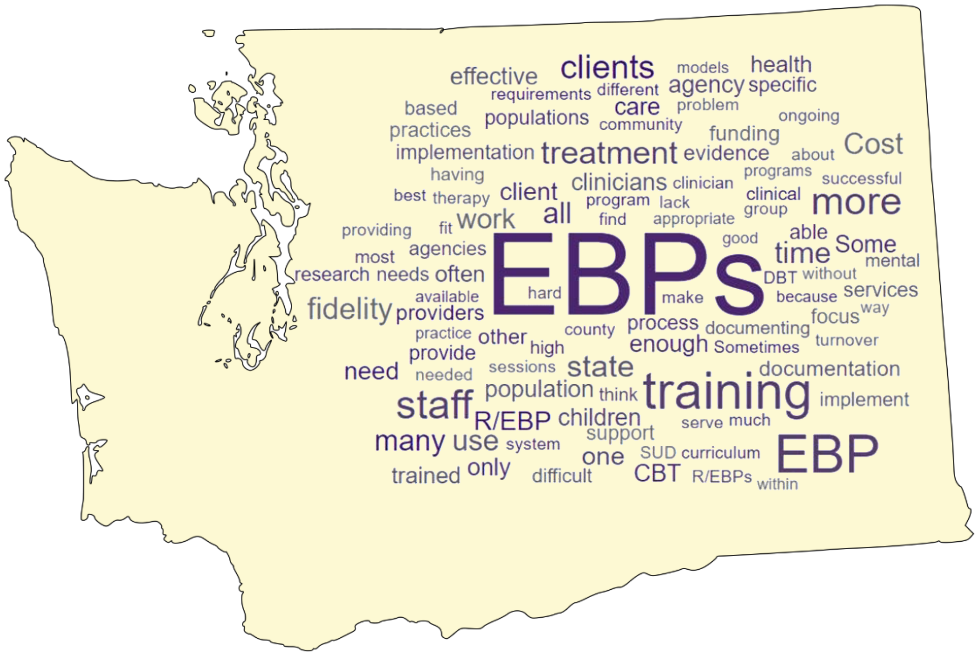
Evidence-Based Practices in Washington State

Report to the Division of Behavioral Health and Recovery,

Washington State Department of Social and Health Services

September 2018



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Introduction

For more than a decade, the State of Washington has promoted the use of evidence-based practices in the treatment of mental health and substance use disorders in Washington residents.[1] In a recent nationwide analysis, Washington emerged as a national leader among states of the USA in evidence-based policymaking.[2] In most domains, being a leader means blazing trails and doing a lot of heavy lifting. Accordingly, as a leader in implementing evidence-based practices and engaging in evidence-based policymaking, Washington State continually has had to grapple with challenging issues that have not previously been resolved by other states; Washington's experiences are have added importance because such experiences stand to inform other states as they increasingly follow suit. Furthermore, in reflecting on its own experiences to date Washington State can inform its own decisions moving forward.

This paper reviews Washington State's experience advancing evidence-based practices in mental health and substance use treatment. It will present a brief history of the evidence-based practices movement; touch upon how the movement has affected policy-making in Washington State; describe how policies have been translated into procedures in treatment for children and youth; contextualize and characterize where things stand with policies and procedures in treatment of adults and substance use disorders; identify key partners in the efforts to advance evidence-based practices in Washington State; present findings from a statewide survey regarding challenges identifying, selecting, implementing, and documenting evidence-based practices; make conclusions; and offer some basic recommendations for the future.

Evidence-Based Practices Movement in Behavioral Health

The evidence-based practices (EBP) movement in behavioral health traces its roots to the EBP movement in psychology. Ultimately borrowing the term "evidence based" from a similar movement in medicine, the EBP movement in psychology grew out of efforts to address perceptions that psychological treatments were ineffective. The movement started to pick up steam in the mid-1990s, spurred as Division 12 (Clinical Psychology) of the American Psychological Association (APA) published criteria for specifying empirically validated treatments in clinical psychology (subsequently termed empirically supported treatments) in 1995. The task force that delineated the criteria used them to identify 18 treatments which they deemed empirically validated on the basis of having been manualized and tested in randomized controlled trials (RCTs) with well-defined populations. [3]

While the report drew attention to the need to promote treatments with good evidence for effectiveness, it also ignited a debate about the extent to which psychology as a discipline ought to confine itself to brief, manualized treatments and emphasize high-fidelity implementation of these specific treatments over common factors that account for substantial variance in treatment outcomes.[3] Other APA divisions and professional societies established their own task forces to delineate criteria for empirically supported treatments and practices for their respective domains. APA Division 29 (Psychotherapy) established such a task force in 1999, APA Division 17 (Society of Counseling Psychology) did so in 2002, and the Society of

Behavioral Medicine did so in 2003. In 2005, the APA established a broad presidential task force on evidence-based practice that sought to include scientists and practitioners from a range of diverse perspectives and traditions with a goal of creating a document to set forth APA's commitment to EBPs and to define the terms that were viewed as central to the specification of EBPs. The resulting document defined evidence-based practice in psychology (EBPP) and clarified its relationship to empirically supported treatments.[3]

> *"Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."*
> *—APA Presidential Task Force on Evidence-Based Practice, 2005*

EBPP was meant to be a much broader concept than empirically supported treatments. While empirically supported treatments specifically referred to treatments that have been shown to be efficacious in controlled clinical trials, EBPP was meant to comprise the full range of clinical activities in which psychologists participate, including but not limited to psychological assessment, case formulation, therapy relationships, and treatment provision with the best available evidence from a broader range of research designs were considered to have value.[3]

> *"Best research evidence refers to scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields. APA endorses multiple types of research evidence (e.g., efficacy, effectiveness, cost-effectiveness, cost– benefit, epidemiological, treatment utilization) that contribute to effective psychological practice."*
> *—APA Presidential Task Force on Evidence-Based Practice, 2005*

Notably, while randomized controlled trials have been prioritized in the identification of empirically supported treatments, the APA Presidential Task Force on EBPP recognized a much broader range of research designs that could be included in consideration of the best available research evidence.[3] Valuable studies might have any of the following designs:

- Clinical observations, including individual case studies
- Basic psychological science and experimental research
- Qualitative research
- Systematic case studies
- Single-case experimental designs
- Public health and ethnographic research
- Process–outcome studies
- Studies of interventions delivered in naturalistic settings (effectiveness research)

- Randomized controlled trials and their logical equivalents (efficacy research)
- Meta-analyses

In addition, the APA Presidential Task Force document specified components of clinical expertise, emphasized the importance of attention to individual differences (including gender, gender identity, culture, ethnicity, race, age, family context, religious beliefs, and sexual orientation), and delineated topic area priorities for future research related to EBPP.[3]

Notwithstanding the APA's efforts to advance a broader concept of EBPP, the emphasis on empirically supported treatments and the need for randomized controlled trials (RCTs) to evaluate them has persisted and perpetuated a divide between treatment researchers and treatment practitioners. Kazdin[4] articulated a number of concerns about EBPs with respect to applicability and generalizability to clinical practice that have repeatedly been raised in the literature. Participants in RCTs often differ meaningfully from clients/patients/consumers in community settings. Specifically, research participants have been characterized as having less severe disorders and fewer comorbidities. Moreover, processes in RCTs differ meaningfully from those in community settings. Specifically, community settings do not or cannot engage in recruitment of particular types of clients/patients/consumers; specify eligibility criteria; strictly adhere to treatment manuals; closely monitor for fidelity; maintain a small, closed pool of clinicians carefully trained by treatment developers/evaluators; or focus primarily on symptom reduction.

Criteria for evaluating strength of the evidence do not translate well to clinical practice. Statistical significance or "clinical significance" for outcomes assessed in research studies may not translate to clinically meaningful improvement in community settings. For example, while a decrease in drinking of half a standard deviation might be statistically significant in a study, such a degree of change might not make a difference in any given client's quality of life. Similarly, in a research study, when a participant goes from meeting criteria for a diagnosis to not meeting criteria for that diagnosis, it's considered a "clinically significant" change; however, in real world settings such a change might not practically mean any given consumer's life has improved.

Outcome measures used in research studies may not map well onto the lives of persons seeking treatment in community settings. It is often unclear how to interpret studies in which a treatment affected some outcomes but not others or studies for which the evidence across studies is mixed. Furthermore, it is unclear how to tailor EBPs that were demonstrated efficacious or effective in one culture to another. Tailoring a treatment potentially changes it in a way that deviates meaningfully from what was empirically supported. On the other hand, treatments developed for a particular culture—or without regard to culture—can impose inappropriate cultural frameworks on culturally diverse clients.[4]

To help bridge the gap between research and practice Kazdin made specific recommendations for psychotherapy research and for clinical practice.[4] He recommended that psychotherapy research focus more on mechanisms of change so we can better understand *how* EBPs work rather than simply examine *whether* EBPs work, emphasized the importance of examining

moderators of treatment response so we can better understand *for whom* EBPs work, and pointed to the value of qualitative research to gain a better understanding of clients' individual experiences and *the qualitative contexts in which* EBPs work. On the clinical side, Kazdin recommended that clinical practice increasingly incorporate systematic measures to evaluate progress and guide clinical decision-making. In addition, he pointed to the value of documenting the experiences of clinicians in practice to help generate testable hypotheses.[4] This has been called the accumulation of "practice-based evidence."[5] Finally, Kazdin called for increasing direct collaboration between psychotherapy researchers and clinical practitioners to work directly on bridging the gap.

Work in these areas has been ongoing over the past decade. In practice, the emphasis on EBPs as meant that EBPs are increasingly promoted, incentivized, and/or mandated by federal and state policies and initiatives. This has created a new status of “evidence-based” that treatment developers now strive to achieve. Yet, thorny issues remain in how to define EBPs and broader issues of how to implement and sustain high-fidelity use of EBPs in real-world settings with diverse populations.

Evidence-Based Policymaking Movement

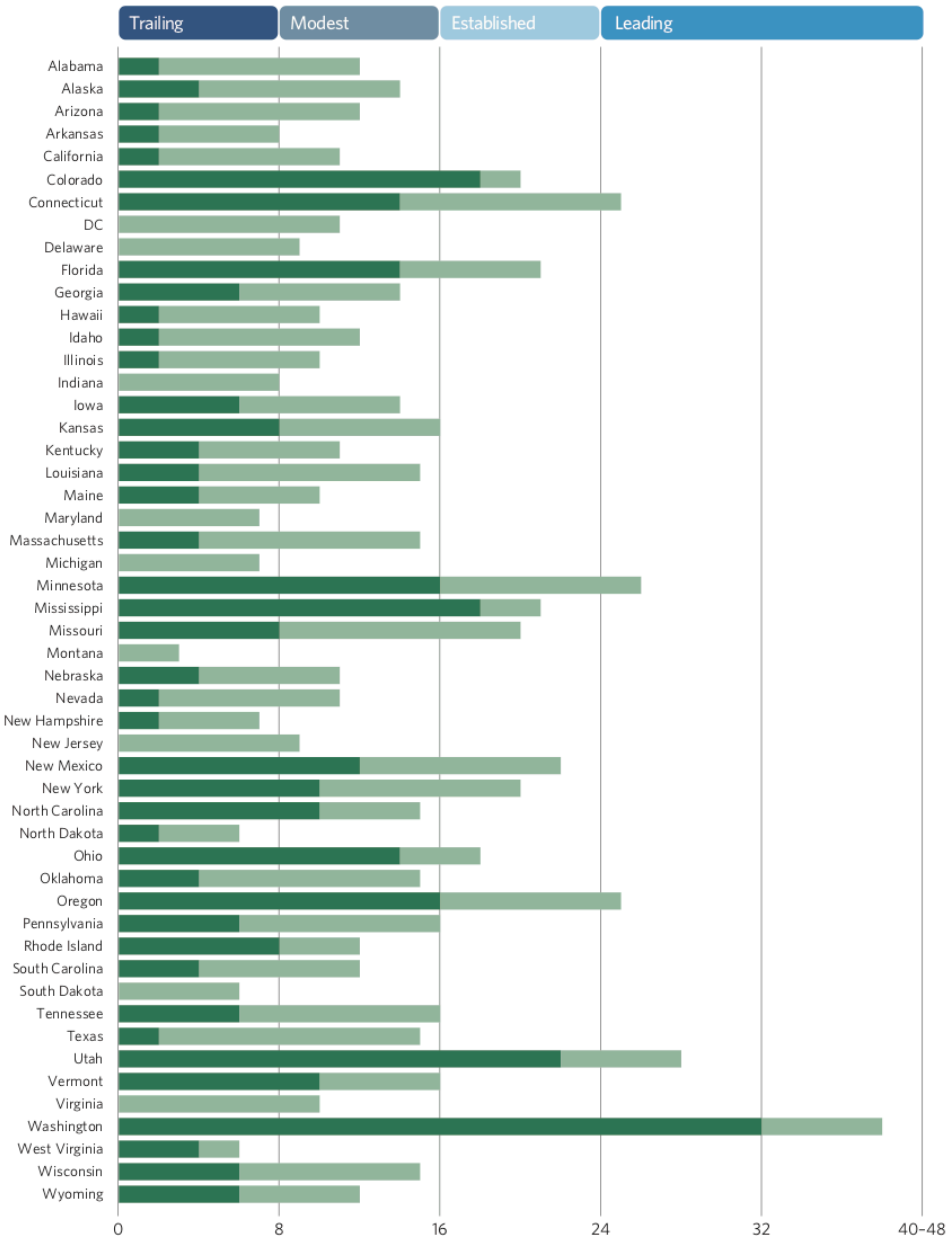
Parallel to the EBP movements in psychology and medicine, there emerged an evidence-based policymaking movement. Published in the British Medical Journal in 1995, an editorial by Ham et al. argued, "at a time when ministers are arguing that medicine should be evidence based, is it not reasonable to suggest that this should also apply to health policy? If doctors are expected to base their decisions on the findings of research surely politicians should do the same."[6] As a debate was ignited in the UK, the US was witnessing an exploding proliferation of managed care-related legislation on the state level. It was reported that during the first 6 months of 1996, states introduced more than 1000 bills affecting managed care plans, and by 1997, 28 states had passed legislation mandating minimum lengths for various kinds of hospital stays.[7] Such legislation was a backlash against managed-care limits on hospitalizations and access to specialists that was driven by public opinion rather than research evidence. Against this backdrop, an evidence-based policy movement began to take shape in the US near the turn of the millennium.

It has been noted that scientific evidence often carries little weight in “real world” policymaking settings as policymakers evaluate evidence differently than do scientists.[8] Interviews with policymakers revealed that many could not distinguish between good and bad data and thus were prone to influence by misused facts often presented to them by interest groups.[9] To provide policymakers with more impartial views, over the past 20 years a number of independent non-profit foundations have advocated and advanced evidence-based policymaking initiatives.

In 2014, the Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation partnered to launch the Results First Initiative. In November of that year, they published *Evidence-Based Policymaking: A Guide for Effective Government*,[10] which articulated a vision of

evidence-based policymaking. Evidence-based policymaking was defined as consisting of six key actions: defining levels of evidence, inventorying existing programs, comparing program costs and benefits, reporting outcomes in the budget, targeting funds to evidence-based programs, and requiring action through state law. The document contained a protocol for assessing efforts by each state in the U.S. to incorporate research and analysis of programs into policy and funding decisions in four key areas: behavioral health, child welfare, criminal justice, and juvenile justice.

The Results First Initiative conducted the assessment—consisting of an analysis of statutes, administrative codes, executive orders, and state documents—through 2015 and 2016 and published the results in January 2017.[11] Washington was first among 5 states *leading the way* in evidence-based policymaking by developing processes and tools that use evidence to inform policy and budget decisions across the areas examined. The report examined each state in the four domains of behavioral health (BH), child welfare, criminal justice, and juvenile justice. Though Washington was strong in all domains compared to other states, the domain with the most room for improvement was behavioral health. For each of the six actions that represent key elements of evidence-based policymaking, each state was awarded 0-2 points for each domain. With regard to BH, Washington State was awarded 2 points for defining levels of evidence, 1 point for inventorying existing



programs, 2 points for comparing program costs and benefits, 0 points for reporting outcomes in the budget, 1 point for targeting funds to evidence-based programs, and 2 points for requiring action through state law.

That Washington is a national leader in evidence-based policymaking for behavioral health is shown by the fact that several other states refer to the inventory of EBPs created by the Washington State Institute for Public Policy. For example, Mississippi refers to WSIPP's inventory in their state law (MS code § 27-103-159), and the South Carolina Center for Excellence in Evidence-Based Intervention refers policymakers to the WSIPP Benefit-Cost analysis webpage.

Implications of Washington State Being a National Leader in Evidence-Based Policymaking

Being a leader means blazing trails and doing a lot of heavy lifting; the experiences of Washington State have added importance because they stand to inform other states. Washington has had to grapple with challenging issues that have not previously been resolved, as major systemic issues within which these efforts are unfolding. There are layers upon layers of challenges needing to be addressed.

Review of Washington State's Legislative Activities

SB 5763 – Defining Research- and Evidence-Based Practices

In the 2005-2006 legislative session, Washington passed SB 5763, "enacting the omnibus treatment of mental and substance abuse disorders act of 2005."

- "The legislature finds that a substantial number of persons have co-occurring mental and substance abuse disorders and that identification and integrated treatment of co-occurring disorders is critical to successful outcomes and recovery."
- "Consequently, the legislature intends, to the extent of available funding, to…Improve treatment outcomes by shifting treatment, where possible, to evidence-based, research-based, and consensus-based treatment practices and by removing barriers to the use of those practices."

