
Illness Self-Management/Illness Management & Recovery	—
Incredible Years	—
Integrated Dual Disorders	—
Interpersonal Therapy	—
Medication Management	—
Motivational Enhancement Therapy (MET)	—
Motivational Interviewing	—
Multi-Family Group Treatment (MFG)	—
Multidimensional Family Therapy	—
Multidimensional Treatment Foster Care	—
Multisystematic Therapy	—
Nurse-Family Partnership	—
Parent-Child Interaction Therapy	—
Peer Support	—
Promoting Alternative Thinking Strategies (PATH)	—
Second Step	—
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	—
Strengthening Families Program (SFP)	—
Supported Employment	—
Supported Housing	—
Therapeutic Foster Care	—
Other (Specify:)	Juvenile offenders = 1
Other (Specify:)	—

Q9_Other35: Are there any EBPs that you are NOT currently using but want to use in the future? Other (please specify)

	MHD (N = 12)
ASIST – Scott Miller's Practice Based Evidence	8.3%
DBT	8.3%
DBTS (Substance abuse specific)	8.3%
EBP specific for Crisis Intervention	8.3%
FACT	8.3%
More training is needed on Brief Strategic Therapy	8.3%
Positive Parent Programming	8.3%
Prolonged Exposure	8.3%
There may be others but we would need to know more about them and the applications to our populations and model of delivery	8.3%
We are interested in moving many of our services to EBP's however haven't specifically selected those we would like to use	8.3%
Wrap Around	16.7%

Q9_Other 35: Are there any EBPs that you are NOT currently using but want to use in the future? Other (please specify)

	DASA (N = 6)
Experiential/recreational therapy	16.7%
MRT	16.7%
Seven Challenges	16.7%
Solution-Focused Therapy	16.7%
Treatment of the TBI patient which is now becoming a much more recognized problem and one for which there are few existing treatment guidelines for Substance Use Disorder/Co-Occurring Treatment. This population is not restricted to veteran patients but includes anyone who has suffered a traumatic injury involving the head.	16.7%
Unsure – still considering options	16.7%

Q9_Other 35: Are there any EBPs that you are NOT currently using but want to use in the future? Other (please specify)

	CA (N = 1)
Promoting First Relationships	100.0%

Q9_Other 35: Are there any EBPs that you are NOT currently using but want to use in the future? Other (please specify)

	JRA (N = 2)
DBT-SUD	100.0%

Q9_Other 36: Are there any EBPs that you are NOT currently using but want to use in the future? Other (please specify)

	MHD (N = 4)
EMDR	25.0%
Facilitated 12 Step Referral	25.0%
MDT	25.0%
Seven Challenges	25.0%

Q10_other. Other Barriers in providing EBPs

	MHD (n = 96)
Aggression Replacement Training	Time = 1
Assertive Community Treatment (ACT/PACT)	Missing = 1 Volumes in rural areas = 1
Behavioral Treatment for Substance Abuse in Schizophrenia	Missing = 1
Brief Strategic Family Therapy	—
Cognitive Behavior Therapies (CBT)	Clients tend to like a blend of models… = 1 Missing = 4
Contingency Management (Co-occurring)	Obtaining manuals or trainings for staff = 1 Missing = 1
Dare to be you	—
Dialectical Behavioral Therapy (DBT)	Missing = 3
Eye Movement Desensitization & Reprocessing (EMDR)	Limited scope = 1 Missing = 1 See above = 1
Family Integrated Transitions	—
Family Psychoeducation	Missing = 5
Functional Family Therapy	Missing = 1
Gatekeeper Program	In coordination with outside agency (AAA) = 1 Missing = 1
Illness Self-Management/Illness Management & Recovery	Time = 1 Missing = 3
Incredible Years	Missing = 1
Integrated Dual Disorders	Time commitment = 1 Missing = 4
Interpersonal Therapy	Some training concerns here = 1
Medication Management	Lack of psychiatrist in region = 1 Missing = 3
Motivational Enhancement Therapy (MET)	Missing = 1
Motivational Interviewing	Obtaining manuals or trainings for staff = 1 Missing = 1 See above = 1
Multi-Family Group Treatment (MFG)	Missing = 1
Multidimensional Family Therapy	—
Multidimensional Treatment Foster Care	—
Multisystematic Therapy	—
Nurse-Family Partnership	—
Parent-Child Interaction Therapy	—
Peer Support	Resources = 1 We actually do this = 1
Promoting Alternative Thinking Strategies (PATH)	—
Second Step	Missing = 2
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	Missing = 1

