

**Report to the Legislature**

**Evidence-Based and Research-Based Practices  
Updates and Recommendations**

Engrossed Second Substitute House Bill 2536, Section 3  
Chapter 232, Laws of 2012

RCW 43.20C.020 (3)

December 30, 2015



Washington State Department of Social and Health Services

Department of Social and Health Services

Behavioral Health and Service Integration Administration (BHSIA)

Children's Administration (CA)

Rehabilitation Administration (RA)

and

Washington State  
**Health Care Authority**

Health Care Authority (HCA)

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## EXECUTIVE SUMMARY

Engrossed Second Substitute House Bill (E2HB) 2536, Section 3, passed by the 2012 Legislature, states:

*(3)(a) By December 30, 2013, the department and the health care authority shall report to the governor and to the appropriate fiscal and policy committees of the legislature on recommended strategies, timelines, and costs for increasing the use of evidence-based and research-based practices. The report must distinguish between a reallocation of existing funding to support the recommended strategies and new funding needed to increase the use of the practices.*

*(b) The department shall provide updated recommendations to the governor and the legislature by December 30, 2014, and by December 30, 2015.*

This update was requested by the Legislature to examine the continued expansion of Evidence-based and Research-based practices (E/RBPs) within the state-run systems serving children and youth in Washington.

This multi-system review of the implementation of E/RBPs highlights successes and common challenges that remain unaddressed in reaching the legislative goal of substantial increases in the use of E/RBPs.

As mentioned in previous updates, additional legislative attention is needed around E/RBP fidelity monitoring; increased costs of delivering E/RBP services; on-going training; data/quality assurance; and addressing the unique needs of Medicaid and Tribal populations.

It should be noted that increased and sustained implementation of E/RBPs will require new infrastructure investments. To support this effort, it is recommended that the legislative and executive branches continue to focus on:

- flexible fidelity monitoring that focuses on improving outcomes for children and youth;
- cost implications of ongoing implementation, including training, for providers delivering E/RBPs;
- quality Assurance/Improvement with a focus on improving outcomes by enhancing data collection and analysis to inform decisions and future direction; and
- promising practices that meet the needs of special populations.

A great deal of work has been done and there is still more that needs to be done to accomplish the Legislature's intent that mental health, child welfare, juvenile justice and health care authority services delivered to children and youth be primarily evidence-based and research-based. These child-serving agencies are committed to continuing the work with adequate infrastructure funding.

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**Department of Social and Health Services and Health Care Authority  
Updates and Recommendations**

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**INTRODUCTION**

In accordance with E2SHB 2536, the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) present this update and recommendations for increasing the use of Evidence-based and Research-based practices across the child serving systems of child welfare, juvenile justice, and children's mental health services. The report includes progress on the delivery of Evidence-Based and Research-Based practices and continued needs recommended for:

- Substantial increases in Evidence-Based (EBP) and Research-Based Practices (RBP) (collectively E/RBPs) throughout Washington's Child Serving Systems.
- Cost
- Fidelity
- Cultural Responsiveness

The report provides information regarding how DSHS Behavioral Health and Service Integration Administration's (BHSIA's) Division of Behavioral Health and Recovery (DBHR), Children's Administration (CA), Rehabilitation Administration's (RA) Juvenile Rehabilitation (JR), and the Health Care Authority (HCA) plan to increase the use of evidence-based, research-based, and promising practices.

While Tribal Governments still remain open to the idea of implementing E/RBPs, they reserve the right as sovereign nations to be exempt from E/RBP legislative requirements. Their concern is based on the fact that there have not been a sufficient number of E/RBPs for American Indian and Alaska Native populations.

## INVENTORY OF EVIDENCE-BASED, RESEARCH-BASED AND PROMISING PRACTICES

A defined structure has been established to regularly review the Washington State Institute of Public Policy (WSIPP) list of Evidence-Based, Researched-based, and promising practices that involves conducting a meta-analysis of the research, applying the standard of heterogeneity, and cost benefit. This yearly review will generally keep programs in the same categories but has been known to periodically change a program from one category to another.

July 2015

### Inventory of Evidence-Based, Research-Based, and Promising Practices For Prevention and Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems

More information on the programs and findings can be found by clicking here\*\*

Budget area	Program/Intervention	Manual	Current definitions	Suggested definitions	Cost-beneficial	Reason program does not meet suggested evidence-based criteria (see full definitions below)	Percent minority
Child welfare	<b>Intervention</b>						
	Alternatives for Families (AF-CBT)	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Family Search and Engagement	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Fostering Healthy Futures	Yes	⊙	⊙	N/A	Single evaluation	56%
	Functional Family Therapy (FFT) for children in the child welfare system	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Including Fathers - Father Engagement Program	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Intensive Family Preservation Services (Homebuilders)	Yes	●	●	Yes (99%)		1%
	Multisystemic Therapy (MST) for children in the child welfare system	Yes	⊙	⊙	N/A	Heterogeneity/single evaluation	18%
	Other Family Preservation Services (non-Homebuilders)	Varies*	P	⊙	No (1%)	Weight of evidence	99%
	Parent Child Assistance Program	Yes	P	P	N/A	Weight of evidence	N/A
	Parent-Child Interaction Therapy	Yes	●	●	Yes (100%)		0%
	Parents for Parents	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Partners with Families and Children	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Pathway to Reunification	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Safecare	Yes	⊙	●	Yes (88%)		12%
	<b>Prevention</b>						
	Circle of Security	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Healthy Families America	Yes	●	⊙	No (51%)	Benefit-cost	49%
	Kaleidoscope Play and Learn	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Nurse Family Partnership	Yes	●	●	Yes (75%)	Benefit-cost	25%
	Other Home Visiting Programs for At-Risk Parents	Varies*	●	⊙	No (51%)	Benefit-cost	49%
	Parent Child Home Program	Yes	⊙	⊙	No (35%)	Benefit-cost	65%
	Parent Mentor Program	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Parents and Children Together (PACT)	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Parents as Teachers	Yes	●	P	No (67%)	Benefit-cost/weight of evidence	33%
	Promoting First Relationships	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Safe Babies, Safe Moms	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Triple P (system)	Yes	⊙	P	No (58%)	Benefit-cost/weight of evidence	33%

**Key:**

- Evidence-based
- ⊙ Research-based
- P Promising
- ⊖ Produces null or poor outcomes

For the entire list please click on the link below:

[Inventory of Evidence-Based, Research-Based and Promising Practices-September 2015](#)

## **TRIBAL GOVERNMENTS FEEDBACK**

In honoring the unique government to government relationship between the State of Washington and Tribal Governments and Recognized American Indian Organizations, DSHS and HCA have updated the Tribes on the status of E2HB 2536. The following captures the key sentiments expressed by the tribes and encapsulates relevant information from previous legislative reports and information shared by Tribal leaders during the roundtable process:

- There are limited evidence-based, research-based and promising practices that have been tested in tribal communities. The differences in Washington's tribal communities (urban, rural and frontier) adds another level of complexity to finding E/RBPs that have been adequately normed for tribal communities.
- Acknowledgement that Tribes know what works best in a Tribal community and that a pilot project or study that works in one Tribal community may not necessarily be easily replicated in another. Each tribe in Washington has its own rich and unique history, culture and traditions.
- The Tribes have a strong interest in looking at current Tribal practices and pursuing them as promising practices. Through this process, they seek modalities that will fit within the current Tribal Health system and make adjustments as necessary to keep the core practice.
- Challenges with continuity and consistency exist within the development of E/RBPs.
- Tribes experience the same, if not more, challenges in workforce development necessary to meet the needs of tribal communities.

In collaboration with the Tribes, University of Washington, DSHS, and HCA, work continues to be done to explore the Core Elements in implementing effective E/RBP programs for tribal youth to ensure the research based components of the models will meet the cultural and spiritual aspects unique to each Tribe.

## **CONCERNS EXPRESSED IN IMPLEMENTING EVIDENCE-BASED AND RESEARCH BASED PRACTICES**

As addressed in the initial HB 2536 report in December 2013 and in the subsequent update in December 2014, the concerns expressed by stakeholders still remain relevant within this update. Those are:

- **Cost** — There are serious implications around the costs associated with increasing the availability and use of E/RBPs within DSHS and HCA. The costs associated with increasing a workforce trained in E/RBPs and supporting fidelity were not provided for in the initial legislation and were not addressed subsequently. Additional funding will be required to make meaningful advances in increasing the use of E/RBPs.
- **Fidelity** — Stakeholders have expressed the need for increased and improved guidance, support, and financial infrastructure to support the ongoing task of fidelity monitoring. Because there is no funding allocated to fidelity costs, administrations use direct service funding to purchase fidelity and quality assurance.
- **Cultural Responsiveness** — Stakeholders are concerned that not enough focus has been given to the cultural appropriateness of E/RBPs. DSHS and HCA plan to work with model developers in examining, adapting, and/or exploring promising practices to assure cultural responsiveness. Work needs to continue with engagement of youth and families, diverse communities, and the Family Youth System Partner Round Tables (FYSPRTs) throughout the process. DSHS and HCA continue to encourage communities in recruiting a diverse workforce able to effectively deliver services that meet the diverse cultural, family, and individual needs of the populations we serve. This includes the ability to respect and serve families where there is diversity in religion, sexual orientation, gender identity and expression, language, race, ethnicity, urban/rural locales, socioeconomic status and culture.