SB 5763 included the first codified definitions of research- and evidence-based practices (R/EBPs):

- "Evidence-based means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population."
- "Research-based means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices."
- "Consensus-based means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform

studies with random assignment and controlled groups."

- "Promising practice means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice."

HB 2536 – Requiring Evidence-Based Practices in Children's Mental Health

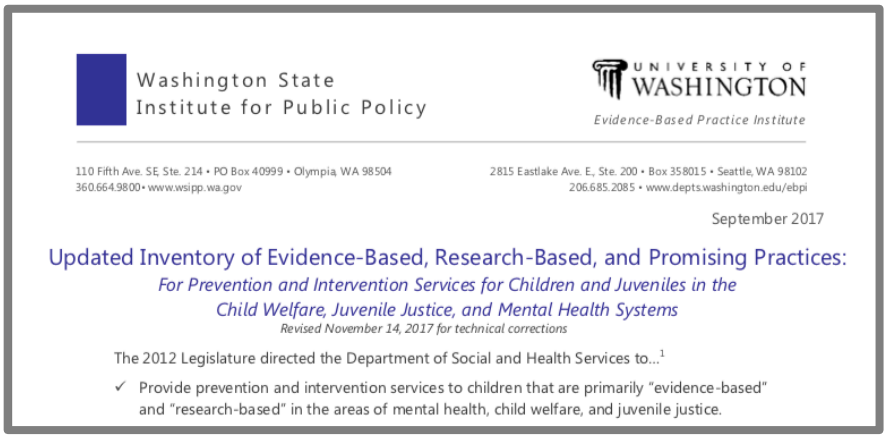
In the 2011-2012 legislative session, Washington passed HB 2536, "an act relating to the use of evidence-based practices for the delivery of services to children and juveniles."

- "The legislature intends that prevention and intervention services delivered to children and juveniles in the areas of mental health, child welfare, and juvenile justice be primarily evidence-based and research-based, and it is anticipated that such services will be provided in a manner that is culturally competent."

In HB 2536, the Washington legislature directed that WSIPP and the Evidence-Based Practices Institute (EBPI) at the University of Washington (UW), in consultation with the Department of Social and Health Services (DSHS), shall:

- publish descriptive definitions of R/EBPs and promising practices in the areas of child welfare, juvenile rehabilitation, and children's mental health services
- prepare an inventory of R/EBPs and promising practices for prevention and intervention services
- conduct a baseline assessment of the extent to which are R/EBPs were presently available and in use in the areas of children's mental health, child welfare, and juvenile justice; the cost of those practices; and the most effective strategies and appropriate time frames for expecting their broader use

HB 2536 resulted in the publication of the first *Inventory of Evidence-Based, Research-Based, and Promising Practices for Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems* in September 2012. It has been updated repeatedly in the intervening years as new research becomes available in the literature. As of this writing, the most recent version was published in September 2017.[12] UW EBPI does an initial review to identify promising practices for children's mental health interventions, and WSIPP uses statistical algorithms to determine whether these promising practices meet criteria for research-based or evidence-based. The excerpt below from the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September 2017

Updated Inventory of Evidence-Based, Research-Based, and Promising Practices:
For Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems
Revised November 14, 2017 for technical corrections

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

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

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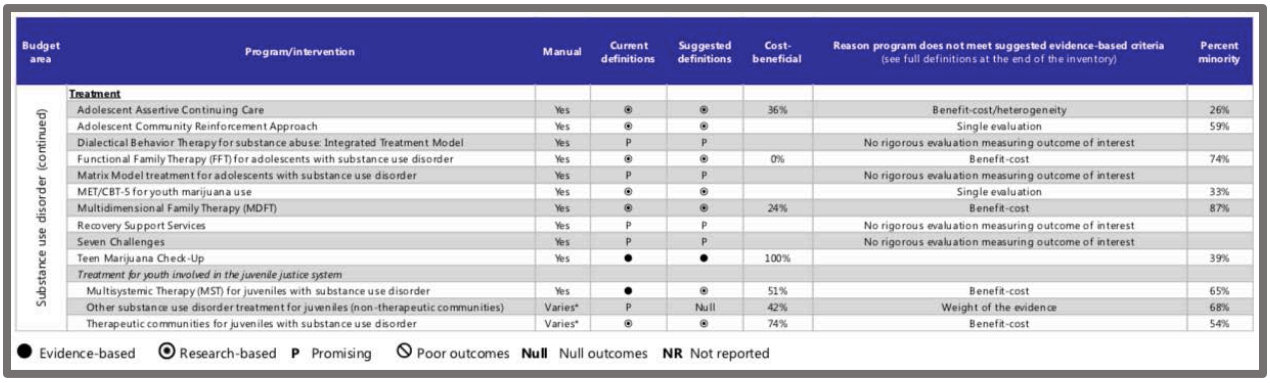
inventory shows the interventions evaluated for substance use disorders in children and youth.



Budget area	Program/intervention	Manual	Current definitions	Suggested definitions	Cost-beneficial	Reason program does not meet suggested evidence-based criteria (see full definitions at the end of the inventory)	Percent minority
Substance use disorder (continued)	**Treatment**						
	Adolescent Assertive Continuing Care	Yes	◉	◉	36%	Benefit-cost/heterogeneity	26%
	Adolescent Community Reinforcement Approach	Yes	◉	◉		Single evaluation	59%
	Dialectical Behavior Therapy for substance abuse: Integrated Treatment Model	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Functional Family Therapy (FFT) for adolescents with substance use disorder	Yes	◉	◉	0%	Benefit-cost	74%
	Matrix Model treatment for adolescents with substance use disorder	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	MET/CBT-5 for youth marijuana use	Yes	◉	◉		Single evaluation	33%
	Multidimensional Family Therapy (MDFT)	Yes	◉	◉	24%	Benefit-cost	87%
	Recovery Support Services	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Seven Challenges	Yes	P	P		No rigorous evaluation measuring outcome of interest	
	Teen Marijuana Check-Up	Yes	●	●	100%		39%
	Treatment for youth involved in the juvenile justice system						
	Multisystemic Therapy (MST) for juveniles with substance use disorder	Yes	●	◉	51%	Benefit-cost	65%
	Other substance use disorder treatment for juveniles (non-therapeutic communities)	Varies*	P	Null	42%	Weight of the evidence	68%
	Therapeutic communities for juveniles with substance use disorder	Varies*	◉	◉	74%	Benefit-cost	54%

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

Currently, the inventory lists the following numbers of research-based practices (RBPs) and evidence-based practices (EBPs) for treatment of children and youth (using suggested definitions):

Issue	RBPs	EBPs
Anxiety	3	0
Attention Deficit Hyperactivity Disorder	2	0
Depression	4	0
Disruptive Behavior	10	4
Fetal Alcohol Syndrome	0	0
Serious Emotional Disturbance	5	0
Trauma	1	2
Other/Multiple Issues	2	0
Substance Use Disorders	7	1

In 2015, Walker et al. published a description of the development of the WSIPP inventory as a case study for the process of defining evidence-based practice in a policy context, compared it to other well-known evidence-based practice inventories, and examined consistencies and differences in the process of identifying and developing program ratings.[13] The authors noted that, although inventories help treatment administrators identify empirically validated programs that may meet the needs of the populations they serve, substantial barriers to implementation of research- and evidence-based practices threaten their external validity. It is noted that the use of inventories is but one option to encourage the use of EBPs by treatment providers. Additional strategies, such as provision of training and technical assistance, should be considered to help promote sustained implementation of EBPs in real world settings.

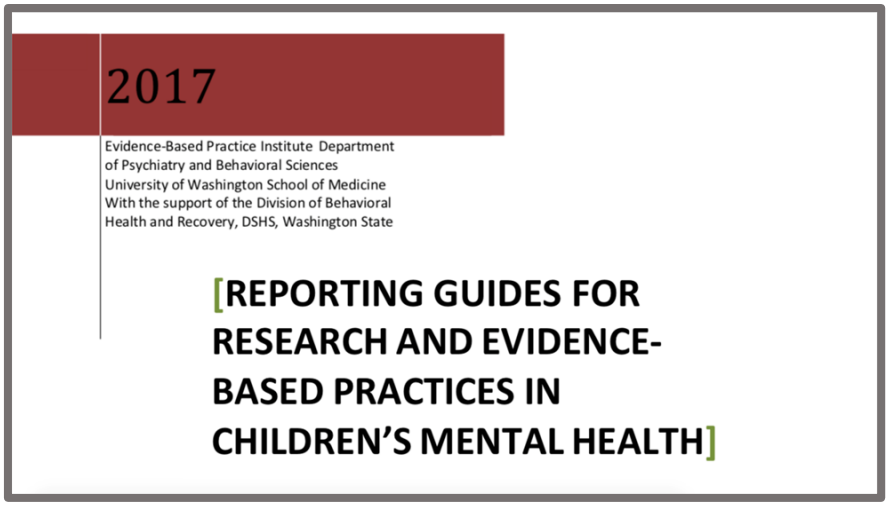
In the 2011-2012 legislative session, HB 2536 also directed DSHS to:

- Develop strategies to use unified and coordinated case plans for children, youth, and their families who are or are likely to be involved in multiple systems within the department
- Use monitoring and quality control procedures designed to measure fidelity with

evidence-based and research-based prevention and treatment programs

- Utilize any existing data reporting and system of quality management processes at the state and local level for monitoring the quality control and fidelity of the implementation of evidence-based and research-based practices

Thus, as detailed in a series of reports to the legislature,[14,15,16,17] a substantial amount of work was done to increase the utilization of evidence-based practices (EBP) and research-based practices (RBP) in the children's public mental health system. EBP and RBP codes were built into the Provider One reporting and billing system for providers, and guidance with regard to using the RBP and EBP codes and monitoring fidelity was developed. In 2017, UW EBPI published the current *Reporting Guides for Research- and Evidence-Based Practice in Children's Mental Health*.[18] The guides outline the eligible programs, encounter types, and documentation requirements for reporting an encounter as an RBP/EBP and provide instructions for how to report RBPs/EBPs using the codes.



SB 6312 – Prioritizing Purchasing of Services that Utilize Evidence-Based Practices

In the 2013-2014 legislative session, Washington passed SB 6312, "concerning state purchasing of mental health and chemical dependency treatment services." This bill provided that:

- "A task force shall undertake a systemwide review of the adult behavioral health system and make recommendations for reform."
- "Maximization of the use of evidence-based practices will be given priority over the use of research-based and promising practices, and research-based practices will be given priority over the use of promising practices."

Definitions of EBPs, RBPs, and promising practices were modified as follows:

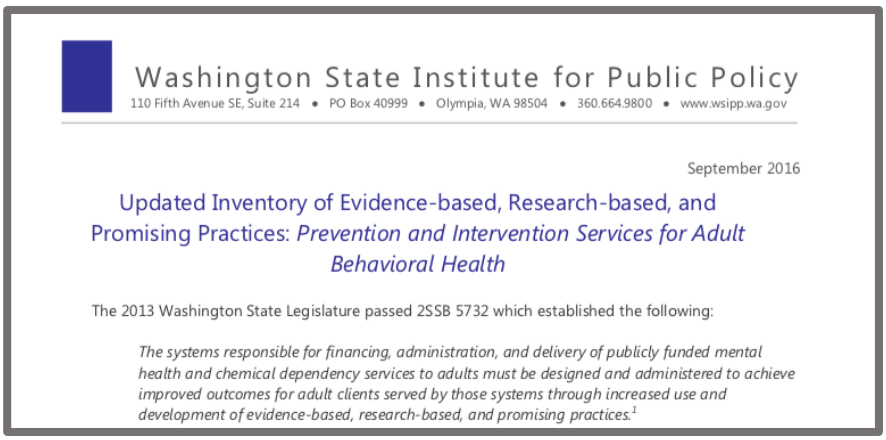
- "Evidence-based means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from a systemic review demonstrates sustained improvements in at least one outcome… also… a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial."

- "Research-based means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes... but does not meet the full criteria for evidence-based."
- "Promising practice means a program or practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the evidence-based or research-based criteria, which may include the use of a program that is evidence-based for outcomes other than those listed in…this section."

SB 5732 – Increasing Use of Evidence-Based Practices in Adult Behavioral health

SB 6312, "concerning state purchasing of mental health and chemical dependency treatment services, and SB 5732, "relating to improving behavioral health services provided to adults in Washington state," also passed in the 2013-2014 legislative session directed that:

- "WSIPP, in consultation with DSHS, the UW EBPI, UW ADAI, and the Washington Institute for Mental Health Research and Training, shall prepare an inventory of evidence-based, research-based, and promising practices for prevention and intervention services pursuant to subsection (1) of this section. The department shall use the inventory in preparing the behavioral health improvement strategy. The department shall provide the institute with data necessary to complete the inventory."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September 2016

Updated Inventory of Evidence-based, Research-based, and Promising Practices: *Prevention and Intervention Services for Adult Behavioral Health*

The 2013 Washington State Legislature passed 2SSB 5732 which established the following:

The systems responsible for financing, administration, and delivery of publicly funded mental health and chemical dependency services to adults must be designed and administered to achieve improved outcomes for adult clients served by those systems through increased use and development of evidence-based, research-based, and promising practices.[1]

Thus, WSIPP published the first *Inventory of Evidence-based, Research-based, and Promising Practices for Prevention and Intervention Services for Adult Behavioral Health* in May 2014, largely replicating the methods used pursuant to HB 2536 to establish the inventory for prevention and intervention services for children and juveniles in the child welfare, juvenile justice, and mental health systems. It has been updated repeatedly in the intervening years. As of this writing, the most recent version was published in September 2016, as shown.[19] Promising practices were designated based on review by a panel of experts at the University of Washington, which reviewed and scored applications submitted by community behavioral health providers and/or their service coordination entity or by WSIPP when research evidence was not sufficient to qualify a program as evidence- or research-based using the same criteria as established for the HB 2536 inventory. An EBP Workgroup was created to make recommendations on how to choose programs and practices to be listed on the Inventory and how to get selected programs and practices up and running.[20] Below is the WSIPP inventory for

interventions for substance use disorders for adults.

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

HB 2144 – Restricting Funding from Dedicated Marijuana Account to Research- and Evidence-Based Practices

In the 2013-2014 legislative session, Washington passed HB 2144, "relating to the establishment of a dedicated local jurisdiction marijuana fund and the distribution of a specified percentage of marijuana excise tax revenues to local jurisdictions." This bill stipulated that "funds are earmarked for DSHS DBHR for the development, implementation, maintenance, and evaluation of programs and practices aimed at the prevention or reduction of maladaptive substance use, substance use disorder, substance abuse or substance dependence…among middle school and high school-age students…provided that:

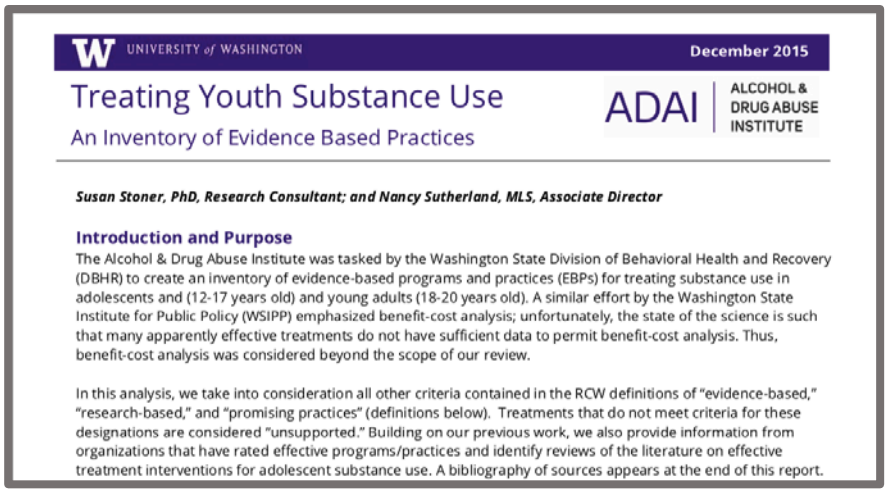
(A) Of the funds appropriated…at least 85% must be directed to evidence-based or research-based programs and practices that produce objectively measurable results and, by September 1, 2020, are cost-beneficial; and

(B) Up to 15% of the funds appropriated…may be directed to proven and tested practices, emerging best practices, or promising practices.

The bill specified that, in deciding which programs and practices to fund, DSHS must consult, at least annually, with UW Social Development Research Group and UW Alcohol and Drug Abuse Institute (ADAI). This resulted in the initial creation by ADAI of an inventory of research- and evidence-based practices (R/EBPs) for treatment of youth cannabis use.[21]

Evidence-Based Practices in Washington State: Report to DBHR, September 2018

Considering that treatment for cannabis use disorders would often use methods designed for treatment of substance use disorders in general, in 2015 this inventory was expanded to include R/EBPs for youth substance use disorders. The ADAI inventory sought to adhere to the definitions set forth in HB 5732 with the exception of the cost-benefit analysis. *In practice, this has meant there are two different inventories of R/EBPs – WSIPP and ADAI – that do not necessarily identify the same R/EBPs.*



UNIVERSITY of WASHINGTON December 2015

Treating Youth Substance Use

An Inventory of Evidence Based Practices

ADAI ALCOHOL & DRUG ABUSE INSTITUTE

Susan Stoner, PhD, Research Consultant; and Nancy Sutherland, MLS, Associate Director

Introduction and Purpose

The Alcohol & Drug Abuse Institute was tasked by the Washington State Division of Behavioral Health and Recovery (DBHR) to create an inventory of evidence-based programs and practices (EBPs) for treating substance use in adolescents and (12-17 years old) and young adults (18-20 years old). A similar effort by the Washington State Institute for Public Policy (WSIPP) emphasized benefit-cost analysis; unfortunately, the state of the science is such that many apparently effective treatments do not have sufficient data to permit benefit-cost analysis. Thus, benefit-cost analysis was considered beyond the scope of our review.