Q10_other. Other Barriers in providing EBPs (cont)

	MHD (n = 96)
Strengthening Families Program (SFP)	Missing = 1
Supported Employment	Missing = 2
Supported Housing	Obtaining manuals or trainings for staff = 1 Missing = 3
Therapeutic Foster Care	Missing = 1 We do this as well = 1
Other (Specify:)	Finding appropriate EBP for medically compromised homebound adults and older adults = 1 Just started = 1 Missing = 1 We are just starting this program = 1 We are trainers of this model = 1
Other (Specify:)	—

Q10_other. Other Barriers in providing EBPs

	DASA (n = 154)
Aggression Replacement Training	—
Assertive Community Treatment (ACT/PACT)	Waiting for training = 1
Behavioral Treatment for Substance Abuse in Schizophrenia	—
Brief Strategic Family Therapy	—
Cognitive Behavior Therapies (CBT)	—
Contingency Management (Co-occurring)	—
Dare to be you	—
Dialectical Behavioral Therapy (DBT)	—
Eye Movement Desensitization & Reprocessing (EMDR)	This is over-used by staff = 1
Family Integrated Transitions	Unsure = 1
Family Psychoeducation	—
Functional Family Therapy	—
Gatekeeper Program	—
Illness Self-Management/Illness Management & Recovery	—
Incredible Years	—
Integrated Dual Disorders	—
Interpersonal Therapy	—
Medication Management	—
Motivational Enhancement Therapy (MET)	—
Motivational Interviewing	—
Multi-Family Group Treatment (MFG)	Not enough couples = 1
Multidimensional Family Therapy	—
Multidimensional Treatment Foster Care	—
Multisystematic Therapy	—
Nurse-Family Partnership	—
Parent-Child Interaction Therapy	—
Peer Support	—
Promoting Alternative Thinking Strategies (PATH)	Unsure = 1
Second Step	—
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	—
Strengthening Families Program (SFP)	—
Supported Employment	—
Supported Housing	—
Therapeutic Foster Care	—
Other (Specify:)	—
Other (Specify:)	—

Q10_other. Other Barriers in providing EBPs

	JRA (n = 17)
Aggression Replacement Training	Transfer of youth to other facilities not doing ART = 1 Transfers of youth to community facilities, other programs = 1
Assertive Community Treatment (ACT/PACT)	—
Behavioral Treatment for Substance Abuse in Schizophrenia	—
Brief Strategic Family Therapy	—
Cognitive Behavior Therapies (CBT)	—
Contingency Management (Co-occurring)	—
Dare to be you	—
Dialectical Behavioral Therapy (DBT)	Lack of adherence measures = 1 Lack of DBT Fidelity Measures = 1 Lack of fidelity measures = 4
Eye Movement Desensitization & Reprocessing (EMDR)	—
Family Integrated Transitions	Low referrals = 1
Family Psychoeducation	—
Functional Family Therapy	—
Gatekeeper Program	—
Illness Self-Management/Illness Management & Recovery	—
Incredible Years	—
Integrated Dual Disorders	—
Interpersonal Therapy	—
Medication Management	—
Motivational Enhancement Therapy (MET)	—
Motivational Interviewing	—
Multi-Family Group Treatment (MFG)	—
Multidimensional Family Therapy	—
Multidimensional Treatment Foster Care	—
Multisystematic Therapy	—
Nurse-Family Partnership	—
Parent-Child Interaction Therapy	—
Peer Support	—
Promoting Alternative Thinking Strategies (PATH)	—
Second Step	—
Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse	—
Strengthening Families Program (SFP)	—
Supported Employment	—
Supported Housing	—
Therapeutic Foster Care	—
Other (Specify:)	Lack of DBT Fidelity Measures = 1 Lack of fidelity measures = 1
Other (Specify:)	—

Q11_Other6: Other assistance needed to help facilitate the adoption and implementation of evidence based practices.

