# SENATE BILL REPORT
# E2SHB 2536

As of February 27, 2012

**Title**: An act relating to the use of evidence-based practices for the delivery of services to children and juveniles.

**Brief Description**: Concerning the use of evidence-based practices for the delivery of services to children and juveniles.

**Sponsors**: House Committee on Ways & Means (originally sponsored by Representatives Dickerson, Johnson, Goodman, Hinkle, Kretz, Pettigrew, Warnick, Cody, Harris, Kenney, Kagi, Darneille, Orwall, Condotta, Ladenburg, Appleton, Jinkins and Maxwell).

**Brief History:** Passed House: 2/13/12, 97-1.
**Committee Activity**: Human Services & Corrections: 2/21/12, 2/23/12 [DPA-WM, w/oRec].
Ways & Means: 2/27/12.

## SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

**Majority Report**: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Hargrove, Chair; Regala, Vice Chair; Stevens, Ranking Minority Member; Carrell and McAuliffe.

**Minority Report**: That it be referred without recommendation.
Signed by Senators Harper and Padden.

**Staff**: Jennifer Strus (786-7316)

## SENATE COMMITTEE ON WAYS & MEANS

**Staff**: Tim Yowell (786-7435)

**Background**: Evidence-based practices are generally defined as those programs or policies that are supported by a rigorous outcome evaluation clearly demonstrating effectiveness. Since the mid-1990s, the Washington State Institute for Public Policy (WSIPP), has undertaken comprehensive reviews of evidence-based programs. It has examined programs and policies in the juvenile and adult criminal justice arenas, as well as in other public policy

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*This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.*

areas, including early childhood education, child welfare, children's and adult mental health, and substance abuse.

A research-base practice has some research demonstrating effectiveness, but it does not yet meet the standard of an evidence-based practice. A promising practice or emerging best practice does not meet evidence-based standards but presents potential for becoming a research-based practice.

In 2007 the Legislature established the University of Washington Evidence Based Practice Institute (EBPI) which collaborates with WSIPP and other entities to improve the implementation of evidence-based and research-based practices by providing training and consultation to mental health providers and agencies that serve the needs of children. The EBPI also provides oversight of the implementation of evidence-based practices to ensure fidelity to program models.

**Summary of Bill**: The Juvenile Rehabilitation Administration (JRA), the Children's Administration (CA), and agencies that administer children's mental health services funds must expend state funds on programs and services that are evidence-based or outcome based, as identified by WSIPP and a university-based evidence-based entity in Washington. The Department of Social and Health Services (DSHS) must work to identify and contract for evidence-based and outcome-based practices that are effective for ethnically diverse clients and must consult with tribal governments and experts in ethnically diverse communities and community organizations that serve those communities. CA may also expend funds on research-based practices. The requirements for these expenditures are imposed incrementally.

Under this act, an evidence-based program or practice is defined as one that is cost-effective and includes at least two randomized or statistically controlled evaluations that have demonstrated improved outcomes for the intended population. Preventive and treatment services are defined as services and programs for children and youth and their families that are specifically directed to address behaviors that have resulted or may result in truancy, abuse or neglect, out-of-home placements, chemical dependency, substance abuse, delinquency, aggression, family dysfunction recidivism, sexual aggressiveness, or mental or emotional disorders. An outcome-based program is a program or practice that is cost-effective and has been assessed as demonstrating effectiveness in improving outcomes for its intended population.

In consultation with EBPI, JRA and the agencies that provide children's health must initiate or continue their review of sound promising and research-based practices with the goal of identifying and expanding the number of evidence-based and outcome-based practices that are cost-beneficial and effective. CA must initiate or continue their review of sound promising and research-based practices in consultation with a university-based evidence-based entity in Washington.

DSHS must use existing data reporting systems and quality management processes at the state and local level toward implementing provisions of the bill. It must also identify components of evidence-based and outcome-based practices for which federal matching funds might be claimed and seek such matching funds to support implementation of evidence-based or outcome-based practices.

DSHS must designate a lead agency to coordinate training for the delivery of services by agencies in the juvenile justice system and those agencies that provide children's mental health services. Training for the child welfare workforce must be delivered through the Alliance for Workforce Excellence at the University of Washington, School of Social Work in accordance with an existing agreement as funds are available and in a manner that optimizes federal reimbursement.

DSHS must redirect existing funding resources to coordinate the purchase of evidence-based and outcome-based services. It is not required to redirect funds in a way that conflicts with federal requirements or that reduces federal financial participation.

Use of Funds. For JRA and agencies that provide children's mental health services, the determination of the amount of funds expended on evidence-based or outcome-based programs includes program costs necessary to directly implement evidence-based or outcome-based programs, including discrete staffing and training costs which would not have been incurred but for the implementation of an evidence-based or outcome-based program. Funds expended for indirect administrative costs may not be included. CA may include funds expended on both research-based and evidence-based practices in their determination of amounts expended.