In this analysis, we take into consideration all other criteria contained in the RCW definitions of "evidence-based," "research-based," and "promising practices" (definitions below). Treatments that do not meet criteria for these designations are considered "unsupported." Building on our previous work, we also provide information from organizations that have rated effective programs/practices and identify reviews of the literature on effective treatment interventions for adolescent substance use. A bibliography of sources appears at the end of this report.

Current Status

As of this writing, in the children's mental health domain, there exists one inventory of R/EBPs and reporting guides for R/EBPs, with providers documenting their use of R/EBPs following the Service Encounter Reporting Instructions (SERI). In the adult mental health domain, there exists one inventory of R/EBPs but no reporting guides, and providers are not necessarily documenting their use of R/EBPs. In the children and youth substance use disorders (SUD) and co-occurring disorders (COD) treatment domain, there exist two inventories of R/EBPs but no reporting guides. In the adult SUD/COD treatment domain, there exists one inventory of R/EBPs but no reporting guides. In child and adult SUD/COD treatment, providers are not necessarily documenting their use of R/EBPs.

University Partners with Washington State in R/EBP Efforts

In addition to the Washington State Institute for Public Policy, multiple University of Washington (UW) institutes and centers have partnered with the Washington State Division of Behavioral Health and Recovery (DBHR) to advance R/EBP uptake across the state.

UW Evidence-Based Practices Institute (EBPI). In 2007, the Washington State Legislature passed House Bill 1088 which established EBPI. The Institute serves as a statewide resource to promote the implementation of R/EBPs for children's mental health systems in Washington State. EBPI works with DBHR to propose and evaluate policy solutions for challenges facing EBP implementation at the state level, including developing clear guidelines for EBP reporting as well as appropriate monitoring and counting of EBPs from the state billing database. These guidelines have been disseminated in published reporting guides as well as through webinars and workshops. In addition, EBPI offers training and technical assistance via webinars and workshops to community mental health agencies to support EBP implementation by collaborating with regional behavioral health organizations across the state. EBPI also gauges the extent to which the state mental health workforce is prepared to administer R/EBPs.[22]

Washington Institute for Mental Illness Research & Training (WIMIRT). With both western and eastern branches at University of Washington and Washington State University, respectively, WIMHRT was a key participant in early efforts to advance EBPs in the state. In September 2003, it published the first inventory in its *Summary of Best and Promising Mental Health Practices for Select Consumer Populations*[23] as well as *A Literature Review & Resource Guide for Evidence Based Best and Promising Mental Health Practices.*[24]

UW Alcohol and Drug Abuse Institute (ADAI). ADAI is a multidisciplinary research center at the University of Washington. Its mission is to advance research, policy, and practice in order to improve the lives of individuals, families, and communities affected by alcohol and drug use and abuse. To that end, ADAI has been involved in researching SUD treatment effectiveness and health services in specialty SUD and primary care treatment settings. It has served as the Pacific Northwest Node of the National Drug Abuse Treatment Clinical Trials Network (NIDA CTN) since 2001, which has contributed to the evidence base for various treatments for SUDs. ADAI has created an inventory of treatments for youth substance use disorders.[25]

Northwest Addiction Technology Transfer Center (NWATTC). Established at UW ADAI in 2017, NWATTC covers region 10 of the Substance Use and Mental Health Services Administration's (SAMHSA) Addiction Technology Transfer Network, which includes Washington, Oregon, Idaho, and Alaska. Its mission is to accelerate the adoption and implementation of evidence-based and promising addiction treatment and recovery-oriented practices and services; heighten the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use or other behavioral health disorders; and foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, funders, and the recovery community. NWATTC offers training and technical assistance to support the implementation of R/EBPs for SUDs, with increasing emphasis on technical assistance.[26]

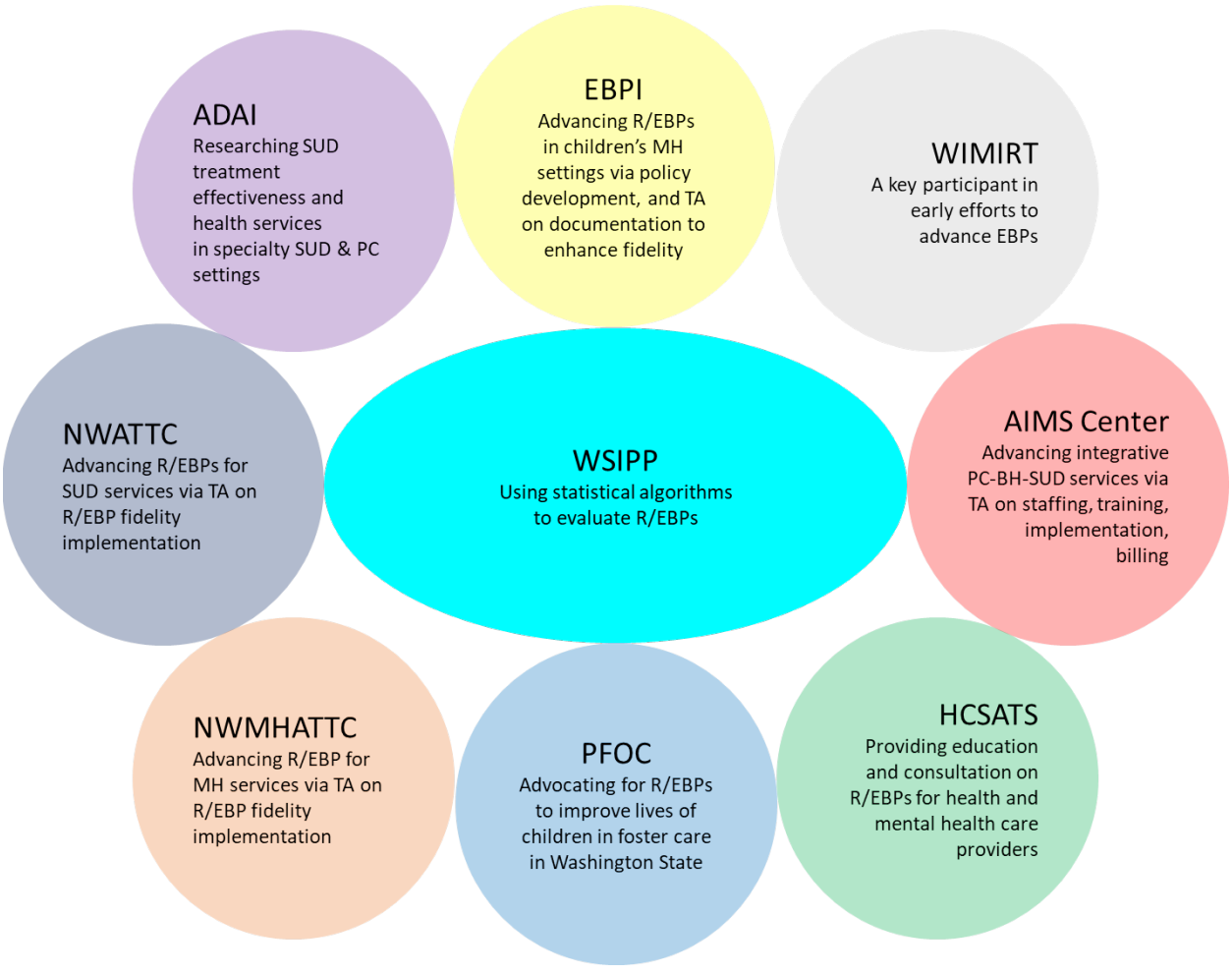
Northwest Mental Health Technology Transfer Center (NWMHTTC). Established at UW in 2018 as part of a new program by SAMHSA, NWMHTTC's mission is to accelerate the adoption and implementation of mental health related EBPs in region 10; heighten the awareness, knowledge, and skills of the workforce that addresses the needs of individuals living with mental illness; foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, family members, and consumers of mental health services; and ensure the availability and delivery of publicly available, free of charge, training and technical assistance to the mental health field. It will offer training and technical assistance to support the implementation of R/EBPs for mental illness, with an emphasis on technical assistance.

Harborview Center for Sexual Assault and Traumatic Stress (HCSATS). In UW Medicine, HCSATS provides professional training and consultation on EBPs, including Trauma Focused Cognitive Behavioral Therapy (TF-CBT); CBT for depression in children; CBT for anxiety in children and parent management training including PCIT and AF-CBT. HCSATS also provides training on treatment for adults who have symptoms related to their traumatic experiences: Cognitive Processing therapy (CPT) and Common Elements Treatment Approach (CETA). Free monthly 90-minute trainings are designed for social service & mental health providers, and

those interested in topics related to abuse, violence, trauma, treatment, recovery, cultural competency and prevention.[27]

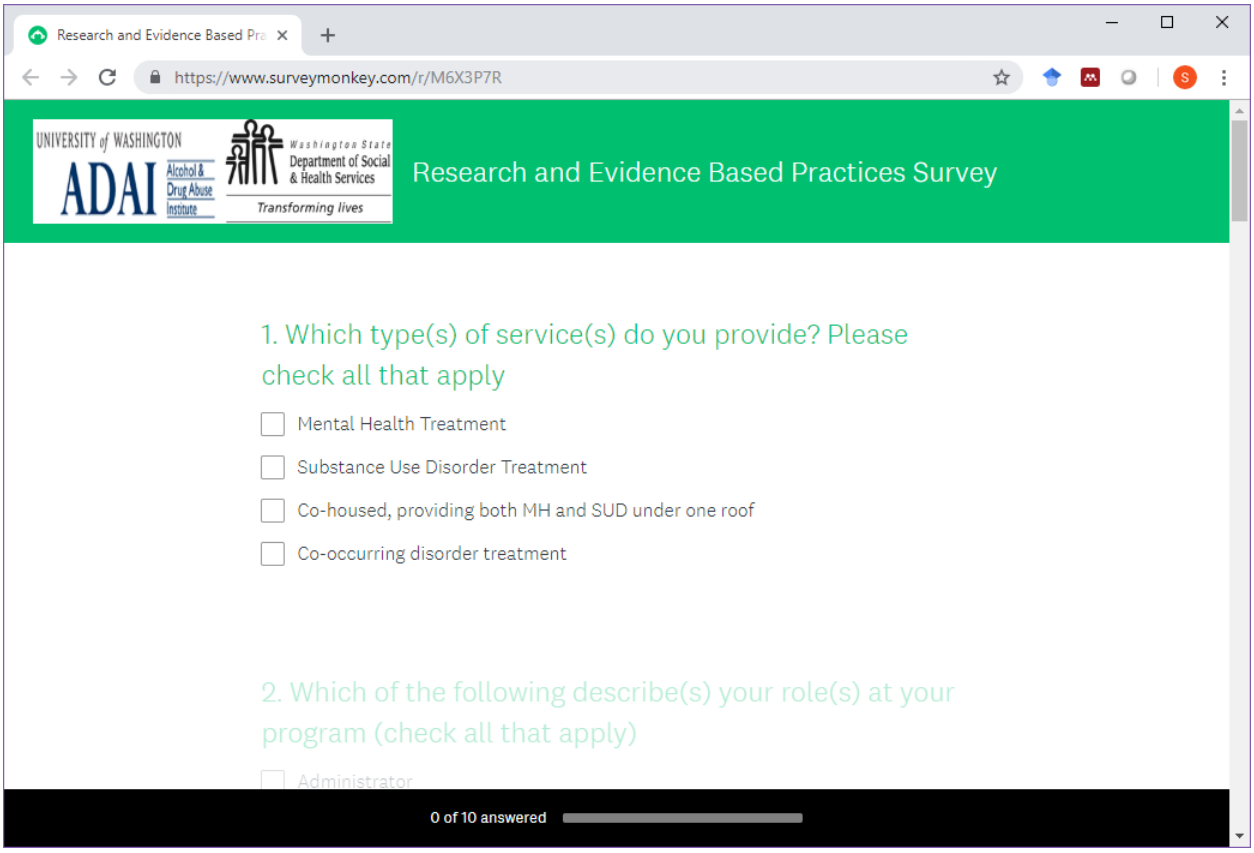
UW AIMS Center. The AIMS Center develops, tests and helps implement an evidence-based collaborative care model and bi-directional mental health-primary care integration strategies. The center provides coaching and implementation support, research collaborations, and education and workforce development. Along with promoting the collaborative care model as one of the few integrated care models with a substantial evidence base for its effectiveness, the AIMS Center also promotes evidence-based psychotherapies proven to work in primary care, such as problem-solving therapy (PST), behavioral activation (BA) and CBT, and medications.[28]

Partners for Our Children (PFOC). Founded at the UW School of Social Work, PFOC seeks to bring together the best minds from the academic and child-welfare communities, state leadership, and the private sector to improve the lives of children in foster care in Washington State. PFOC works with partners to identify critical issues facing children in state care and launch to initiatives outline the issues, define the challenges, and present possible solutions based on research, testing and evaluation. As part of the Alliance for Child Welfare Excellence, POC identifies training innovations to improve the workforce and evaluates the effectiveness of training activities of state child welfare workers in Washington State.[29,30]



Washington State Research and Evidence Based Practices Survey – June 2018

Recognizing that treatment program administrator and clinician feedback is critical with regard to the success or failure of EBP implementation and sustainment, the Division of Behavioral Health and Recovery conducted a survey of MH and SUD treatment providers in June 2018.[31] The survey was distributed to BHOs/MCOs across Washington; both administrators and frontline staff were invited to participate. Questions addressed the challenges treatment providers faced in identifying, selecting, implementing, and documenting R/EBPs (see Appendix A). The survey was completed by 126 respondents.



Instructions were as follows: "As you are most likely aware, RCW 43.20A.433 requires that any vendor rate increases provided for contracted or subcontracted mental health and chemical dependency treatment providers or programs be prioritized to those providers and programs that maximize the use of evidence-based and research-based practices (R/EBPs). **We are interested in challenges that you, as a mental health or chemical dependency treatment provider or program, may have experienced maximizing the use of R/EBPs.** To that end, the Division of Behavioral Health and Recovery, in partnership with the University of Washington Alcohol and Drug Abuse Institute, are conducting a survey of mental health and chemical dependency treatment providers and programs to identify challenges in selecting, implementing, and documenting use of R/EBPs. We hope that you will consider participating in this important survey."

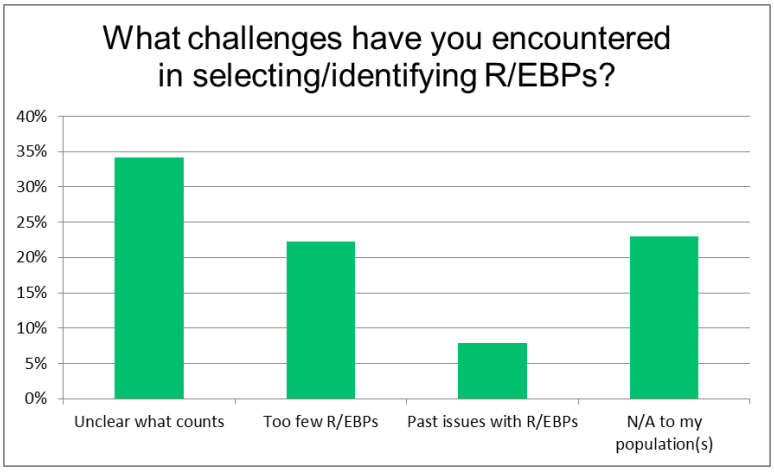
Sixty-three percent of respondents worked in mental health (MH) treatment, 43% in substance use disorder (SUD) treatment, and 36% in co-occurring disorder treatment. A third reported working in a facility where MH and SUD treatment were co-housed. The survey did not query whether the respondent worked with children or youth. However, this could be inferred from open-ended commends for some respondents. Twenty-two percent of respondents were identified as working with children or youth. Differences in responses were examined between 1) those who indicated they worked with children or youth and those who did not and 2) those who indicated they worked in SUD treatment and those who did not. There were no differences found between those who indicated they worked in SUD treatment and those who did not. Differences between those who worked with children/youth and those who did not will be described below, where they were found.

Half of respondents (63) reported they were administrators, 32% (40) were clinical supervisors, and 43% (54) were clinicians. Three respondents self-identified as trainers. Twenty-two percent of the administrators and 53% of the clinical supervisors also self-identified as clinicians. Forty-eight percent of the administrators and 62% of the clinical supervisors reported having decision-making or influencing capacity with regard to what R/EBPs are used in their program(s). Among the clinicians, 35% reported having some decision-making or influencing capacity with regard to what R/EBPs they personally used.

Percentage of EBPs Reportedly Used

Respondents were asked, "What percentage of the services that you provide would you say are R/EBPs? (If you do not personally provide treatment, please estimate the percentage provided by your program/agency.)" While responses ranged from 3% to 100% (mean = 71%, SD = 28%), the most common response was 100%. The median was 80%.