	MHD (N = 9)
Finances would provide support to address several of the challenges above	11.1%
Leadership in promoting them	11.1%
More training dollars	11.1%
Not geriatric specific	11.1%
Resistance from administration…	11.1%
We feel that some of our practices could be evidenced based if we could get the funding to do the research and the technical assistance to do the work to establish our practices as EBP…	11.1%
Wanted to select multiple responses	33.3%

Q11_Other6: Other assistance needed to help facilitate the adoption and implementation of evidence based practices.

	DASA (N = 8)
Financing and resistance…then finding the appropriate trainers	12.5%
Financing to hire additional staff when we work for fee for service	12.5%
For TBI patients	12.5%
Lack of cdp's	12.5%
Training and finances	12.5%
Training on implementing EBP specifically to our needs and population	12.5%
Wanted to select multiple responses	25.0%

Q11_Other6: Other assistance needed to help facilitate the adoption and implementation of evidence based practices.

	JRA (N = 3)
Fidelity measures for DBT	33.3%
Lack of DBT fidelity measures	33.3%
Lack of fidelity measures	33.3%

Q12b. Populations served for which there are no known or available evidence-based practices.

	MHD (n = 59)
Children/Youth	13.6%
Adults	6.8%
Older Adults	5.1%
Families	6.8%
Personality/Psychiatric Disorders	18.6%
Minority Populations	20.3%
Substance Abuse Related	10.2%
EBPs covering a broad array of services	6.8%
Other	10.2%
Missing	1.7%

Q12b. Populations served for which there are no known or available evidence-based practices.

	DASA (n = 50)
Minority Populations	42.0%
Personality/Psychiatric Disorders	6.0%
Substance Abuse Related	8.0%
Children/Youth	10.0%
Services/Client Needs	22.0%
Other Populations	8.0%
Other	4.0%

Q12b. Populations served for which there are no known or available evidence-based practices.

	JRA (n = 47)
Youth With Sex Offenses	34.0%
Youth With Cognitive Impairments	34.0%
Female Offenders - General	6.4%
Female Offenders - Recidivism	19.0%
Cultural Programs	2.1%
Suicidal Youth	2.1%
Developmentally Delayed Youth	2.1%

Q12b. Populations served for which there are no known or available evidence-based practices.

	CA (n = 7)
Clients/Children With Co-Occurring Issues- Including Mental Health and Substance Abuse	57.1%
Parents/Families Referred For Neglecting Children	42.9%

Q14_Other7: Other initiative promoting the adoption of evidence-based practices

	MHD (N = 7)
Beginning the process of attempting to gain recognition of our model(s)/program(s) as best practices on the SAMHSA registry	14.3%
Consumer Outcome Measures	14.3%
Looking at caseload specialty for community members referred through gatekeeper program at Senior Information and Assistance.	14.3%
Ongoing consultation to adhere to the model	14.3%
Partnering with allied systems and stakeholders to promote use of EBPs in the Thurston/Mason community	14.3%
Recruiting trained staff	14.3%
We are working with out-patient & in-patient managers in the organization to start providing behavioral health services across the organization.	14.3%

Q14_Other7: Other initiative promoting the adoption of evidence-based practices

	DASA (N = 9)
Addition of a research position to keep us abreast of new EBP and monitoring systems	11.1%
BUMED is moving in that direction	11.1%
Increasing the staff's knowledge about EBPs and the effectiveness of using these approaches when the clinical staff carry huge caseloads.	11.1%
Individual training	11.1%
Research Involvement/Participation	33.3%
Unsure	11.1%
We need the finances to implement!	11.1%

Q14_Other7: Other initiative promoting the adoption of evidence-based practices

	JRA (N = 4)
Developing DBT fidelity measures	75.0%
Developing fidelity measures & processes	25.0%