The graduated implementation requirements under the bill apply only to treatment or service needs for which evidence-based, research-based, or outcome-based practices have been identified. Where it is unable to meet requirements of this act, DSHS must report to the Legislature regarding its efforts and plans to achieve compliance.

Juvenile Rehabilitation Administration. The percentage of funds expended on evidence-based or outcome-based programs that reduce criminal recidivism of the participants must be:

- no less than 60 percent in fiscal years 2014 and 2015;
- no less than 65 percent in fiscal years 2016 and 2017; and
- no less than 75 percent in fiscal years 2018 and 2019.

DSHS must prioritize spending on prevention and treatment services to juvenile offenders in a manner that maximizes cost benefit to the state.

Children's Mental Health Services. DSHS must meet the requirements under this bill to the extent that the requirements do not conflict with any obligation DSHS has under a court order or a court-approved agreement.

By June 30, 2013, DSHS must establish a baseline of evidence-based or outcome-based practice usage within the managed mental health program. During the 2013-2015 biennium, at least 25 percent of the encounters delivered to children must be evidence-based or outcome-based practices. That percentage must be increased by 15 percent for each subsequent biennium until 75 percent of the encounters are for evidence-based or outcome-based services. DSHS must establish a descriptive baseline of evidence-based or outcome-based service utilization for children's mental health services by July 1, 2012, and a quantitative baseline by June 30, 2013. It must implement changes in contracts, information

systems, and data reporting instructions for consistent implementation of client level reporting of participation in evidence-based and promising practices and outcome-based practices by October 1, 2012.

By July 1, 2012, DSHS must seek federal technical assistance regarding the Medicaid financing of evidence-based or outcome-based practices. It must match evidence-based or outcome-based practices to the Medicaid mental health state plan and provide guidance to begin implementation of encounter reporting of evidence-based or outcome-based practices within existing resources. This must be completed by October 1, 2012.

Over a five-year period, ending in June 2019, DSHS must, subject to the appropriation of funds to support it, implement a standardized assessment tool that will direct children toward available evidence-based or outcome-based practices as appropriate. Subject to available funds, DSHS must also initiate statewide workforce development for at least one additional evidence-based or outcome-based practice within a two-year period, and reinforce standardized implementation of evidence-based and outcome-based practices for which training and workforce development has already occurred but which are not yet fully implemented statewide. DSHS must place language in prepaid inpatient health plans contracts requiring implementation of evidence-based and outcome-based practices for which workforce development is provided.

Children's Administration. CA must meet the following requirements for three specific areas: (1) the percentage of funds expended for child welfare services that reduce abuse and neglect, safely reduce the rates of out-of-home placement, decrease the length of time required to provide permanency for children in out-of-home care, or improve child well-being for participants; (2) the percentage of families being served with evidence-based, research-based, or outcome-based programs; and (3) the percentage of contractors proving evidence-based, research-based, or outcome-based services must each be:

- no less than 35 percent in fiscal years 2014 and 2015;
- no less than 50 percent in fiscal years 2016 and 2017; and
- no less than 75 percent in fiscal years 2018 and 2019.

System of Care. With consultation from a university-based evidence-based practice institute entity in Washington, the Washington Partnership Council on Juvenile Justice, the Child Mental Health Systems of Care Planning Committee, the Children, Youth, and Family Advisory Committee, the Washington State Racial Disproportionality Advisory Committee, the Washington State Juvenile Court Administrator's Association, a university-based child welfare research entity in Washington state, and WSIPP, DSHS must: (1) develop an integrated and accountable system of care for the coordination and delivery of mental health prevention and treatment services to children and youth; (2) ensure that implementation of research-based and evidence-based prevention and treatment programs are accompanied by monitoring and quality control procedures designed to ensure that they are delivered with fidelity to the program and that corrective action is taken when the standards are not met; and (3) acknowledge any existing system of quality control for the juvenile justice system and work within that system in meeting the graduated requirements set forth in the provisions of the bill.

Private Funding. WSIPP and EBPI are encouraged to seek private funding to complete the requirements under this act.

Reports. *DSHS.* DSHS must track and document its compliance with the requirements of this act. It must also report annually to the Legislature regarding its progress in the coordination of the purchase of evidence-based services and the development of a trained workforce to implement those services. A preliminary report is due by December 31, 2012. A subsequent report is due December 31, 2013, and annually thereafter.

*Other Entities.* WSIPP, in consultation with a university-based, evidence-based entity and with any necessary assistance from DSHS, must report to the Legislature. The reports must include:

- an assessment of the amount of funds expended on evidence-based services;
- an assessment of program fidelity to evidence-based models;
- an assessment of outcomes for children and youth who receive evidence-based services, including an analysis that illustrates results by race, ethnicity, and gender of the children and youth served; and
- a description of the method of DSHS's documentation of its compliance with the requirements of the act.