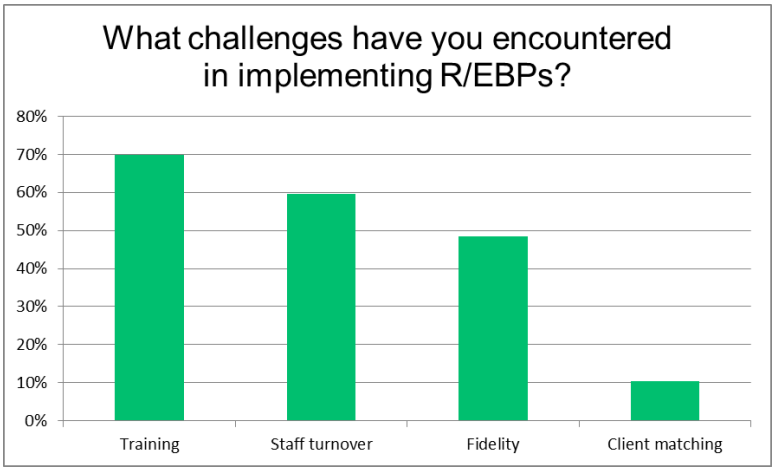
Challenges Faced Selecting R/EBPs



With regard to the challenges respondents faced in selecting R/EBPs, the most commonly endorsed challenge was that it's not clear what treatments are considered R/EBPs by the state though this was endorsed by only 34% of respondents. Less than one quarter stated that there are too few R/EBPs to choose from (22%). Those who indicated they work with children/youth were more likely to endorse this response (39%) than those who did not indicate they do so (17%). Nearly one quarter stated that identified R/EBPs are not demonstrated effective with the population(s) they work with (23%). Those who work with children/youth were more likely to endorse this response (18%) than those who did not indicate they do so (5%). Only 8% indicated

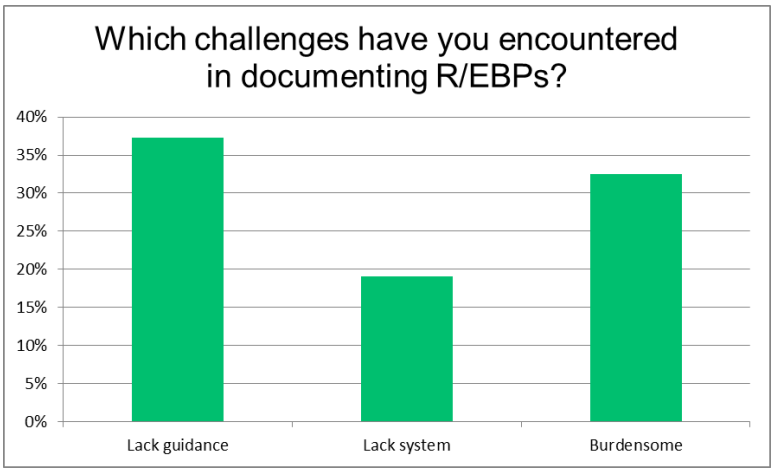
that "past experience with certain R/EBPs make me not want to use them." Again, those who work with children/youth were more likely to endorse this response (39%) than those who did not indicate they do so (18%). Over 62% commented on this question. Comments are provided in Appendix B and summarized below.

Challenges Faced Implementing R/EBPs



The most commonly endorsed challenge that providers faced in implementing EBPs (70%) was that training is costly and/or difficult to obtain. Providers serving children/youth were more likely to endorse this item (86%) than other providers (65%). More than half (60%) endorsed that staff turnover creates an ongoing need for training new staff. Again, providers serving children/youth were more likely to endorse this item (82%) than other providers (53%). Nearly one half (48%) endorsed that procedures for maintaining/monitoring fidelity are not sufficiently well-specified. Providers serving children/youth tended to endorse this item (57%) more than other providers (46%). Relatively few (10%) endorsed that it is unclear which R/EBP to use with a particular client. One third (33%) commented on this question. Comments are provided in Appendix B and summarized below.

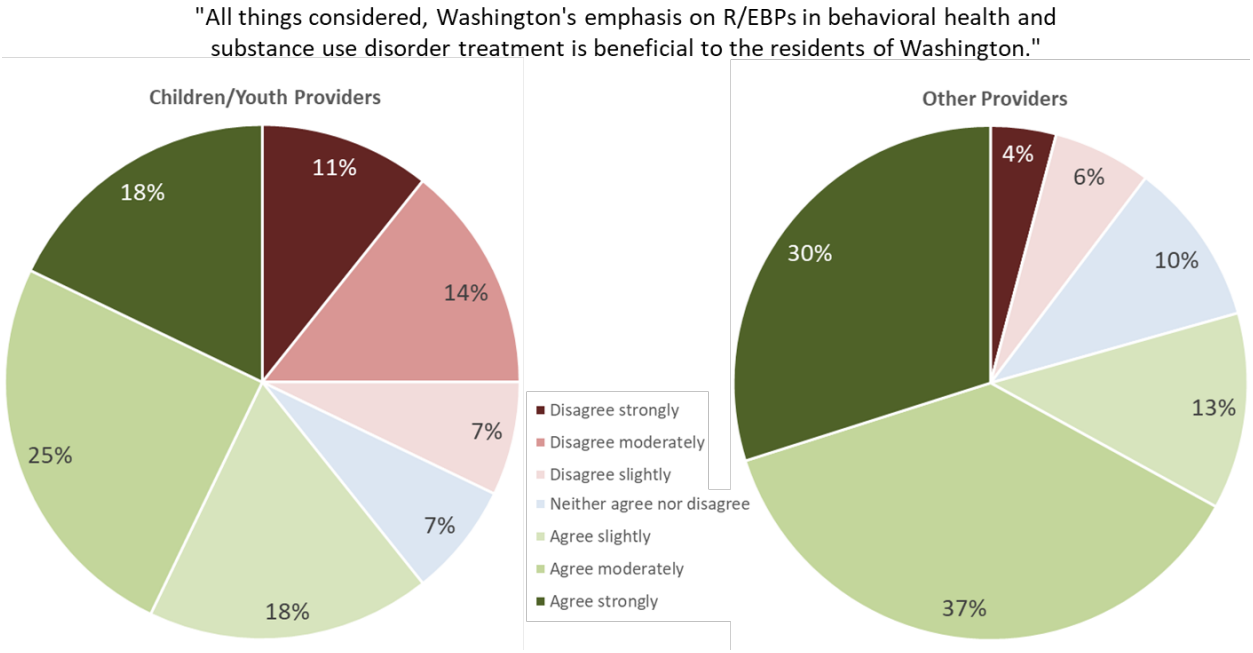
Challenges Faced Documenting R/EBPs



The most commonly endorsed challenge with respect to challenges in documenting R/EBPs was that there is not enough guidance on how to do so; however, this was endorsed by only 37% of respondents. One third (33%) indicated that documenting R/EBPs is excessively burdensome. Fewer than one in five (19%) indicated they lacked a system in place for documenting R/EBPs. Over a third (36%) commented on this question. See Appendix B for their comments, which are summarized below.

Belief in Benefit of R/EBPs

Respondents were asked, "Please rate the extent to which you agree with the following statement: 'All things considered, Washington's emphasis on R/EBPs in behavioral health and SUD treatment is beneficial to the residents of Washington.'" Overall, 61% of respondents agreed with that statement, either moderately or strongly, only 9% disagreed moderately or strongly, and 29% were in the middle from disagree slightly (6%) to agree slightly (13%). Those who indicated they worked with children/youth were more prone to disagree than those who did not indicate they worked with children/youth.



Content Analysis of Open-Ended Comments

In open-ended comments, respondents made little distinction between challenges identifying/selecting, implementing, and documenting R/EBPs. Thus, all open-ended responses were aggregated for each individual for content analysis. In an initial review of responses, typos and spelling errors were corrected. High prevalence words were selected from a first-pass analysis that was used to generate a word cloud. After filtering for pronouns and common verbs, the most frequent words, in order, were as follows:

EBPs EBP training staff more clients treatment state fidelity time use many all Cost work one R/EBP need client care effective Some enough CBT agency clinicians children population only often trained health evidence funding providers documentation other populations services process provide specific practices focus able implementation support difficult research agencies implement based needs mental clinical high most having think documenting SUD therapy different about requirements needed ongoing turnover Sometimes clinician make county community serve successful much fit find best lack without sessions system DBT problem curriculum providing program group hard R/EBPs programs available because practice way good appropriate within

The analysis generated the following word cloud:

Responses were coded for the presence/absence of the following words/word stems, selected from the list of most frequent words:

- Cost
- Pay
- Fund (excluding "fundamental")
- Train
- Time
- List (excluding "listen")
- Fidelity
- Client
- Turnover
- Staff
- Limit

Responses were then coded for overall tone (negative, neutral/balanced, or positive) and for whether they referred to any of the following emergent themes:

- **Affirmation** – respondent expressly affirmed the value of R/EBPs
- **Money** – respondent used one or more of the following words/word stems: cost, pay, fund.
- **Lacking Clarity** – respondent indicated they lacked clarity on R/EBP requirements
- Extra Work – respondent indicated that R/EBP emphasis was burdensome or they experienced increased work due to the R/EBP emphasis
- **Lack Resources** – respondent mentioned they were lacking resources to fully address emphasis or would benefit from additional resources
- **Place Limits** – respondent mentioned that the R/EBP emphasis places limits on what clinicians can do with clients/consumers

- **Poor Fit** – respondent indicated that available R/EBPs do not fit their clients/population in some way
- **Poor Communication** – respondent described issues related to communication as being problematic
- **Lacking R/EBPs** – respondent indicated there were not any or enough R/EBPs for their population or certain groups with whom they work

Frequencies of each theme were examined overall and for differences by whether or not respondents indicated 1) they worked with children/youth and 2) they worked in SUD treatment.

Overall, 79% of respondents made at least one comment in general or specifically regarding challenges they encountered identifying/selecting, implementing, or documenting R/EBPs. While 26 respondents who did not indicate working with children/youth (27%) left these comments blank, only one respondent who indicated working with children/youth (4%) did not make a comment.

Frequency of Words/Word Stems

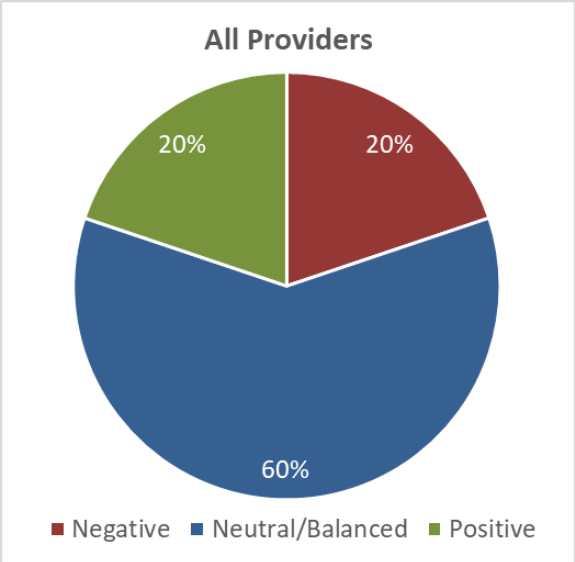
- Cost 19%
- Pay 6%
- Fund 11%
- Train 36%
- Time 27%
- List 6%
- Fidelity 18%
- Client 24%
- Turnover 6%
- Staff 26%
- Limit 6%

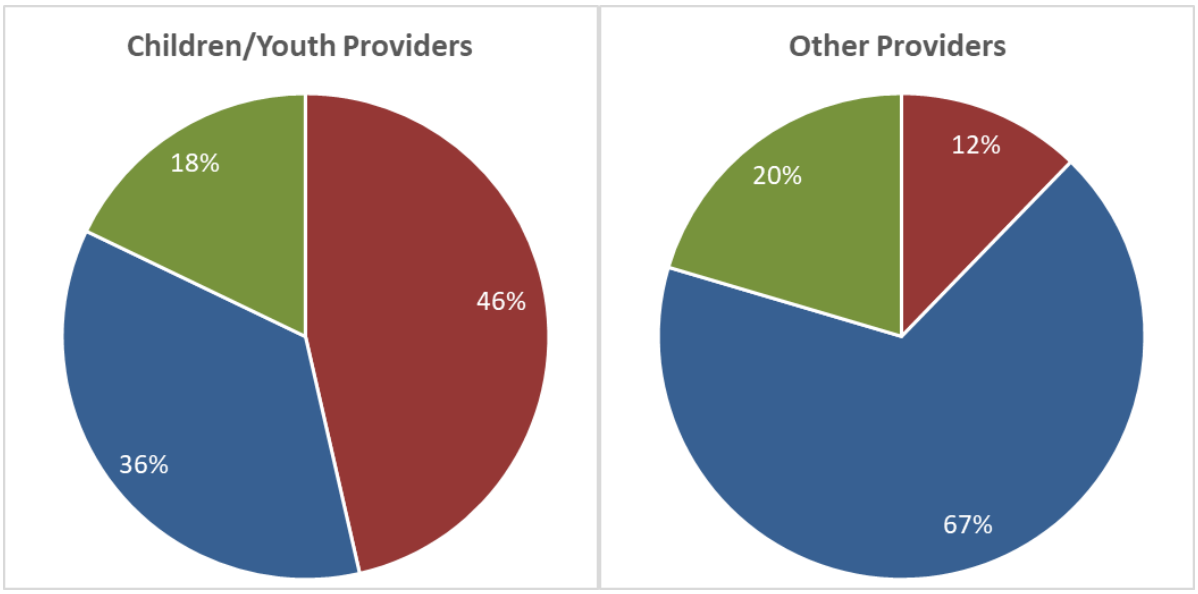
Those who indicated they worked with children/youth were more likely than those who didn't to mention cost (36%), fund (25%), train (54%), time (39%), turnover (18%), staff (43%), and list (14%). There were no differences between those who indicated they worked in SUD treatment and those who did not.

Frequency of Themes

Overall tone. The overall tone of comments was balanced. Sixty percent of respondents either did not comment, expressed a neutral tone, or were fairly balanced in their negative and positive themes. An overall negative tone was expressed by 20% of respondents, and an overall positive tone was expressed by another 20% of respondents.

Those who indicated they worked with children/youth tended to have a more negative tone than those who did not.





Affirmation. The value of R/EBPs was implicitly or explicitly affirmed by 24% of respondents. This percentage did not vary according to whether respondents indicated they worked with children/youth or in SUD treatment. Affirmations were sometimes followed by an implicit or explicit caveat, along the lines of "Using R/EBPs is very important, but…" Examples follow.

- *I strongly believe in EBP. However, our agency does not provide the support to obtain EBP for everyone.*
- *We are advocates for utilizing R/EBP curriculum, we believe it increases efficacy.*
- *Providing R/EBP has been beneficial for my agency.*
- *I believe in EBP and am highly trained and certified. I think that it is essential that treatment practices be proven effective and used skillfully.*
- *I have always believed in R/EBPs because they can apply to a variety of clients, and the more training I have in them, the better I can apply the most effective ones to the population I serve.*
- *I think R/EBPs are…more needed on the substance use side of treatment especially with the lower education requirements of staff.*
- *It is generally a good thing for collaborating care. It is only a problem when collecting evidence (e.g. writing a note) causes clinicians to miss things about the client in the moment.*
- *It gives me a good focus.*
- *We've been able to implement an EBP that has the evidence to show that it works. Unfortunately, within our community, no other providers believe it is appropriate (contingency management is seen as paying clients to do well).*
- *I believe it makes clinicians and companies more accountable. Clinicians have to be specific in documentation, companies need to invest in training in R/EBPs.*
- *It is critical that we adhere to R/EBPs. They are fundamental to our work.*
- *R/EBP work for targeted populations and people outside those populations are left out…These*

models are still effective for a large portion of the population seeking help though.

- *Funding sources want to pay for clients to be engaged in some kind of fidelity based curriculum and I understand why. Ethically, the clinician and agency should be promoting proven tools.*
- *Our staff want to provide evidenced based treatment but accessing affordable training, etc. can be difficult in community mental health settings.*
- *Overall the movement is positive and we have been committed to training clinicians in CBT and DBT. We are concerned about decisions made about EBP without specific input from providers.*
- *Implementing EBPs is a complex process…It is really important for patient care and I have observed benefit of EBPs among our patients.*
- *To the extent that the focus on R/EBPs increases appropriate treatment for clients it is good. However… R/EBPs sometimes have too narrow a focus and seem subject to special interests.*
- *I ONLY do EBPs. I think it's critical that the state emphasizes them.*
- *EBPs are great however…EBPs do not fit all people.*
- *I think a focus on EBPs is a good thing as I believe clients deserve treatment that is shown to be effective. However, having the state put such requirements on it has made the implementation feel sterile and more about checking boxes than the actual treatment.*
- *The best place for students/interns to learn EBPs is during internships at CBHC agencies. However CBHC's need funding and involvement from local experts/trainers.*
- *I agree with the goal of EBPs, but the identification of what is an EBP is not transparent, and lots of changes have made it hard to keep up with the process.*
- *The emphasis in children's services is clear and well supported; unfortunately, this is not true for adults.*
- *I am a firm believer in EBPs.*
- *We are very much in favor of and support the use of EBPs at our agency. But staff turnover is the primary barrier.*
- *R/EBPs are important and helpful for so many clinicians and families - however, to expect that every clinician is trained and delivers on the expectation that an R/EBP is followed to its core intent is something that is a way to reduce how clinicians can use both the science and the art of therapy.*
- *However, I must say there are useful and effective EBPs such as various kinds of CBT, and my clinicians are finding components of CBT are useful.*
- *We can see the benefits of the R/EBPs…I wish R/EBPs were available to promoted when I first began practicing in the late 1980s.*

Money. The money theme came up in 26% of responses, i.e., any mention of the words/word stems cost, pay, or fund. Those who indicated they worded with children/youth were more likely than others to make a comment with this theme (57%). Representative comments follow:

- *The EBP expectation is an unfunded mandate and hard to implement in community mental*

health without allocating resources…I think if the Washington State legislature really cares about EBPs for children then they need to increase reimbursement rates for child providers to promote appropriate training and use of EBPs. Without allocating resources, the expectation is not viable.