APPENDIX G

Fidelity Measures/Methods Used

Agency Type = MHD

Q4_Other1: Aggression Replacement Training

	MHD
180 day review/ outcomes at discharge	1
ART Protocol	1
client report, observations, clinical documentation, case reviews	1
DJR Consultant reviews taped sessions	1
Protocol is followed	1
supervisio, consultation	1
Utlization Reviews	1

Q4_Other2: Assertive Community Treatment (ACT/PACT)

	MHD
As indicated by the MHD	1
dact	1
Dartmouth fidelity scale	1
Dartmouth Standards	1
following guidelines	1
missing	1
pact	1
State reviews	1
the one provided in SAMSHA's toolkit for this best practice	1
WA-DACH	1
WA DACT	1
washington st pact standard	1
Washington State PACT standards	1

Q4_Other3: Behavioral Treatment for Substance Abuse in Schizophrenia

	MHD
180 day review /outcomes at discharge	1

Q4_Other4: Brief Strategic Family Therapy

	MHD
client family feedback, case consultations, documentations, supervision.	1
following guidelines	1
Review	1
Supervision, chart review	1
University of Miami consultants	1

Q4_Other5: Cognitive Behavior Therapies (CBT)

	MHD
180 day review /outcomes at discharge	1
CCRSN reviews, COA accredidation	1
checklist, bi-weekly in house supervision, monthly outside consultation	1
clinical supervision	1
following guidelines	1
Individualized Tx goals	1
Munoz Adherence scale	1
none	1
Protocol is followed	1
Rewiew	1
Supervision, chart review	1
Supervision/chart review	1
Training and supervision of clinical staff	1
U of W participation in training and monthly consultation groups	1
Utilization Reviews/supervision	1
Utilzation Review, Supervision	1
UW Laura Merchant's consultation	1
weekly homework reviewed, periodic measurements of established tools	1

Q4_Other6: Contingency Management (Co-occurring)

	MHD
weekly supervision, ongoing instruction and workshops, documentation, client report	1

Q4_Other8: Dialectical Behavioral Therapy (DBT)

	MHD
180 day review /outcomes at discharge	1
Behavioral Health Tech Measures	1
DBT Consultant	1
DBT curriculum levels to 94% fidelity	1
following guidelines	1
Internal UR	1
Just getting started	1
Manual - course outlines	1
Occasional review by outside reviewer	1
Pre and post test	1
Protocol is followed	1
Review	1
SAMHSA	1
Self-assessment	1
Supervision from accedited supervisors	1
TAM	1
Utilization Reviews/supervision	1
video tape groups; team reviews	1

Q4_Other9: Eye Movement Desensitization & Reprocessing (EMDR)

	MHD
Internal UR	1
self-assessment	1
Utilization Review, Supervision, Consultation	1
Utilizations Reviews/supervision	1

Q4_Other10: Family Integrated Transitions

	MHD
TAM	1
TAMS, SAMS	1
Therapist Adherence Measurement Scores	1

Q4_Other11: Family Psychoeducation

	MHD
180 day review/ reduction of family dysfunctionality reported by members	1
feedback, roleplays, peer support.	1
Just getting started	1
none	1
Review	1
Supervision, chart review	1
therapist rating, self reports, outcome/goal achievement	1

Q4_Other12: Functional Family Therapy

	MHD
client and family report, collateral reports, documentations, case reviews, changing patterns in family	1
FFT Inc Protocol	1
FFT LLC Quality Assurance System	1
missing	1
Online Monitoring	1
Protocol is followed	1
Regular consultation	1
Review	1
Supervision, chart review	1
URs/ supervision	1
Weekly consultation with certified State QA approved FFT Supervisor	1

Q4_Other13: Gatekeeper Program

	MHD
Gatekeeper program for elders was developed at SMH	1
Internal Monitoring by Supervisor	1

Q4_Other14: Illness Self-Management/Illness Management & Recovery

	MHD
Fidelity monitored internally	1
following guidelines	1
measures accessed through WIMIRT	1
missing	1
none	1
SAMHSA	1
SAMHSA Toolkit Fidelity Scael	1
the one provided in SAMSHA's toolkit for this best practice	1
WRAP program offered by trained facilitators	1