The first report is due no later than July 1, 2013. A second report is due July 1, 2015, and a final report is due December 1, 2019.

**EFFECT OF CHANGES MADE BY HUMAN SERVICES & CORRECTIONS COMMITTEE (Recommended Amendments)**: Adds outcome-based programs to be included as those programs on which the expenditure of funds should be made as well as included in the implementation percentages. Adds a definition of outcome-based programs.

**Appropriation**: None.

**Fiscal Note**: Available.

**Committee/Commission/Task Force Created**: No.

**Effective Date**: The bill contains several effective dates. Please refer to the bill.

**Staff Summary of Public Testimony as Heard in Committee (Human Services & Corrections)**: PRO: This bill provides strong accountability in assessing effective practices and allows for flexibility in approaches. We are familiar with worries and concerns people have about adopting EBPs as the primary framework. One big concern is how does one get on the list as an EBP. The definition in the bill of EBP is a standard one accepted by people in the scientific world. EBPs are those programs that are results-oriented; results have been shown to be true over time. The bill allows for more programs to get in and that is as it should be because science does not stand still. We have also heard concerns about the cost of EBPs. It is correct that it costs something and some interventions are pretty expensive but most of these were designed for a small percentage of high risk offenders and disturbed kids. Most interventions for mental health are not expensive to adopt or deliver. Doing many of things they have always done just doing it in a more structured way and using outcome

measures. The vision of this bill that we expand practices that keep children with their families. This bill aligns us in the direction of improved accountability and outcomes on behalf of the taxpayers of this state.

CON: EBPs that are used today are typically developed and formed for the population at large. Although developers attempt to design interventions appropriate to a broad spectrum of American society, the literature suggests that behavioral health does not yet have a totally culture-free evidence-based protocol, one devoid of all possible cultural bias. The trend toward wider use of EBPs has given rise to questions about the effectiveness of EBPs with people of diverse racial, ethnic, regional and cultural distinctions. For these reasons, this bill is not an effective solution to improve quality, enhance outcomes and strengthen the stewardship of public resources.

OTHER: While support evidence-based concepts large sums of money and subjects must be involved in the testing of programs so that they may be considered evidence-based. Increased costs of EBP mandates in the bill will be borne by mental health centers. Use EBPs now but are concerned about the cost especially with the percentages in the bill. Ongoing fidelity requirements of EBPs are costly as well. In some cases, facilities have to be remodeled to accommodate the fidelity requirements of EBPs. Because of the funding cuts of recent years, some EBPs lose their credentials because fidelity to the model cannot be sustained. There are many individuals dealt with by the systems mentioned in the bill that would not be appropriate subjects for EBPs. The bill does not provide that a baseline of what EBPs are being used and paid for by the state now be developed and that is critical to deciding where to go. The bill puts the cart before the horse. There should be a greater focus on outcomes rather than EBPs.

**Persons Testifying (Human Services & Corrections)**: PRO: Representative Dickerson, prime sponsor; Representative Johnson; Andres Soto, THS-MST; Eric Trupin, University of Washington; Lucy Berliner, Harborview.

CON: Janet St. Clair, Asian Counseling and Referral Services.

OTHER: Leslie Emerick, Assn. of Advanced Practice Psychiatric Nurses; Gregory Robinson, WA Community Mental Health Council; Joe Roszak, Kitsap Mental Health Services; Gary Romjue, Catholic Community Services.

**Staff Summary of Public Testimony (Ways & Means)**: PRO: The bill is a bipartisan effort that is about reform, accountability, and getting the best return on state expenditures. WSIPP has concluded that for every $1 spent on evidence-based practices the state gets a $3 return. National philanthropies are very interested in this legislation. Children and youth can be served more effectively than they are now by redirecting the way funds are being spent.

CON: Many evidence-based practices require higher staffing ratios, additional staff training, and licensing fees to national organizations in order to use the practice and for those organizations to monitor the fidelity with which it is implemented. Professional groups must therefore oppose the legislation because the funds aren't available to cover these costs without reducing spending on other critical services.

OTHER: There is no baseline information about the extent to which evidence-based practices are presently in place in the mental health and child welfare systems. Randomized trials and evaluations often just demonstrate that a practice is better than a placebo, not that it's more effective than an alternate practice. Evidence-based practices often have large start-up costs for licensing and staff training that will take funds away from direct services.

**Persons Testifying (Ways & Means)**: PRO: Representative Dickerson, prime sponsor; Ramona Hattendorff, Washington PTSA; Eric Trupin, University of WA School of Social Work.

CON: Seth Dawson, WA Coalition for Children in Care; Leslie Emerick, WA Society of Advanced Psychiatric Nurses.

OTHER: Gregory Robinson, WA Community Mental Health Council; Gary Romjue, WA Catholic Community Services; Rashi Gupta, WA Assn. of Counties.