- *Payers are not reimbursing so we are not providing… The process of all things having to be obtained through UW and pay UW for them is not serving our State BH clients well.*
- *R/EBPs include elements (case management, flexible appointment times, after-hours phone consultation, care coordination with other clinicians, care coordination with friends/family members) that do not generate revenue and are therefore not practical to implement in productivity-driven clinical settings…Therefore, emphasizing the need to implement R/EBPs without addressing the contingencies (payment, regulatory, legal systems) does not advance the quality of care.*
- *The lack of funding to ensure ongoing training and supervision to fidelity is a huge problem. Staff are trained, but often drift away from EBP without specific fidelity supervision.*
- *Expecting that R/EBPs are delivered without fail at nearly ever session with every child is one that does not take into account how a poorly funded system can support such an expensive bar.*
- *The cumbersome training requirements for EBPs has cost us money and time. With the huge staff turnover, clients cannot be seen quickly.*
- *Agency does not provide EBP funding or free training. We get paid very little so going to private trainings is very costly.*
- *I know funding sources want to pay for clients to be engaged in some kind of fidelity based curriculum and I understand why. Ethically, the clinician and agency should be promoting proven tools.*
- *While instituting mandates there has been no funding for the costs associated with training, infrastructure, and staff turnover.*
- *I would like to see support for specific programs like DBT receive the same level of funding and support as crisis services, clubhouse.*
- *Some of these EBPs which are effective have high training and on-going costs*
- *The State has not given sufficient dollars for implementation or training and direction for establishing R/EBPs and their documentation.*
- *Training and the follow-up to maintain one's eligibility to call themselves "trained" is not only financially costly but takes time away from families…The emphasis on EBPs has NOT improved our level of client-care yet has cost money and time. It's a huge frustration and must be re-thought.*
- *Cost of training staff is prohibitive, we are a small agency that can't have supervisors trained for every EBP…Our agency provides effective treatment that includes many elements of EBPs, but fidelity to EBPs is cost prohibitive and counter-productive.*
- *We have identified our high priority EBPs and have reasonable success rate at implementing/sustaining. The biggest challenges are cost of training and ongoing supervision by providers with sufficient expertise.*

- *Put the money where the mouth is. Mental health is and has been on a starvation diet the past 15 years. Clients suffer from staff shortages and staff suffers from poor pay and data entry expectations with no clerical support and decreased job satisfaction.*
- *Usually the cost to maintain fidelity is a challenge.*
- *Lack of funding for clinical supervision but most EBPs requires on-going clinical supervision to ensure fidelity and QA… lots of administrative work involved and not enough funding to cover for the time spend.*
- *Contingency management is costly and revenue changes frequently although the evidence states it is the most effective with the OUD population.*
- *Need more funding to ensure that staff are adequately trained and that R/EBPs can be followed to fidelity.*
- *The cost and ongoing training needed to implement EBPs in the current environment of high turnover and low reimbursement rates make them ineffectual.*
- *EBPs further privilege and power disparities as they are costly and can be maintained more easily by those with wealth and privilege.*
- *We have tried a variety of EBP (MST, FFT, PPT and wraparound models) that we have not been able to maintain due to cost, lack of referral/coverage, staff turnover, and [the need to] keep family engaged.*
- *It took us several thousand dollars and a lot of labor to update our EHR to reflect EBP usage…I had therapists wanting us to count several expensive EBPs that I didn't feel we could sustain financially as an agency or treat to fidelity…I'm concerned that DBHR is reducing funding for CBT+. CBT+ has been the most cost effective way to get many new therapists trained in an EBP for a variety of targets. The low cost ($150 per person) make it financially feasible and the advanced trainings have been great. If DBHR underfunds the initiative the agencies will have to pay more and might not be able to send as many people which will decrease EBP percentages across the county.*

Lacking clarity. The theme of lacking clarity on requirements or "what counts" as an R/EBP came up in 10% of responses. Lacking transparency was also counted under this theme. Those who indicated they worked in treatment of children/youth were more likely than others to make a comment with this theme (25%). Representative comments follow:

- *Confusion between King County and the EBP Institute at UW on what "counts." I don't feel our county understands what data to collect and is doing a poor job of disseminating information…It's also unclear to me who "counts" as an in-house trainer. We have a staff member we invested a lot of time and money in to help them complete an advanced DBT training and they do the in-house training and ongoing consultation group to fidelity (or as close as we can get in community mental health). If I can't "count" her training then my EBP percentage will drop for anyone reporting DBT as their EBP. One more thing- King County accepts "CBT+" as an EBP category but I've heard that we should be using "CBT for depressed adolescents" or "CBT for anxious children" or the behavior management one. So I'm concerned that so many organizations are reporting out CBT+ and maybe that's just junk data at the state level? Lastly- King County allows an "other CBT" EBP category that I've also heard isn't allowed at the state level?*

- *The process the state and the UW has been engaged in has not been transparent in the implementation of EBPs by providers…The current process has the appearance of impropriety in that the UW EBPI appears to have a monopoly in which they are the only providers of input to the state and also gain monetarily from the relationship.*
- *Importantly, our staff are NOT comfortable documenting EBPs because their knowledge of what counts as evidence-based practice runs contrary to how they are being directed to report…Staff have questions about how ethical it is to report pieces of EBPs outside of the EBP-specified best-practice environment.*
- *[Lacking] clarity on what to document certain types of the service as.*
- *[Regarding documentation] expectations are unclear or do not take into consideration the context within which clinicians are working and documenting…The emphasis in children's services is clear and well supported, unfortunately, this is not true for adults AND adults are far more likely to be served in our systems than children (more individuals, more services)*
- *The process has been disruptive/unclear at times. I agree with the goal of EBPs, but the identification of what is an EBP is not transparent, and lots of changes have made it hard to keep up with the process.*
- *No way to prove that I have training in EBPs.*
- *Little has been shared by the state specific to SUD care.*
- *Identifying elements of R/EBPs rather than entire protocols or programs is unclear.*
- *Inconsistent guidelines and imposed guidelines that do not take into account the reality of providing services to different populations.*
- *There are so many and varied approaches and clinical interventions - hard to keep up with what are considered EBPs and the extent to required training needed to be considered "trained."*
- *It's not clear which R/EBPs Washington endorses.*
- *A lot of my person-centered therapy has elements of EBPs, but are not strictly EBPs. For example, building therapeutic alliance, clarifying or paraphrasing, are also elements of other EBPs. For example, although I measure goals with a client, I do not assign them homework as I would as a CBT therapist. Can I fully say that I am using CBT, even if I am only using an element of it? I'm not sure how "trained" I need to be to say that I am using one. Is one training enough?*

Extra work. The theme of the emphasis on R/EBPs being burdensome or creating extra work came up in 22% of responses. Those who indicated they worked with children/youth were more likely than others to make a comment with this theme (50%). Examples of representative comments include the following:

- *It was an unfunded mandate. It took us several thousand dollars and a lot of labor to update our EHR to reflect EBP usage.*
- *To program a new EBP into our EHR takes time and we are one program in a much larger system with many demands on the programmers.*
- *There are so many and varied approaches and clinical interventions - hard to keep up with what are considered EBPs and the extent to which required training is needed to be considered "trained". DBT is a good example - years ago you were required to do extensive weeks long*

training to be approved to do DBT- now a two day staff training is allowed for some DBT, such as DBT groups.

- *It is TIME CONSUMING, and it doesn't really effect my modality with a client. It lengthens my session notes, which my agency wants to be collaborative with the client-- so I end up having a lot of work to do outside of meeting with them, which is stressful.*
- *R/EBPs also include elements (case management, flexible appointment times, after-hours phone consultation, care coordination with other clinicians, care coordination with friends/family members) that do not generate revenue and are therefore not practical to implement in productivity-driven clinical settings.*
- *Meeting all the requirements adds to more time and takes away from other clinical focus.*
- *Not all components of EBP and not all focus of sessions can be just EBP manualized content.*
- *Prohibitively cumbersome…to prove fidelity with the model.*
- *The cumbersome training requirements for EBPs has cost us money and time. With the huge staff turnover, clients cannot be seen quickly.*
- *Staff turnover is the primary barrier - we have to offer multiple trainings per year, and have had to select a handful of core EBPs to focus on. In addition, keeping everyone focused on it requires diligent effort by supervisors to ensure continued practice of the EBP after training.*
- *We have obtained grant funding to train some staff in the incredibly expensive EBP of Child-Parent psychotherapy, but this is only evidence based for some families we work with, and the training lasts 18 months, so with average staff turnover, we may not be able to provide this R/EBP for the long term.*
- *Most EBPs require on-going clinical supervision to ensure fidelity and QA…lots of administrative work involved and not enough funding to cover for the time spend.*
- *Degree programs (esp. Master's level programs) do not provide training in EBPs generally, which they should, and come to us poorly equipped to provide community behavioral health treatment. We have to train all of our staff after they get here.*
- *Having the state put such requirements on it has made the implementation feel sterile and more about checking boxes than the actual treatment. Additionally, requirements for training are burdensome (as noted in previous questions as well).*
- *One thing for sure and you'll get this from all CDP people: TOO MUCH DOCUMENTATION. You hire advanced degree professionals and then do not trust us to do our job correctly, so there are far too many measures and far too many mandatory types of notes to write. Evidence should show more work with the clients and more time to plan groups that are fun and meaningful would help tremendously. I have about 10 minutes prior to group to plan my group or I have to work overtime for free to find interesting ways to present the material.*
- *Procedures for measuring fidelity are cumbersome…the need for post workshop consultation is essential in increasing uptake of EBPs.*
- *The cost and ongoing training needed to implement EBPs in the current environment of high turnover and low reimbursement rates make them ineffectual.*
- *Implementing EBPs is a complex process that requires a lot of time and resources to do*

effectively, and can be negatively impacted by competing initiatives, both from within and outside agencies. Agencies need support to do this work.

- *We have a great documentation system but now there are additional documentation requirements.*
- *Federal and State requirements are already so big of a burden that adding more time consuming specialized documentation is difficult to dictate to staff and also take time away from face to face work and other required documentation.*
- *Sometimes they make it difficult to reach a client.*
- *Documenting EBPs is also an issue in our current EHR, so it's difficult to capture them. The state has frequently changed EBPs and sometimes becomes too specific. There is often resistance from staff, particularly older, more experienced clinicians. It's difficult to meet fidelity guidelines in rural clinics.*
- *Our agency does not provide the support to obtain EBP for everyone. Some people are chosen to receive this training and others are not. It doesn't make sense. All staff should have access.*

Lack of resources. Fifteen percent of respondents referred to a lack of or need for resources to use EBPs. Examples include:

- *I'm concerned that DBHR is reducing funding for CBT+.*
- *The EBP expectation is…hard to implement in community mental health without allocating resources.*
- *Expecting that R/EBPs are delivered without fail at nearly ever session with every child is one that does not take into account how a poorly funded system can support such an expensive bar.*
- *[We need] qualified clinicians and sufficient clinical supervisors to oversee the implementation.*
- *The best place for students/interns to learn EBPs is during internships at CBHC agencies. However CBHC's need funding and involvement from local experts/trainers (e.g. University of Washington, Behavioral Tech) to create successful programs.*
- *I don't believe that the state is providing EBPs as there is the false belief that attending a training will make one an expert. Most agencies do not record sessions for fidelity or observe sessions to know to be able to judge how adherent staff are to the treatment that they are supposed to be providing. Agencies think that they are providing EBP without all of the elements that are needed to be truly adherent.*
- *We are a small agency that can't have supervisors trained for every EBP.*
- *Need more funding to ensure that staff are adequately trained and that R/EBPs can be followed to fidelity.*
- *The lack of funding to ensure ongoing training and supervision to fidelity is a huge problem. Staff are trained, but often drift away from EBP without specific fidelity supervision.*
- *State needs to invest way more in this effort than it does.*
- *Our staff want to provide evidenced based treatment but accessing affordable training, etc. can be difficult in community mental health settings.*

- *The State has not given sufficient dollars for implementation or training and direction for establishing R/EBPs and their documentation.*
- *Some EBPs are proprietary and require investment in training and materials that is not financially feasible for our agency. Ongoing monitoring/supervision for fidelity is challenging.*
- *More monies for training to gain skills using R/EBPs like EMDR would be great!*
- *Caseload size is too large to provide the frequency of treatment contacts to implement best practices consistently and according to fidelity.*
- *Training for clinicians is expensive, timely, and hard to come by…if there were more/more affordable trainings it would be so much easier!*
- *[There are] insufficient resources and structural supports given to support implementation. Implementing EBPs is a complex process that requires a lot of time and resources to do effectively, and can be negatively impacted by competing initiatives, both from within and outside agencies. Agencies need support to do this work…Any effort to create a learning healthcare system that continues to improve upon EBPs and how they can be utilized most effectively within our agencies and with our patients is needed.*

Place limits on practice. Thirteen percent of respondents spoke to the theme that EBPs place limits on what clinicians or agencies can do. Those who indicated they work with children/youth (25%) were more likely than others to bring up this theme.

- *The mandate that all services being delivered to all children in the Medicaid system must be R/EBPs is limiting to sessions and the training each clinician comes to their careers with. Often, therapists feel their creativity and humanistic values are discarded because there is a belief that these interventions are not valid unless they are coded as an R/EBP; which is not the be-all-end-all for every case. Several children and families gain many skills from several R/EBP components - however, these sessions are not wholly successful because of the R/EBP, and it is limiting to think that the only thing 'worth' paying for is something that meets a belief that it must be on the 'approved' list. It is important to have EBPs as a foundation, and it is not the only thing that helps influence a child to get better. Attunement to the child's' needs and the family's needs is actually one of the most critical factor for a child to experience improvement. Attunement is not an element of an R/EBP. It is simply one component that helps facilitate the child's response to therapeutic techniques and interventions. Relationship is another facet of therapy that helps it be successful for many children. This is not an R/EBP either. My final point is that R/EBPs are important and helpful for so many clinicians and families - however, to expect that every clinician is trained and delivers on the expectation that an R/EBP is followed to its core intent is something that is a way to reduce how clinicians can use both the science and the art of therapy to address the needs of children in our mental health system.*
- *[R/EBPs] take away from other clinical focus.*
- *Seven Challenges Program has been used and approved by the county and federally but it's not considered to be EBP by the state. We got positive feedback from the clients and would like to continue to use the program.*
- *The very few EBPs available for children (especially non-cognitive-based ones) has this [negative] impact.*
- *A general criticism of EBPs is they are often too focused on one problem when the complexity of*

the family situation makes it very hard to focus just on one problem. Having more flexibility around documentation and content of EBP visits would help address that.

- *I always wonder that if we can only use EBP then how are new ideas and treatments supposed to emerge? No offense but they are not going to come from the lab! (unless it's medical / medicine interventions).*
- *There has also been a blind eye turned towards the use of promising practices that appear effective nor for "relationally based" practices that have evidence to support them*
- *This model leaves less room for innovation and the creation of culturally responsive engagement. It leaves little room for Promising Practices as well.*
- *EBPs are limiting in the scope of practice.*
- *Some staff prefer to lecture on their own material, which in general I don't like, so it eliminates their ability to do that.*
- *Fidelity is overly onerous & limits flexibility.*
- *At times they help but there are other things that work as well.*
- *Therapy must be organic and meet the unique characteristics of the individual. Sometimes this means blending several R/EBPs together.*
- *Psychodynamic psychotherapy is not listed. Nor is EFT.*
- *Becoming hyper-focused stifles innovation.*

Poor fit. A somewhat more common theme emerged with a number of respondents (25%) pointing out how R/EBPs are often a poor fit for their clients/populations/agencies. Those who indicated they work with children/youth (46%) were more likely than other respondents to bring up this theme.

- *The children we serve are not the typical children whom are studied in these research projects that endorse or deny R/EBPs.*
- *[We desire EBPs to address] cultural practices that focus on belief of Native American and Hispanic pop, also more school based services.*
- *It is evident that those who push implementation have little to no experience working with the populations we serve. Forcing families to fit models rather than fitting models to families is unethical and disrespectful.*
- *The EBPs approved by the state don't address all of the needs we see with our population…A general criticism of EBPs is they are often too focused on one problem when the complexity of the family situation makes it very hard to focus just on one problem. Having more flexibility around documentation and content of EBP visits would help address that.*
- *Mostly group work from one EBP that the clients do not like, they find boring and many times the curriculum does not reflect the group at all so they are SUPER bored…EBPs are great however with a dynamic population with changing drug usage, with age differences, with ethnic and race differences the EBPs do not fit all people.*
- *EBPs don't work for every consumer. The evidence bears this out. There must be latitude to diverge from EBPs when it's not effective. (Individual results will vary). Further, if we only*

provide EBPs new best practices will fail to emerge and we have clearly not found all the best practices yet…There is often resistance from staff, particularly older, more experienced clinicians. It's difficult to meet fidelity guidelines in rural clinics… There is also a lack of acknowledgement that what works in clinical settings with carefully selected participants is not always as effective with clients with multiple problems. The real world is very different than the sterilized clinical settings of most trials.