Q4_Other16: Integrated Dual Disorders Treatment

	MHD
following guidelines	1
IDDT fidelity scale	1
Internal UR	1
Manualized Curriculum	1
missing	1
Oversight by another agency	1
SAMHSA	1
SAMSHA IDDT Fidelity Scale	1
SAMSHA Treatment Improvement Protocol	1
Supervision/chart review	1
the one provided in SAMSHA's toolkit for this best practice	1
Under development - new program	1

Q4_Other17: Interpersonal Therapy

	MHD
Review	1
weekly client report, decrease of negative symptoms, increase in positive with patient report and therapist observation	1

Q4_Other18: Medication Management

	MHD
CCRSN reviews, COA accredidation	1
Clinical Reviews	1
following guidelines	1
Internal audit through Quality Management System	1
none	1
psych evaluations / monitoring clients's symptoms	1
psychiatrist monitors	1
Review	1
review of APA guidelines	1
Supervision, chart review	1
Supervision/chart review	1
team review	1
URs/ supervision	1
utilization of a systematic plan for medication management	1

Q4_Other19: Motivational Enhancement Therapy (MET)

	MHD
180 day review/ otucomes at discharge	1
align with patient focusing on discrepancies, role with resistance, client feedback and engagement with therapy, self report.	1
as assigned by the MHD	1

Q4_Other20: Motivational Interviewing

	MHD
180 day review/ otucomes at discharge	1
as assigned by the MHD	1
following guidelines	1
none	1
Review	1
same as with MET	1
supervision	1
Supervision, chart review	1
TAM	1
URs/supervision	1
Utilization Review, Supervision,	1

Q4_Other21: Multi-Family Group Treatment (MFG)

	MHD
clinical supervision	1
Just getting started	1
measures accessed through WIMIRT	1
Original 5 year research condumcted at SMH	1
Protocol is followed	1

Q4_Other22: Multidimensional Family Therapy

	MHD
self report, collateral reports, UA and BALs, school and juvenile reports, decrease in acting out and connecting better with family, peers, school and decrease in alcohol abuse.	1

Q4_Other23: Multidimensional Treatment Foster Care

	MHD
Consultation and use of database	1
MTFC measures	1
TFC - Consultant	1
weekly consultation with OSLC,	1

Q4_Other24: Multisystemic Therapy

	MHD
180 day review/ reduction in family conflicts	1
MST measures	1
MST,INC	1
none	1
Pre and post test	1
self and family reports, legal input and feedback, reduction of antisocial behaviors and acting out behaviors as measured by arrest records, academic records, casemanagement	1
self report	1
Supervision, chart review	1
TAM	1
TAMS	1
TAMS, SAMS	1
We use a fidelity method administered by UW School of Medicine, Dept. of Psychiatry & Beh. Sciences, Div of Public Behavioral Health & Justice Policy	1

Q4_Other26: Parent-Child Interaction Therapy

	MHD
180 day review/ observable changes in child/s behavior	1
checklist, weekly in-house supervision focused on PCIT, Monthly outside consultation	1
Childrens Administration PCIT Quality Assurance System	1
Haborview provides supervision 2x/ month plus video review of cases etc	1
observation, supervision	1
PCIT Measurements	1
Review	1
Supervision, chart review	1

Q4_Other27: Peer Support

	MHD
CCRSN reviews, COA accredidation	1
following guidelines	1
goal achievement	1
missing	1
none	1
Supervision, chart review	1
Training and supervision of peer support counselor	1
URs/supervision	1

Q4_Other28: Promoting Alternative Thinking Strategies (PATH)

	MHD
as assigned by the MHD	1

Q4_Other29: Second Step

	MHD
Manual	1
none	1

Q4_Other30: Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse

	MHD
180 day review/ elimination of substance consumption	1
LIsa Najavitz desigend Fidelity Scale	1
Manualized Curriculum	1
URs/supervision	1

Q4_Other31: Strenghthening Families Program (SFP)

	MHD
Collaboration with the developer	1
Collaboration with WSU	1
none	1
outcome data measurement	1
Protocol is followed	1

Q4_Other32: Supported Employment

	MHD
changes in consumer job status	1
following guidelines	1
ICCD standards and WSCC reporting	1
ICCD Standards/Certification	1
In the process	1
missing	1
Periodic reviews by external reviewers	1
SAMHSA	1

SAMHSA Fidelity Scales	1
SAMSHA Fidelity Scale	1
Supported Employment fidelity scale and CARF	1
team review	1
the one provided in SAMSHA's toolkit for this best practice	1
URs/supervision	1

Q4_Other33: Supported Housing

	MHD
supervision	1
team review	1

Q4_Other34: Therapeutic Foster Care

	MHD
State Sponsored Fidelity Measures	1
supervision	1
Using MTFC measures	1

Q4_Other35: Other (Specify:)

	MHD
180 day review/ observable changes in child's behavior	1
ASIST tool	1
collaboration with Theraplay Institute (Chicago)	1
fidelity monitored internally	1
following guidelines	1
Harborview Standards	1
HOMEBUILDERS Quality Enhancement System	1
ICCD Accreditation	1
ICCD standards	1
ICCD Standards/Certification	1
In depth training by the principal investigator at UW, audio recording sessions, weekly clinical supervision	1
Interagency staffing team (1st)	1
Internal UR	1
K. Gorskey	1
Manual	1
National consultation, Supervisory consultation and review	1
peer review	1
pre and post survey	1
Regular consultation	1
Review	1
Risk Assessment tool developed by a staff at SMH	1
SAMHSA MODEL ADAPTED	1
supervision	1
Supervision, chart review	1
Training and supervision of clinical staff, outcome tools	1
WA PACT Fidelity Measure (DACT)	1
Wraparound Milwaukee and Wash Institute	1

Q4_Other36: Other (Specify:)

	MHD
180 day review/ reduction of trauma and symptoms associated	1
Consultation from Dr. Bernstein	1
Consultation through Specialist	1
DSM 4 or ASAM levels	1
following guidelines	1
ICCD standards	1
ICCD Standards/Certification	1
Manual	1
pre and post survey	1
Review	1
Review by University consultants	1
Supervision, chart review	1
TF CBT Measure	1

Agency Type = Children's Administration

Q4_Other12: Functional Family Therapy

	CA
Following FFT QA plan for state	1

Q4_Other15: Incredible Years

	CA
Monitoring by model developer	1

Q4_Other23: Multidimensiona Treatment Foster Care

	CA
consultation by TF Consultants	1
consultation from TFC Consultants	1
Consultation from TFC Consultants	1

Q4_Other25: Nurse-Family Partnership

	CA
consultation from model developer	1

Q4_Other26: Parent-Child Interaction Therapy

	CA
Following PCIT QA plan for state	1
following state QA plan for PCIT	8
Following state QA plan for PCIT	1

Agency Type = JRA

Q4_Other10: Family Integrated Transitions

	JRA
TAM-R, MST Protocols	4

Q4_Other12: Functional Family Therapy

	JRA
adherence measures, consultation	5
consultation, adherence measures	1

Q4_Other23: Multidimensional Treatment Foster Care

	JRA
videotape, reports	1

Q4_Other35: Other (Specify:)

	JRA
adherence measures, consultation	5
consultation, adherence measures	1

Agency Type = DASA

Q4_Other1: Aggression Replacement Training

	DASA
Clinical review of effectiveness	1
clinical supervision	1
Clinical supervision	1
Clinical Supervision	1
communication with instructor	1
survey/implementation	1
usign ART as it was designed - adn identify outcomes	1
Washington State Quality Assurance	1
yes	1

Q4_Other2: Assertive Community Treatment (ACT/PACT)

	DASA
Dartmouth	1
state	1
TARGET	1

Q4_Other3: Behavioral Treatment for Substance Abuse in Schizophrenia

	DASA
Combination of CD and MH coordination together with regular UA's, workbooks and outside support groups.	1

Q4_Other4: Brief Strategic Family Therapy

	DASA
Clinical supervision	1
same as above	1
screening evaluating tx	1

Q4_Other5: Cognitive Behavior Therapies (CBT)