- *We would like there to be additional focus on practices that recognize the value of the relationship in the therapeutic process , practices that are shown to be effective with the specific populations groups we work with…I would like to see more promotion of services that are explicitly shown to be successful with the minority groups that we serve. Would like to see the EBPI steer dollars towards research that is not primarily based on the majority white population, because often that is not who the providers are necessarily serving.*
- *EBPs are very often based on dominant culture research/psychology and practice and so they are responsive to only this population and this practice then institutionalizes those disparities. EBPs also further privilege and power disparities as they are costly and can be maintained more easily by those with wealth and privilege.*
- *It should never be presumed that clients fit perfectly into boxes.*
- *I find that it can often get in the way, and sometimes use modalities they may not fit the client but can check the EBP box.*
- *Many EBPs are psychotherapies. These are often designed to be conducted as weekly appointments for something like 6, 12, 20, or 50 weeks - depending on the treatment. They also rely on the therapist and client predictably knowing when they will meet again so they can plan for practice between sessions and keep focus and momentum on treatment targets. Medicaid and other system's (e.g. Kaiser) focus on access to care has resulted in difficulty making weekly commitments to clients across a long enough period to complete a therapy. Medicaid tiers mean that services are funded at a low dollar figure over a long period (one year). The rate/month is insufficient to cover the costs of weekly therapy and maintaining the person for the rest of the year in order to be paid enough to make the 3-4 months of therapy cost-effective is hard to justify ethically and clinically when the client has improved sufficiently to be discharged.*
- *EBP protocols are insular which is so far from the reality of our community-based work. Staff have questions about how ethical it is to report pieces of EBPs outside of the EBP-specified best-practice environment.*
- *King County or State frequently chose for us the mandated EBPs rather than we selecting EBPs that fit our clients.*
- *R/EBPs are tested in research subjects that do not represent the full scope of patients undergoing care. As a result, the patient populations I see are not good candidates for R/EBPs…R/EBPs include elements of counseling and coordination of care that do not align with current payment, regulatory and legal systems that drive health care delivery systems. Therefore, emphasizing the need to implement R/EBPs without addressing the contingencies (payment, regulatory, legal systems) does not advance the quality of care.*
- *Most of the EBPs are not tested with Asian Pacific Islander immigrants and refugee population in mind, thus it is not culturally tailored for our target population…It seems meaningless to be mandated to use EBPs because there is not enough evidence that they work with Asian Pacific*

Islander immigrants and refugee population. Our knowledge and experience tell us that our clinicians cultural and language expertise, their ability to engage with clients work much better than EBPs.

- *There are not R/EBPs available to address all the client populations that I work with.*
- *Fidelity is designated for too narrow of populations and are not culturally appropriate…The failure to address varied ethnic and culturally diverse populations and those with SMI and personality challenges make EBPs inappropriate for many of the clients we serve.*
- *R/EBP work for targeted populations and people outside those populations are left out…I work with a specific population, those with multiple issues and they do not easily fit into these models.*
- *Some clients do not respond to EBP so I choose a different method. Some clients don't want change-just to be listening to.*
- *EBPs would be more beneficial if they looked more into the social/economical and geographical setting to which they served. I have worked in 2 separate EBP that had significant flaws in serving children in a rural area. Not that the EBP wasn't beneficial, but it needed some room for flexibility due to the rural area it was serving.*
- *Clients with long history of treatment often report previous negative experiences with identified/identifiable (i.e. name brand or "programs") R/EBPs…However, due to the limits of research dollars, the influence of for profit ventures (name branded R/EBPs), and the continued gap between academia and the lived world of clients, R/EBPs sometimes have too narrow a focus and seem subject to special interests that may not have the best care for clients as the primary focus.*
- *Inconsistent guidelines and imposed guidelines…do not take into account the reality of providing services to different populations.*
- *Youth and families often have very different and specific needs which are not adequately addressed by purely EBPs. Similarly, individuals with learning disabilities, many housing or other case management barriers, low literacy or education levels, etc. are often not able to engage in the strict EBP fidelity models.*
- *I think we do have to be careful about imposing EBPs on clients and ensuring that those used are a good fit and culturally relevant to the individual/family.*
- *The conditions for EBP implementation in research is very different than those for an agency implementing outside of the research arena. It is much more difficult to implement EBPs with fidelity in the real world.*
- *Difficult to apply EBPs to short stay residential SUD treatment for non-homogeneous patient population that varies by drug of choice, age, race, sexual orientation, mental health issues, maturity, trauma exposure, culture, criminal background, resilience, employment skills, home/homeless variables.*
- *[There are challenges with] adaptations for under-represented groups; note that this is an issue with ANY talk therapy.*
- *Complex presentations (comorbid medical and mental health concerns) may pose a challenge to identifying EBPs that provide intervention for specific concerns.*
- *Appropriate to promote this as a best practice, but still a need to acknowledge that narrowly*

defined EBPs do not fit all patients.

- *Institutional rules/expectations do not support EBPs.*
- *Seldom, some clients report not wishing to take EBP approaches due to not feeling they have the time to complete work outside of sessions.*
- *Most evidence based practices are validated with relatively controlled populations. Clients who seek care from community mental health services generally have multiple comorbid health issues along with socioeconomic barriers that make it difficult to a) find EBP for that population or b) implement them effectively.*

Poor communication. A small number of respondents (3%) brought a theme of problematic communication related to EBPs.

- *Providers [have] little word in offering their expertise in the services that show success with the clients they serve…I would value a more open process in the implementation…EBPI appears to [be] the only providers of input to the state.*
- *Little has been shared by the state specific to SUD care.*
- *We are concerned about decisions made about EBPs without specific input from providers as to which practices can be used, how people are trained (accepting only one training pathway for example-being rigid and narrow in guidelines), and how EBPs are documented.*
- *Basically besides funding my biggest concern is the various entities not speaking to each other with muddies the waters.*

Lacking EPBs. A number of respondents (24%) pointing out how there is a lack of evidence for or R/EBPs from which to choose for the populations they treat. More than two thirds of those who indicated they work with children/youth (68%) indicated this, and these respondents were more likely than others to bring up this theme.

- *We would like there to be additional focus on…recognition of promising practices.*
- *This model…leaves little room for Promising Practices…Listed EBPs for SUD care does not match up with CDP certification curriculum specifically MI.*
- *Sessions are not wholly successful because of the R/EBP, and it is limiting to think that the only thing worth paying for is something that meets a belief that it must be on the approved list.*
- *[We have abandoned] prevention, parenting, group support and case-management.*
- *[There are] very few EBPs available for children (especially non-cognitive-based ones).*
- *Positive behavior support and motivational interviewing are both considered EBPs but are not on the WA state list...The list is too restrictive, it needs to include more EBPs. We also see a very large number of consumers who are hard to engage, so that many sessions are not considered EBPs although they could be if motivational interviewing were included on the approved list.*
- *The state has frequently changed EBPs and sometimes becomes too specific.*
- *We have not looked around a lot of R/EBPs because there are not very many that are tested with API immigrants and refugee populations.*
- *I work with children under age 6, and there are not enough R/EBPs available…There are not*

R/EBPs available to address all the client populations that I work with. We have obtained grant funding to train some staff in the incredibly expensive EBP of Child-Parent psychotherapy, but this is only evidence based for some families we work with, and the training lasts 18 months, so with average staff turnover, we may not be able to provide this R/EBP for the long term. We do not have options available to us to provide R/EBPs to the many other clients we serve under age 6 who do not have a condition that warrants CPP or who are not stable enough for CPP.

- *Motivational Interviewing [is not on the list].*
- *Difficult to find adult specific EBPs…There is guidance related to children's EBPs, but minimal for EBPs for adults.*
- *There are few EBPs for SUD residential treatment.*
- *Limited options to select from for EBPs for our documentation.*
- *Clients who seek care from community mental health services generally have multiple comorbid health issues along with socioeconomic barriers that make it difficult to a) find EBP for that population or b) implement them effectively.*
- *The EBP list does not include EBP for other populations we serve such as eating disorders, OCD, etc.*
- *I think R/EBPs are more challenging and more needed on the substance use side of treatment especially with the lower education requirements of staff.*
- *The emphasis in children's services is clear and well supported, unfortunately, this is not true for adults AND adults are far more likely to be served in our systems than children (more individuals, more services).*
- *Only aware of EBPs for Children on MH side; not adult or SUD EBPs that have been approved by the state. (We do them, just not able to report.)*
- *As a medication provider, the evidence base is limited to first line and sometimes second line choices, so the evidence base would need to expand to be able to increase use of evidence based strategies.*
- *The state has clear guidelines for R/EBPs for children. I do not know of any guidelines for adults. The one EBP that is missing is for Bipolar Disorder in adults. I am very concerned with the question.*
- *Services requiring parent participation are not used (PCIT).*
- *State's list of R/EBP needs to be flexible as the evidence changes and expands.*
- *There are far too many excellent therapeutic approaches which are not considered EBPs, EBPs are continually changing, not enough trainings.*
- *In the field of Infant and Early Childhood there are few EBPs due to the relative newness of the field.*
- *Little evidence regarding inpatient treatment, the setting in which I work.*
- *Therapeutic communities - method is still being used, but needs new research… There needs to be more research for SUD treatment that doesn't include medications, but rather behavioral treatment methods such as therapeutic communities and effectiveness of remaining in SUD*

treatment longer for better retention rates.

- *I have seen products (such as Breaking Barriers by Instar) cost upwards of $20K or more. Meanwhile, lesser known products such as Connect Core Concepts in Health (CCCH) only costs about $11.00 per manual with free worksheets. While CCCH is SAMHSA approved and CARF recommended, I had to do a lot of research to uncover it. Perhaps DBHR could provide a list of suggested R/EBP curricula.*
- *Focus has been on MH EBPs, not SUD or COD treatment. I encourage the state to look at SBIRT as part of the MH intake process.*
- *It is my experience working in high schools that a strength-based, person-centered approach to therapy is highly effective. But that does not translate into any EBP label.*

Practices That Might Have Been Abandoned Due to the Emphasis on EBPs

Respondents were asked, "Are there treatment approaches you would have wanted to continue to use but abandoned because they were not R/EBPs? If so, what were they?" Approaches mentioned include the following.

- *Clinical case management*
- *DIR/Floortime approach*
- *Experiential family therapy; family therapy using Gottman values and interventions without having "formal Gottman certification/training" due to expense.*
- *Internal Family Systems, Art Therapy, Sand Tray Therapy*
- *Life management skills workbooks*
- *Motivational Interviewing*
- *Play therapy (Child centered)*
- *Play therapy, ARC model*
- *Prevention, parenting, group support and case-management*
- *Prosocial activities for Adults and youth*
- *Psychodynamic psychotherapy, EFT.*
- *Seven Challenges*
- *Object relations theory*
- *Solution Focused Therapy*
- *Therapeutic communities*
- *Positive behavior support*
- *Art therapy*
- *TF-CBT (Trauma-Focused Cognitive Behavioral Therapy)*

Practices That Would Have Been Interested In Were It Not for Emphasis on EBPs

Respondents were asked, "Are there treatment approaches you would be interested in

implementing but will not do so because they are not R/EBPs? If so, what are they?" Approaches mentioned include the following.

- *Criminal thinking*
- *Cultural practices that focus on beliefs of Native American and Hispanic populations, also more school based services*
- *EMDR (Eye-Movement Desensitization and Reprocessing)*
- *DBT (Dialectical Behavior Therapy)*
- *Humanist approaches*
- *Services that are explicitly shown to be successful with minority groups*
- *Motivational Interviewing*
- *Play therapy (Child centered)*
- *Play therapy, ARC model*
- *Solution Focused Therapy*
- *Texas Christian University's research based modules.*
- *New variants of CBT such as BA, as well as new approaches for working w suicidal youth— CAMS and mentalization.*
- *Any that are tested with API immigrants and refugee populations.*

Conclusions from Survey

In interpreting the results of the survey, it should be noted that comments are often biased towards the negative as those who do not have negative opinions often do not comment.

Nonetheless, overall, there appears to be a high degree of penetration of R/EBPs in use across the state and quite a bit of enthusiasm for R/EBPs. While there were some skeptics, most who commented addressed barriers to adopting R/EBPs that they would like to overcome. Treatment providers do seem frustrated with the limits of the breadth and depth of the evidence base, which limits the number of R/EBPs from which to choose. Some felt strongly that they were aware of effective treatments that were not on the list and/or were disappointed not to be able to use preferred treatment strategies they felt were effective.

Many of the comments were from providers from the children's mental health domain, who have been grappling with reporting requirements. They offered their feedback on their experiences, which in many cases expressed frustration with the level of documentation required. A clear message from the survey is that in many cases treatment providers feel they are not getting enough training and technical assistance to sustain high quality delivery of R/EBPs. Some providers were worried that the resources they currently had for training and technical assistance were being cut back.

Recommendations

Over the past 15+ years, quite a bit of important work has been done to advance the uptake of evidence-based practices in behavioral health treatment across Washington State. In particular, the advanced work done in the children's mental health domain would seem to provide a roadmap for adult mental health and SUD treatment. If providers are to increase and demonstrate their use of R/EBPs they need to know "what counts" as an R/EBP, how to deliver the R/EBP with fidelity, and how to document that they did so. In most cases, this requires ongoing training and technical assistance. Specific recommendations include:

- Consider standardizing procedures and requirements for children's and adults' mental health, substance use disorders, and co-occurring disorders. Providers expressed some confusion why this wasn't the case. This includes providing training guidelines and reporting guides for adult mental health treatment providers and SUD/COD treatment providers.

- Consider establishing an Advisory Board that would meet regularly (e.g. annually) to review and specify "what counts" as R/EBPs. While the definitions established in current laws appear specific on their face, there remains quite a bit of ambiguity in interpretation and application of these definitions. The analysis by WSIPP is informative and important. The analysis by ADAI based on the same laws generated different results. An Advisory Board could weigh the complexities and ambiguities involved in interpreting evidence and conducting systematic reviews.

- Consensus that incorporates stakeholder perspectives should be sought in the creation of inventories of R/EBPs. An expert panel could be used to evaluate R/EBPs wherein the statistical analysis would provide information rather than serve as the ultimate arbiter of whether a practice is research- or evidence-based.

- Consider examination of common elements of empirically supported treatments in determining evidence based practices.

- Consider expanding the definition of evidence-based practices to bring it more in line with the definition of Evidence Based Practice of Psychology (EBPP) according the American Psychological Association. The current definition of EBPs is more aligned with the narrower definition of "empirically supported treatments," and it is a high bar for treatments to meet. Expanding the definition would allow consideration of different kinds of evidence as well as allow for expert consensus.

- Consider regularly eliciting input from stakeholder groups. As it stands, treatment providers in many cases feel EBPs are thrust upon them rather than feeling that they have a say in the EBP selection and implementation process.

- Consider expanding availability of training and especially technical assistance to support fidelity of implementation of EBPs.

- Consider allowing provisional use of promising practices with measurement of outcomes so that programs can demonstrate if their use of promising practices yields sustained improvements that would be comparable to EBPs in terms of effect sizes.

- Increase routine measurement of outcomes and analyze results so that the evidence base can include actual consumers in Washington State rather than solely participants in RCTs whose comparability to Washington consumers may be questionable.

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Appendix A. Research and Evidence Based Practices Survey (R/EBP Survey)

1. Which type(s) of service(s) do you provide? Please check all that apply

- ☐ Mental Health Treatment
- ☐ Substance Use Disorder Treatment
- ☐ Co-housed, providing both MH and SUD under one roof
- ☐ Co-occurring disorder treatment

2. Which of the following describe(s) your role(s) at your program (check all that apply)

- ☐ Administrator
- ☐ Clinical supervision
- ☐ Treatment provider (clinician)
- ☐ Decision-maker/influencer about what R/EBPs we use as a program
- ☐ Decision-maker/influencer about what R/EBPs I use as a treatment-provider
- ☐ Other (please specify)

3. What percentage of the services that you provide would you say are R/EBPs? Please enter a number between 0-100. If you do not personally provide treatment, please estimate the percentage provided by your program/agency.

4. What challenges have you encountered in selecting/identifying R/EBPs?

- ☐ It's not clear what treatments are considered R/EBPs by the state
- ☐ There are too few R/EBPs to choose from
- ☐ Past experience with certain R/EBPs make me not want to use them
- ☐ Identified R/EBPs are not demonstrated effective with the population(s) I work with
- ☐ Other (please specify)

5. What challenges have you encountered in implementing R/EBPs?

- ☐ Training is costly and/or difficult to obtain
- ☐ Staff turnover creates an ongoing need for training new staff
- ☐ Procedures for maintaining/monitoring fidelity are not sufficiently well-specified
- ☐ It is unclear which R/EBP to use with a particular client

- [ ] Other (please specify)

6. Which challenges have you encountered in documenting R/EBPs?

- [ ] There is not enough guidance on documenting R/EBPs
- [ ] We do not have a system in place for documenting R/EBPs
- [ ] Documenting R/EBPs is excessively burdensome
- [ ] Other (please specify)

7. Are there treatment approaches you would have wanted to continue to use but abandoned because they were not R/EBPs? If so, what were they?