	DASA
Antidotal/tx goals met	1
clincial supervision	1
clinical supervision	1
Clinical supervision	2
Clinical Supervision	2
Completion Rates and Behavioral Change Agreement, Behavioral Discharge reviews	1
Focused Training and Clinical Supervision	1
GAIN m-90 Followups	1
GAIN M90 follow-ups	1
group process	1
Model adherance	1
Monitor Outcomes	1
OBSERVATION	1
On going Program evaluations	1
Ongoing Assessment	1
ORS/SRS ~ Miller, Scott	1
outcome surveys	1
OUtcomes - Clinical Client Survey - CM- Supervision- Peer Review	1
Program Evaluations	2
Program Monitoring and Evaluations	1
pt follow through	1
resident feedback/counselor review of material	1
same	1
same as above	1
SRS/ORS	1
Supervision	1
supevision: individual & group	1
TRA/ASAM	1
trained providers/manuals	1
UofW consultation	1

Q4_Other6: Contingency Management (Co-occurring)

	DASA
CD staffings with MH	1
Focused Training and Clinical Supervision	1
OBSERVATION	1
Ongoing Assessment	1
pt.feedback	1
supervision: individual & group	1

Q4_Other8: Dialectical Behavioral Therapy (DBT)

	DASA
Antidotal/tx goals met	1
DBT Fidelity Questionnaire	1
Direct observation, consultation	1
Focused Training and Clinical Supervision	1
Group process	1
IP Manager Supervision	1
observation	1
Ongoing Assessment	1
Program Assessment	1
program monitoring	1
Program Monitoring and Evaluations	2
Program Monitoring, Benchmarks and Evaluations	1
skils code, program evaluations and participation in reach development project	1
trainging by authroized trainers	1
visits to emergency room	1
Yes	1

Q4_Other9: Eye Movement Desensitization & Reprocessing (EMDR)

	DASA
supervision	1

Q4_Other10: Family Integrated Transitions

	DASA
individual counseling	1
program evaluations	1
Program Monitoring and Evaluations	1

Q4_Other11: Family Psychoeducation

	DASA
Focused Training and Clinical Supervision	1
internal supervision	1
Program Review	1
Supervision	1
TRA/ASAM	1
We have a CDP that specializes in Family Psychoeducation and does two montly groups	1

Q4_Other12: Functional Family Therapy

	DASA
County (program audit)	1
individual counseling	1
internal supervision	1

Q4_Other16: Integrated Dual Disorders Treatment

	DASA
CD staffings with MH	1
DASA guidelines	1
Focused Training and Clinical Supervision	1
IDDT tool	1
OBSERVATION	1
Ongoing Assessment	1
Pt. goals for short term success	1
same	1
samsha	1
staff continuing ed.	1
supervision	1
supervision: individual & group	1
Treatment retention and clean UA	1
We meet every two weeks with with Mental Health staff to discuss client progress	1

Q4_Other17: Interpersonal Therapy

	DASA
1:1's, group, and Tx plan	1
internal supervision	1
same	1
Supervision	1

Q4_Other18: Medication Management

	DASA
compliance, retention, outcomes	1
continued monitoring of efficacy of medication	1
MD visits	1
Med Reviews	1
Medical Director	1
Ongoing Assessment	1
Psych. Does it	1
retention, outcomes	4
Supervision: individual & group	1
TRA/ASAM	1
We have a ANRP that meets with clients regularly to manage medications	1

Q4_Other19: Motivational Enhancement Therapy (MET)

	DASA
# of pt.s returning to group	1
clinical supervision	1
Clinical supervision	2
Clinical Supervision	2
Counselor Observation - Clinical Supervision	1
Direct observation	1
Focused Training and Clinical Supervision	1
GAIN m-90 Followups	1
GAIN M90 follow-ups	1
increased quality of identifyed values	1
Ongoing Assessment	1
same	1
TARGET	1