8. Are there treatment approaches you would be interested in implementing but will not do so because they are not R/EBPs? If so, what are they?

9. Please rate the extent to which you agree with the following statement: "All things considered, Washington's emphasis on R/EBPs in behavioral health and substance use disorder treatment is beneficial to the residents of Washington."

- ○ Disagree strongly
- ○ Disagree moderately
- ○ Disagree slightly
- ○ Neither agree nor disagree
- ○ Agree slightly
- ○ Agree moderately
- ○ Agree strongly

10. Please share any additional comments on Washington State's emphasis on R/EBPs and how it has affected your work.

Appendix B. Comments from the R/EBP Survey, by question.

What challenges have you encountered in selecting/identifying R/EBPs?

A lot of my person-centered therapy has elements of EBPs, but are not strictly EBPs. For example, building therapeutic alliance, clarifying or paraphrasing, are also elements of other EBPs. For example, although I measure goals with a client, I do not assign them homework as I would as a CBT therapist. Can I fully say that I am using CBT, even if I am only using an element of it?

adaptations for under-represented groups; note that this is an issue with ANY talk therapy

As a medication provider, the evidence base is limited to first line and sometimes second line choices, so the evidence base would need to expand to be able to increase use of evidence based strategies.

Can be costly to pay for training and/or supportive materials.

case management, CBT, MI, all EBPs

Caseload size does not allow for adequate follow up in terms of visit frequency to execute Best Practices properly and consistently

Clinical staff may not have enough training according to the state to be able to use a R/EBP regardless of their education and background.

Complex presentations (comorbid medical and mental health concerns) may pose a challenge to identifying EBPs that provide intervention for specific concerns

Contingency Management is costly and revenue changes frequently although the evidence states it is the most effective with the OUD population

Cost

Cost - including whether the EBP is proprietary

cost and training availability

cost associated with EBP implementation and fidelity

Cost of fidelity programs

cost of training and supervising clinicians is a barrier

cost of training staff is prohibitive, we are a small agency that can't have supervisors trained for every EBP, not many EBPs geared toward children, client/family needs are more complex than

the scope of many EBPs, EBPs are prohibitively rigid, so many EBPs are cognitive based, purveyors of EBPs seem more interested in the existence and use of the models than the well-being of the clients/families, EBPs are usually individual-based not systemic (therefore often inherently racist/oppressive), interns interventions not counting is problematic

Cost of training, implementation, and ongoing support in a context of broad and deep service provision

Cost to train, implementing and maintain

Cost, training and mastery, narrow effective population

Difficult to find adult specific EBPs

EBPs don't work for every consumer. The evidence bears this out. There must be latitude to diverge from EBPs when it's not effective. (Individual results will vary). Further, if we only provide EBPs new best practices will fail to emerge and we have clearly not found all the best practices yet.

Expense and training

Fidelity issues

Finding accessible training and retaining trained staff.

Getting clients to do their part

I am not a clinician so I cannot respond to this other than to say that the information on R/EBPs is readily available to me.

I don't find this particularly challenging and I keep up with the research.

I don't have challenges selecting R/EBPs.

I work with children under age 6, and there are note enough R/EBPs available.

In order for particular practices to become EBPs they have to go through extensive research and in the field of Infant and Early Childhood there are few EBPs due to the relative newness of the field.

inadequate supervision, lack of trained staff

Institutional rules/expectations do not support EBPs

It should never be presumed that clients fit perfectly into boxes. Accordingly, therapy must be organic and meet the unique characteristics of the individual. Sometimes this means blending several R/EBPs together.

Keeping staff trained and retained once they have had EBP trainings is expensive and not easily accessible to ensure every provider has a "proper" EBP training that will be recognized as appropriate for use of EBP Codes in SERI, WA State, and King County.

King County or State frequently chose for us the mandated EBPs rather than we selecting EBPs that fit our clients

Lack of training available in certain R/EBPs

Lack of training.

little evidence regarding inpatient treatment, the setting in which I work

More advanced EBPs training's needed

No way to prove that I have training in EBPs.

None; I adapt for special populations as needed.

Not having enough ongoing training for EBPs

Only aware of EBPs for children on MH side; not adult or SUD EBPs that have been approved by the state. (we do them, just not able to report)

Payers are not reimbursing so we are not providing

Peer support/EBP

prohibitively cumbersome and expensive to prove fidelity with the model

Qualified clinician and sufficient clinical supervisor to oversee the implementation

Seldom, some clients report not wishing to take EBP approaches due to not feeling they have the time to complete work outside of sessions

some clients do not respond to EBP so I choose a different method. Some clients don't want change-just to be listening to.

Some EBPs are proprietary and require investment in training and materials that is not financially feasible for our agency. Ongoing monitoring/supervision for fidelity is challenging. High staff turnover makes it difficult to assure all staff are trained in EBPs appropriately.

Sometimes I use them but in writing notes have difficulty recalling specific terms to indicate use

Sometimes you have to just go with the flow of the client and think outside the box

Staff turnover and having to retrain new staff is time consuming

State's list of R/EBP needs to be flexible as the evidence changes and expands

The EBP list does not include EBP for other populations we serve such as eating disorders, OCD, etc.

The EBPs approved by the state don't address all of the needs we see with our population.

The training demands. Many clinicians are not adequately prepared to deliver

There are few EBPs for SUD residential treatment.

There are not enough EBPs that are clinically appropriate for young children

There is no space for creativity in service with populations that sometimes demand flexibility in their treatment plans.

Too costly to train staff

Training for clinicians is expensive, timely, and hard to come by

training requirements for providers of EBPs and lack of training provided in schools

Use Hazelton and other CBT but not among all staff or all services provided across 24 hour treatment

Usually the cost to maintain fidelity is a challenge. The state has clear guidelines for R/EBPs for children. I do not know of any guidelines for adults. The one EBP that is missing is for Bipolar Disorder in adults. I am very concerned with the question. We have been very successful in selecting and implementing R/EBPs.

Vendors are difficult to deal with.

We find that we need to be very eclectic and flexible in our approaches. Not a one size fits all proposition

we have identified our high priority EBPs and have reasonable success rate at implementing/sustaining. the biggest challenges are cost of training and ongoing supervision by providers with sufficient expertise

When an EBP is deemed that in a larger city and then administered in a rural area

While the EBPs recognized by the state do have research to back them there appears to be a clear bias towards recognizing CBT type EBPs . The process the state and the U of W has been engaged in has not been transparent in the implementation of EBPs by providers. While instituting mandates there has been no funding for the costs associated with training, infrastructure, staff turnover. There has also been a blind eye turned towards the use of promising practices that appear effective nor for "relationally based" practices that have

evidence to support them. The "partnership" is clearly between the U of W and the state with providers having little word in offering their expertise in the services that show success with the clients they serve.

Youth and families often have very different and specific needs which are not adequately addressed by purely EBPs. Similarly, individuals with learning disabilities, many housing or other case management barriers, low literacy or education levels, etc. are often not able to engage in the strict EBP fidelity models

What challenges have you encountered in implementing R/EBPs?

(1) Insufficient funding or problematically organized funding for EBPs and (2) demand for access to care is taking up all the resources that is limiting ability to improve quantity and quality of care

Lack of funding for clinical supervision but most EBPs requires on-going clinical supervision to ensure fidelity and QA.

Agency does not provide EBP funding or free training. We get paid very little so going to private trainings is very costly.

Caseload size is too large to provide the frequency of treatment contacts to implement Best practices consistently and according to fidelity

Clients with long history of treatment often report previous negative experiences with identified/identifiable (i.e. name brand or "programs") R/EBPs.

confusion between king county and the EBP institute at UW on what 'counts'. I don't feel our county understands what data to collect and is doing a poor job of disseminating information

degree programs (esp. Masters level programs) do not provide training in EBPs generally, which they should, and come to us poorly equipped to provide community behavioral health treatment. We have to train all of our staff after they get here

Difficulty having the time to adequately research different EBPs and identify for our populations.

Documenting EBPs is also an issue in our current EHR, so it's difficult to capture them. The state has frequently changed EBPs and sometimes becomes too specific. There is often resistance from staff, particularly older, more experienced clinicians. It's difficult to meet fidelity guidelines in rural clinics.

Engagement is huge with our population and we often need multiple visits before any manualized EBP can begin. That engagement time is often rich with effective treatment but is not considered valid time under the EBP structure from the state.

Ensuring continued fidelity.

Few approaches for short stay residential treatment

Fidelity is designated for too narrow of populations and are not culturally appropriate

fidelity is overly onerous & limits flexibility

High caseloads limit clinician availability to deliver EBP, time devoted by the agency to the implementation process, perception that attending a workshop is sufficient to implement an EBP, insufficient resources and structural supports given to support implementation

I have noted anecdotes that staff turnover is high and some trainers from out of state are not supporting EBPs, especially when it comes to the need for MAT.

I'm not sure how 'trained' I need to be to say that I am using one. Is one training enough?

Interns

It is not possible to conduct EBPs close to fidelity in a community mental health setting. Training and the follow-up to maintain one's eligibility to call themselves "trained" is not only financially costly but takes time away from families.

Little has been shared by the state specific to SUD care.

More monies for training to gain skills using R/EBPs like EMDR would be great!

Most of the EBPs are not tested with Asian Pacific Islander immigrants and refugee population in mind, thus it is not culturally tailored for our target population.

Mostly group work from on EBP that the clients do not like, they find boring and many times the curriculum does not reflect the group at all so they are SUPER bored.

Procedures for measuring fidelity are cumbersome

R/EBP work for targeted populations and people outside those populations are left out.

R/EBPs are tested in research subjects that do not represent the full scope of patients undergoing care. As a result, the patient populations I see are not good candidates for R/EBPs. R/EBPs also include elements (case management, flexible appointment times, after-hours phone consultation, care coordination with other clinicians, care coordination with friends/family members) that do not generate revenue and are therefore not practical to implement in productivity-driven clinical settings.

See #4 other

services requiring parent participation are not used (PCIT)

Some of these EBPs which are effective have high training and on-going costs

Staff buy-in and willingness to learn new EBPs

The EBP expectation is an unfunded mandate and hard to implement in community mental health without allocating resources.

The expectation from administrators that a workshop is enough. It's not!!!

time constraints

Time needed to illicit desired outcomes does not fall within approved treatment terms

time to maintain/monitor fidelity

We are committed to providing best services to our clients. The continuation of unfunded mandates undermines providers ability to be able to implement and provide EBPs being mindful of the budgets we must live within.

We have address this problem by implementing a committee that oversees each R/EBP to ensure we are maintaining fidelity. We have assigned one staff member as an internal consultant. If you want to know more contact me. [Name, phone number]

What challenges have you encountered in documenting R/EBPs?

Due to WA State legislation, children's mental health providers are required to document EBPs. It is burdensome and takes extra time for staff to do so and this is unfunded mandate that is not fair for the service providers(clinicians, Supervisors, and IT) who already have high load of work.

1. Terms that are required to be included in documentation are not consumer-friendly; and 2., Not all components of EBP and not all focus of sessions can be just EBP manualized content

Clarity on what to document certain types of the service as

Collaborative documentation can create challenges is adding in EBP specific language that is client friendly/understandable.

Ensuring clinician reports the exact clinical element, not a vague description.

Ensuring that screening measures are incorporated into the EHR.

especially re medication use

expectations are unclear or do not take into consideration the context within which clinicians are working and documenting

Federal and State requirements are already so big of a burden that adding more time consuming specialized documentation is difficult to dictate to staff and also take time away from face to face work and other required documentation

I don't know if I am documenting correctly or not but one thing for sure and you'll get this from all CDP people, TOO MUCH DOCUMENTATION, you hire advanced degree professionals and then do not trust us to do our job correctly so there are far too many measures and far too many mandatory types of notes to write, evidence should show more work with the clients and more time to plan groups that are fun and meaningful would help tremendously. I have about 10 minutes prior to group to plan my group or I have to work overtime for free to find interesting ways to present the material.

Identifying elements of R/EBPs rather than entire protocols or programs is unclear.

inconsistent guidelines and imposed guidelines that do not take into account the reality of providing services to different populations

It is not excessively burdensome but is yet another unfunded requirement.

It is TIME CONSUMING, and it doesn't really effect my modality with a client. It lengthens my session notes, which my agency wants to be collaborative with the client-- so I end up having a lot of work to do outside of meeting with them, which is stressful.

it was an unfunded mandate. It took us several thousand dollars and a lot of labor to update our EHR to reflect EBP usage

Knowing how specific in EBP-language, when we need to be documenting client voice & choice. Often these things do not go hand in hand, and all the meanwhile to use layperson language as well

limited options to select from for EBPs for our documentation

lots of administrative work involved and not enough funding to cover for the time spend.

Many EBPs have different requirements

Meeting all the requirements , add to more time and take away from other clinical focus

No problem. Our Agency has a documentation process in place. We survey each group member (pen/paper) at the end of each group session to find out what they got out of the session. We use their written words in our documentation process. It's called a "Group Feedback Form".

Not enough time is allocated

setting up EHR to utilize outcomes measures in easy to use way

some providers do not yet have EMR's systems to allow for easy use and documentation of EBPs,

The computer program currently being used.

There is guidance related to children's EBPs, but minimal for EBPs for adults.

We do not have a challenge with documenting in the case note. The problem is with having a system that can track the outcome scores and having quick access to the score and comparing them over time. There is a software program called MIRAH that solves this problem, but the cost is pretty steep.

We have a great documentation system but now there are additional documentation requirements

We have a system partially in place for documenting EBPs. (To program a new EBP into our EHR takes time and we are one program in a much larger system with many demands on the programmers.) More importantly, our staff are NOT comfortable documenting EBPs because their knowledge of what counts as evidence-based practice runs contrary to how they are being directed to report. EBP protocols are insular which is so far from the reality of our community-based work. Staff have questions about how ethical it is to report pieces of EBPs outside of the EBP-specified best-practice environment.

we have developed templates for documenting EBPS

Without clear incentives, the need to document EBPs has not been high enough to gain compliance in my agency. (it is not a program in my EBP based program)

Are there treatment approaches you would have wanted to continue to use but abandoned because they were not R/EBPs? If so, what were they?

Clinical case management

DIR/Floortime approach

Experiential family therapy; family therapy using Gottman values and interventions without having "formal Gottman certification/training" due to expense.

Internal Family Systems, Art Therapy, Sand Tray Therapy

Life management skills workbooks

Motivational Interviewing

Motivational Interviewing

No but need to remain open to ongoing treatment development research to continue to inform

practice.

No- I had therapists wanting us to 'count' several expensive EBPs that I didn't feel we could sustain financially as an agency or treat to fidelity.

No. We have continued to use R/EBPs that have been identified through training and research even if they are not identified or recognized by the state.

nope. I still use Rogerian, (person-centered) therapy.

Play Therapy (Child Centered)

Play therapy, ARC model

Prevention, parenting, group support and case-management

Prosocial activities for Adults and youth

Psychodynamic psychotherapy is not listed. Nor is eft.

Seven Challenges Program has been used and approved by the county and federally but it's not considered to be EBP by the state. We got positive feedback from the clients and would like to continue to use the program.

Seven challenges, object relations theory.

Solution Focused Therapy

Solution Focused, Motivation Interviewing

Therapeutic communities - method is still being used, but needs new research.

Therapeutic community for non-correctional patients.

Unsure - there are varied interventions we use - but not sure if they are considered EBPS or not

We continue to provide services and treatments that are effective with our consumer population regardless of being on the U of WA list. Positive behavior support and motivational interviewing are both considered EBPs but are not on the WA state list.

We utilize a mix of evidence-based and evidence-informed practices as well as case management/social work practices. Some of our work has been designated as "reportable" as an EBP and some has not. We would not abandon our art and play therapy practices (by clinicians with the education and specialized training to call themselves art therapists or play therapists) because that is supremely effective with much of our young population. Similarly, we use motivational interviewing and CBT principals but those are not recognized under the EBP reporting requirements. Many of us had the TF-CBT training some years ago but that is no

longer recognized.

We would like there to be additional focus on practices that recognize the value of the relationship in the therapeutic process , practices that are shown to be effective with the specific populations groups we work with, recognition of promising practices .

Are there treatment approaches you would be interested in implementing but will not do so because they are not R/EBPs? If so, what are they?

Criminal thinking

Cultural practices that focus on belief of Native American and Hispanic pop, also more school based services

EMDR

EMDR, DBT

I allow my clinical judgement and experience to guide my treatment.

I find compassion focused treatment and mindfulness blend nicely with CBT

I was taught to document them such that they could not be identified but still met overlap characteristics of EBPs

I would be interested to see if tapering for those with OUD would be presented as more of a viable option. I would NOT be a supporter of an abstinence approach to OUD

I would like for humanist approaches had more evidence behind them. As it is, those approaches are only suitable to run in the background.

I would like to see more promotion of services that are explicitly shown to be successful with the minority groups that we serve. Would like to see the EBPI steer dollars towards research that is not primarily based on the majority white population, because often that is not who the providers are necessarily serving.

If we are able to find an R/EBP that is both appropriate for and acceptable to a given client, we pursue that.

innovative approaches

Motivational Interviewing

Not so much treatment approaches as attitudes. Maintaining a relationship with the client is more important than solely providing interventions. If you have the relationship you have opportunities to make interventions as opportunities arise.