Q4_Other20: Motivational Interviewing

	DASA
""	1
Chart reviews and trainings with testing.	1
clinical supervision	1
Clinical supervision	2
Clinical Supervision	3
clinical supervision with audiotaping	1
Counselor Observation-Clinical Supervision	1
Direct observation	1
established guidelines	1
Focused Training and Cinical Supervision	1
internal supervision	1
Model adherance	1
Monitor Otucomes	1
OBSERVATION	1
Observation/Reviews	1
Ongoing Assessment	1
open ended questions during groups one to ones ect...	1
ORS/SRS ~ Miller, Scott	1
Outcome Measures	1
outcome surveys	1
Pre-Post	1
Pre-Posts	1
prochaska - dicliminti	1
Program Evaluation	3
Program Evaluations	2
program evaluations and participation in reach development project	1
Program evaluations and reasurch follow-up	1
Program Monitoring and Evaluations	1
Progress from the Stages of Change	1
staff self care	1
supervision	1
Supervision	1
supervision: individual & group	1
Supervisory review	1
TRA/ASAM/TARGET	1
Used specifically with ambivalent clients who are struggling with why they are in treatment	1
WASBIRT research protocal	1
x	1

Q4_Other21: Multi-Family Group Treatment (MFG)

	DASA
Focused Training and Clinical Supervision	1
Model adherance	1
survey at completion	1

Q4_Other22: Multidimensional Family Therapy

	DASA
""	1

Q4_Other24: Multisystemic Therapy

	DASA
""	1
internal supervision	1
Program Evaluations	1
Program Monitoring and Evaluations	1

Q4_Other26: Parent-Child Interaction Therapy

	DASA
""	1
external supervision	1
Focused Training and Clinical Supervision	1
Patient Evaluation	2
U of WA	1

Q4_Other27: Peer Support

	DASA
""	1
12 step, group account	1
AA meeting attendance	1
established guidelines	1
group process aa support	1
Patient Evaluation	5
Process groups and mentoring	1
resident feedback/staff evaluation	1
state	1
Supervision	1
TRA/CLIENT SURVEY	1
Treatment retention and relapse episodes	1

Q4_Other28: Promoting Alternative Thinking Strategies (PATH)

	DASA
group process indiv counseling	1
Group processing	1

Q4_Other29: Second Step

	DASA
inventory, assignment	1
Observation/Reviews	1
Pre-Post	1
Pre-posts (RMC)	1

Q4_Other30: Seeking Safety: A Psychotherapy for Trauma/PTSD & Substance Abuse

	DASA
internal supervision	1
supervision	1
Supervisor has been trained in SS supervision through the CTN and reviews counselors notes and discusses session progress and adherence on a weekly basis	1

Q4_Other31: Strengthening Families Program (SFP)

	DASA
clinical supervision	1
Clinical supervision	1
Clinical Supervision	1
Observation/Reviews	1
Ongoing Assessment	1
Program Evaluation by Provider	1
Supervision	1
use program with fidelity	1
Victor Bernstein, Ph.D.	1
yes	1

Q4_Other32: Supported Employment

	DASA
county	1
seasonal employmt. tolorance	1
TRA/ASAM	1

Q4_Other33: Supported Housing

	DASA
county	1
Referral	1
track outcomes/stats	1

Q4_Other34: Therapeutic Foster Care

	DASA
track outcomes/stats	1

Q4_Other35: Other (Specify:)

	DASA
fidelity is built into project	1
Focused Training and Clinical Supervision	1
GAIN m-90 Followups	1
GAIN M90 Follow-ups	1
Group observation - MRT Fidelity check lists - Client retention and completion rates	1
looking at less negative impact on pt's life and increase awareness and acceptance of both disorders.	1
Multiple Workbooks	1
Must complete one step per week	1
Observtion/Phone conferences	1
ORS/SRS ~ Miller, Scott	1
Patient satisfaction Survey	1
Program Evaluation	2
Program material/training	1
Program Monitoring and Evaluations	1
QUARTERLY CONSULTS WITH PROGRAM DESIGNER & OBSERVATION	1
same	1
Scales provided by the program developer	1
SRS/ORS	1
Supervisory review	1
Support Group	1
use with fidelity	1
Victor Bernstein, Ph.D.	1
x	1

Q4_Other36: Other (Specify:)

	DASA
Group observation - Case Management - Clinical Supervision	1
OBSERVATION	1
Program Monitoring and Evaluations	1
SRS/ORS	1
x	1