Play Therapy (Child Centered)

Play therapy, ARC model

See above

Solution Focused Therapy

Texas Christian University's research based modules.

We are exploring new variants of CBT such as BA, as well as new approaches for working w suicidal youth— CAMS and mentalization.

We have not looked around a lot of R/EBPs because there are not very many that are tested with API immigrants and refugee populations.

We will continue to choose approaches based on what works at our site whether they have been designated as an EBP or not. We would like to see approaches we have found effective such as motivational interviewing with adults/adolescents, art and play therapies with younger children, recognized as valuable.

Please share any additional comments on Washington State's emphasis on R/EBPs and how it has affected your work.

Appropriate to promote this as a best practice, but still a need to acknowledge that narrowly defined EBPs do not fit all patients.

At times they help but there are other things that work as well.

Becoming hyper-focused stifles innovation. There is also a lack of acknowledgement that what works in clinical settings with carefully selected participants is not always as effective with clients with multiple problems. The real world is very different than the sterilized clinical settings of most trials.

Being able to have access to doctors and ARNP's who prescribe Suboxone has been of great benefit. Some primary care doctors are not educated enough regarding use of Naltrexone for alcoholism. They insist that there be a level of none use prior to starting...this often is impossible and causes clients to not trust primary care even more.

Call me if you want the input of an organization that began adopting R/RBPs in 2008 and now have 17 total R/EBPs. We can see the benefits of the R/EBPs. I been in the field for 29 yrs and practices as a direct service provider for 22 of those years. I wish R/EBPs were available to promoted when I first began practicing in the late 1980s.

Difficult to apply EBPs to short stay residential SUD treatment for non-homogeneous patient population that varies by drug of choice, age, race, sexual orientation, mental health issues, maturity, trauma exposure, culture, criminal background, resilience, employment skills,

home/homeless variables.

EBPs are great however with a dynamic population with changing drug usage, with age differences, with ethnic and race differences the EBPs do not fit all people. I always wonder that if we can only use EBP then how are new ideas and treatments supposed to emerge? No offense but they are not going to come from the lab! (unless its medical / medicine interventions)

EBPs are limiting in the scope of practice

EBPs are very often based on dominant culture research/psychology and practice and so they are responsive to only this population and this practice then institutionalizes those disparities. EBPs also further privilege and power disparities as they are costly and can be maintained more easily by those with wealth and privilege. This model leaves less room for innovation and the creation of culturally responsive engagement. It leaves little room for Promising Practices as well. Listed EBPs for SUD care does not match up with CDP certification curriculum specifically MI.

EBPs would be more beneficial if they looked more into the social/economical and geographical setting to which they served. I have worked in 2 separate EBP that had significant flaws in serving children in a rural area. Not that the EBP wasn't beneficial, but it needed some room for flexibility due to the rural area it was serving.

Focus has been on MH EBPs, not SUD or COD treatment. I encourage the state to look at SBIRT as part of the MH intake process.

I believe in EBP and am highly trained and certified. I think that it is essential that treatment practices be proven effective and used skillfully.

I believe it makes clinicians and companies more accountable. Clinicians have to be specific in documentation, companies need to invest in training in R/EBPs.

I don't believe that the state is providing EBPs as there is the false belief that attending a training will make one an expert. Most agencies do not record sessions for fidelity or observe sessions to know to be able to judge how adherent staff are to the treatment that they are supposed to be providing. Agencies think that they are providing EBP without all of the elements that are needed to be truly adherent,

I find that it can often get in the way, and sometimes use modalities they may not fit the client but can check the EBP box.

I have always believed in R/EBPs because they can apply to a variety of clients, and the more training I have in them, the better I can apply the most effective ones to the population I serve.

I have not done much documenting on EBPs that I have used to have an opinion on it yet

I ONLY do EBPs. I think it's critical that the state emphasizes them

I strongly believe in EBP. However, our agency does not provide the support to obtain EBP for everyone. Some people are chosen to receive this training and others are not. It doesn't make sense. All staff should have access

I think if the Washington State legislature really cares about EBPs for children then they need to increase reimbursement rates for child providers to promote appropriate training and use of EBPs. Without allocating resources, the expectation is not viable.

I think it is hard to implement EBPs to the letter of the manual because each individual is unique and responds in different ways and in different time frames.

I think R/EBPs are more challenging and more needed on the substance use side of treatment especially with the lower education requirements of staff.

I think we do have to be careful about imposing EBPs on clients and ensuring that those used are a good fit and culturally relevant to the individual/family.

I work with a specific population, those with multiple issues and they do not easily fit into these models. These models are still effective for a large portion of the population seeking help though.

I would like to see support for specific programs like DBT receive the same level of funding and support as crisis services, clubhouse.

I would value a more open process in the implementation. The current process has the appearance of impropriety in that the U of W EBPI appears to have a monopoly in which they are the only providers of input to the state and also gain monetarily from the relationship.

If there were more/more affordable trainings it would be so much easier!

I'm concerned that DBHR is reducing funding for CBT+. CBT+ has been the most cost effective way to get many new therapists trained in an EBP for a variety of targets. The low cost ($150 per person) make it financially feasible and the advanced trainings have been great. If DBHR underfunds the initiative the agencies will have to pay more and might not be able to send as many people which will decrease EBP percentages across the county. It's also unclear to me who 'counts' as an in-house trainer. We have a staff member we invested a lot of time and money in to help them complete an advanced DBT training and they do the in-house training and ongoing consultation group to fidelity (or as close as we can get in community mental health). If I can't 'count' her training then my EBP percentage will drop for anyone reporting DBT as their EBP. One more thing- King county accepts 'CBT+' as an EBP category but I've heard that we should be using 'CBT for depressed adolescents' or 'CBT for anxious children' or the behavior management one. So I'm concerned that so many organizations are reporting out CBT+ and maybe that's just junk data at the state level? Lastly- King County allows an 'other CBT' EBP category that I've also heard isn't allowed at the state level? Basically besides funding

my biggest concern is the various entities not speaking to each other with muddies the waters.

I'm confused as to the purpose of this emphasis and the inflexibility of the implementation. Our agency provides effective treatment that includes many elements of EBPs, but fidelity to EBPs is cost prohibitive and counter-productive. It is evident that those who push implementation have little to no experience working with the populations we serve. Forcing families to fit models rather than fitting models to families is unethical and disrespectful. With the very few EBPs available for children (especially non-cognitive-based ones) has this impact.

I'm still an associate so I need more experience to really comment on this.

Implementing EBPs is a complex process that requires a lot of time and resources to do effectively, and can be negatively impacted by competing initiatives, both from within and outside agencies. Agencies need support to do this work. It is really important for patient care and I have observed benefit of EBPs among our patients. Additionally, any effort to create a learning healthcare system that continues to improve upon EBPs and how they can be utilized most effectively within our agencies and with our patients is needed.

Improved treatment options/strategies in addressing client concerns, structure/guidance, theories/practices that are proven to be effective

In regard to question #9, I think a focus on EBPs is a good thing as I believe clients deserve treatment that is shown to be effective. However, having the state put such requirements on it has made the implementation feel sterile and more about checking boxes than the actual treatment. Additionally, requirements for training are burdensome (as noted in previous questions as well).

it gives me a good focus

It is critical that we adhere to R/EBPs. They are fundamental to our work.

It is generally a good thing for collaborating care. It is only a problem when collecting evidence (e.g. writing a note) causes clinicians to miss things about the client in the moment.

It is my experience working in high schools that a strength-based, person-centered approach to therapy is highly effective. But that does not translate into any EBP label.

It seems meaningless to be mandated to use EBPs because there is not enough evidence that they work with Asian Pacific Islander immigrants and refugee population. Our knowledge and experience tell us that our clinicians cultural and language expertise, their ability to engage with clients work much better than EBPs. However, I must say there are useful and effective EBPs such as various kinds of CBT, and my clinicians are finding components of CBT are useful.

It’s not clear which R/EBPs Washington endorses.

Many EBPs are psychotherapies. These are often designed to be conducted as weekly

appointments for something like 6, 12, 20, or 50 weeks - depending on the treatment. They also rely on the therapist and client predictably knowing when they will meet again so they can plan for practice between sessions and keep focus and momentum on treatment targets. Medicaid and other system's (e.g. Kaiser) focus on access to care has resulted in difficulty making weekly commitments to clients across a long enough period to complete a therapy. Medicaid tiers mean that services are funded at a low dollar figure over a long period (one year). The rate/month is insufficient to cover the costs of weekly therapy and maintaining the person for the rest of the year in order to be paid enough to make the 3-4 months of therapy cost-effective is hard to justify ethically and clinically when the client has improved sufficiently to be discharged.

Most evidence based practices are validated with relatively controlled populations. Clients who seek care from community mental health services generally have multiple comorbid health issues along with socioeconomic barriers that make it difficult to a) find EBP for that population or b) implement them effectively.

My only concern is that some clinicians use a personalized version of a curriculum or batch of curricula. These versions tend to incorporate personalized tools the clinician may have developed themselves based on their own experience or based on the population they serve. Requiring R/EBP eliminates a clinician or agency's ability to continue using a personalized curriculum (my understanding). Nevertheless, I know funding sources want to pay for clients to be engaged in some kind of fidelity based curriculum and I understand why. Ethically, the clinician and agency should be promoting proven tools. Also, requiring agencies to use R/EBP curriculum positions agencies to purchase established products. No longer can they develop a program internally. Cost might be less of a factor for large agencies, however, it can be crippling for smaller agencies. I have seen products (such as Breaking Barriers by Instar) cost upwards of $20K or more. Meanwhile, lesser known products such as Connect Core Concepts in Health (CCCH) only costs about $11.00 per manual with free worksheets. While CCCH is SAMHSA approved and CARF recommended, I had to do a lot of research to uncover it. Perhaps DBHR could provide a list of suggested R/EBP curricula. I am a manager at Therapeutic Health Services, one of the largest nonprofit providers in King County. I am just at the tail end of working on a project to identify and institute a R/EBP curriculum at my agency. Ironically, your survey speaks to the process I have been navigating over the last couple months. I would be more than happy to share the details of my process with you. Thank you, [Name, email]

need better training on this.

NEED MORE COST EFFECTIVE TRAINING OPORTUNITIES!

Need more funding to ensure that staff are adequately trained and that R/EBPs can be followed to fidelity.

Not enough training and ongoing support. Unrealistic agency expectations-- e.g. high caseloads, reinforcement of unhelpful bxs (e.g. always rescheduling a client who no-shows or late-cancels) get in the way

Our staff want to provide evidenced based treatment but accessing affordable training, etc. can be difficult in community mental health settings.

Overall the movement is positive and we have been committed to training clinicians in CBT and DBT. We are concerned about decisions made about EBP without specific input from providers as to which practices can be used, how people are trained (accepting only one training pathway for example-being rigid and narrow in guidelines), and how EBP' are documented

Providing R/EBP has been beneficial for my agency

Put the money where the mouth is. Mental health is and has been on a starvation diet the past 15 years. Clients suffer from staff shortages and staff suffers from poor pay and data entry expectations with no clerical support and decreased job satisfaction.

R/EBPs allow for structure and simple measures to review performance standards of staff and patients.

R/EBPs include elements of counseling and coordination of care that do not align with current payment, regulatory and legal systems that drive health care delivery systems. Therefore, emphasizing the need to implement R/EBPs without addressing the contingencies (payment, regulatory, legal systems) does not advance the quality of care.

Since I don't work with the patients, I am unsure if this is going to help

Some staff prefer to lecture on their own material, which in general I don't like, so it eliminates their ability to do that.

Sometimes they make it difficult to reach a client or you have to switch approaches which creates non-fidelity

State needs to invest way more in this effort than it does

The best place for students/interns to learn EBPs is during internships at CBHC agencies. However CBHC's need funding and involvement from local experts/trainers (e.g. University of Washington, Behavioral Tech) to create successful programs. we have created a very successful CBT for Psychosis program, but only because UW had a grant to train a few community providers, worked with us over a 3 year period, and trained up internal trainers within our agency to continue providing ongoing trainings/supervision now that UW involvement is ending

The conditions for EBP implementation in research is very different than those for an agency implementing outside of the research arena. It is much more difficult to implement EBPs with fidelity in the real world.

The cumbersome training requirements for EBPs has cost us money and time. With the huge staff turnover, clients cannot be seen quickly.

the disconnect between the intention of the emphasis, and how it has played out in reality has been very distressing

The emphasis in children's services is clear and well supported, unfortunately, this is not true for adults AND adults are far more likely to be served in our systems than children (more individuals, more services)

The emphasis on EBPs has NOT improved our level of client-care yet has cost money and time. It's a huge frustration and must be re-thought.

The failure to address varied ethnic and culturally diverse populations and those with SMI and personality challenges make EBPs inappropriate for many of the clients we serve. Additionally the cost and ongoing training needed to implement EBPs in the current environment of high turnover and low reimbursement rates make them ineffectual

the lack of funding to ensure ongoing training and supervision to fidelity is a huge problem. Staff are trained, but often drift away from EBP without specific fidelity supervision.

The list is too restrictive, it needs to include more EBPs. We also see a very large number of consumers who are hard to engage, so that many sessions are not considered EBPs although they could be if motivational interviewing were included on the approved list. A general criticism of EBPs is they are often too focused on one problem when the complexity of the family situation makes it very hard to focus just on one problem. Having more flexibility around documentation and content of EBP visits would help address that.

The mandate that all services being delivered to all children in the Medicaid system must be R/EBPs is limiting to sessions and the training each clinician comes to their careers with. Often, therapists feel their creativity and humanistic values are discarded because there is a belief that these interventions are not valid unless they are coded as an R/EBP; which is not the be-all-end-all for every case. Several children and families gain many skills from several R/EBP components - however, these sessions are not wholly successful because of the R/EBP, and it is limiting to think that the only thing 'worth' paying for is something that meets a belief that it must be on the 'approved' list. It is important to have EBPs as a foundation, and it is not the only thing that helps influence a child to get better. Attunement to the child's' needs and the family's needs is actually one of the most critical factor for a child to experience improvement. Attunement is not an element of an R/EBP. It is simply one component that helps facilitate the child's response to therapeutic techniques and interventions. Relationship is another facet of therapy that helps it be successful for many children. This is not an R/EBP either. My final point is that R/EBPs are important and helpful for so many clinicians and families - however, to expect that every clinician is trained and delivers on the expectation that an R/EBP is followed to its core intent is something that is a way to reduce how clinicians can use both the science and the art of therapy to address the needs of children in our mental health system. The children we serve are not the typical children whom are studied in these research projects that endorse or deny R/EBPs. Expecting that R/EBPs are delivered without fail at nearly ever session with every child is one that does not take into account how a poorly funded system can support such an

expensive bar.

The need for post workshop consultation is essential in increasing uptake of EBPs

The process has been disruptive / unclear at times. I agree with the goal of EBPs, but the identification of what is an EBP is not transparent, and lots of changes have made it hard to keep up with the process.

The process of all things having to be obtained through UW and pay UW for them is not serving our State BH clients well.

The State has not given sufficient dollars for implementation or training and direction for establishing R/EBPs and their documentation.

There are far too many excellent therapeutic approaches which are not considered EBPs, EBPs are continually changing, not enough trainings.

There are not R/EBPs available to address all the client populations that I work with. We have obtained grant funding to train some staff in the incredibly expensive EBP of Child-Parent psychotherapy, but this is only evidence based for some families we work with, and the training lasts 18 months, so with average staff turnover, we may not be able to provide this R/EBP for the long term. We do not have options available to us to provide R/EBPs to the many other clients we serve under age 6 who do not have a condition that warrants CPP or who are not stable enough for CPP.

There are so many and varied approaches and clinical interventions - hard to keep up with what are considered EBPs and the extent to required training needed to be considered "trained" ..DBT is a good example - years ago you were required to do extensive weeks long training to be approved to do DBT- now a two day staff training is allowed for some DBT ..such as DBT groups.

There needs to be more research for SUD treatment that doesn't include medications, but rather behavioral treatment methods such as therapeutic communities and effectiveness of remaining in SUD treatment longer for better retention rates.

To the extent that the focus on R/EBPs increases appropriate treatment for clients it is good. However, due to the limits of research dollars, the influence of for profit ventures (name branded R/EBPs), and the continued gap between academia and the lived world of clients, R/EBPs sometimes have too narrow a focus and seem subject to special interests that may not have the best care for clients as the primary focus. But this may be part of the balancing between a population centered approach and a client centered one.

Too much documentation/training

We are advocates for utilizing R/EBP curriculum, we believe it increases efficacy.

We are very much in favor of and support the use of EBPs at our agency. But staff turnover is

the primary barrier - we have to offer multiple trainings per year, and have had to select a handful of core EBPs to focus on. In addition, keeping everyone focused on it requires diligent effort by supervisors to ensure continued practice of the EBP after training.

We have try a variety of EBP (MST, FFT, PPT and Wraparound models) that we have not been able to maintain due to cost, lack of referral/coverage , staff turnover and keep family engaged.

We've been able to implement an EBP that has the evidence to show that it works. Unfortunately, within our community, no other providers believe it is appropriate (contingency management is seen as paying clients to do well). If a client needs more intensive SUD services that we cannot provide, we can refer client to another facility, but the client will not be able to engage in contingency management elsewhere.

With supported training like (CBT+) it has been successful.