## **BEHAVIORAL HEALTH AND SERVICE INTEGRATION ADMINISTRATION (BHSIA)**

In the 2013 Legislative Report, [\*Evidence-based and Research-based Practices, Strategies, Timelines and Costs\*](#), BHSIA set a goal of having 45 percent of children/youth enrolled in a Certified Mental Health Agency (CMHA) be treated with an E/RBP by the end of 2019.

As indicated in Table A, BHSIA set out a six-year plan beginning in 2013, to increase the use of E/RBPs provided to children/youth by stepping-up the target by 15 percent each biennium (7.5 percent each year). The year in Table A covers January through December. As indicated in Table B, benchmarks are also measured biennially. Looking at data at this level allows BHSIA to track progress toward the goal and whether

adjustments must be made in practice, data collection, reporting, or the goal itself prior to the close of the biennium (COB).

Year	COB %
2014	7.5%
2015	15%
2016	22.5%
2017	30%
2018	37.5%
2019	45%

**Table A**

Biennium	COB %
2013-2015	15%
2015-2017	30%
2011-2019	45%

**Table B**

*(Note: Projected increases for the current biennium are dependent on funding set forth in the T.R. v. Quigley and Teeter decision package as well as Federal Block Grant dollars.)*

Progress and Challenges

In 2013, at the request of the legislature, BHSIA established a way for RSNs to report E/RBPs through ProviderOne and placed reporting requirements in Regional Support Network (RSN) contracts. BHSIA continues to use the [Service Encounter Reporting Instructions \(SERI\)](#) (pgs. 104-105) as the means to collect provider level data on the use of E/RBPs. Work continues in partnership with the University of Washington, RSNs and CMHAs in developing a fidelity requirement that will look toward a more simplified approach in attesting and/or certifying adherence to fidelity.

Progress has been made by RSNs and their provider networks in growing the use of research-based and evidenced-based practices. A summary of progress, run on 10/21/2015, reflects the following:

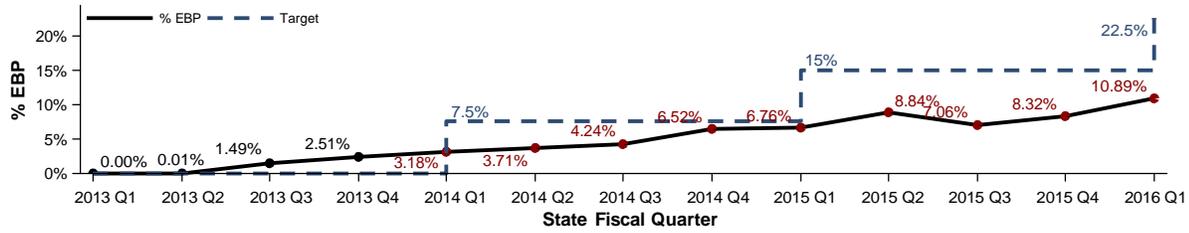
- There is a statewide increase from 8.1% to 10.89%, falling slightly below the ‘stepping’ bench mark of 13.13%, as communicated to RSN Administrators.
- December 31, 2015 is the deadline for meeting the 15% benchmark.

The results captured by RSNs for Quarter 1 of State Fiscal Year 2016 (July 1, 2015—September 30, 2015) are shown on the next page.

# Mental Health Consumers Receiving Evidence Based Practices

## Unduplicated Count of Youth Consumers (under 21) by Regional Support Network and State Fiscal Quarter

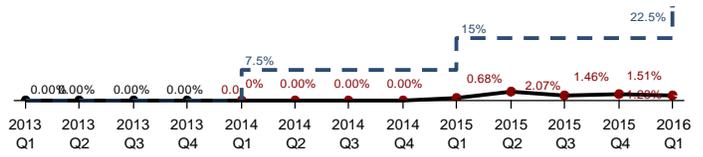
### Statewide



### Spokane County Regional Support Network



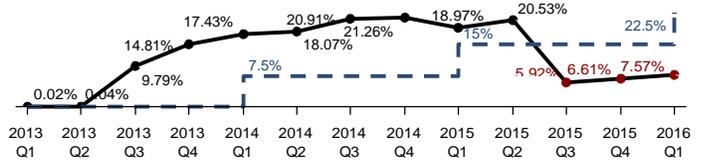
### King County Regional Support Network



### North Sound Mental Health Administration



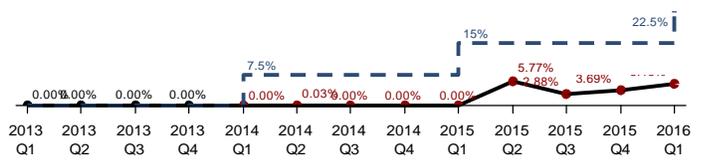
### Greater Columbia Regional Support Network



### Peninsula Regional Support Network



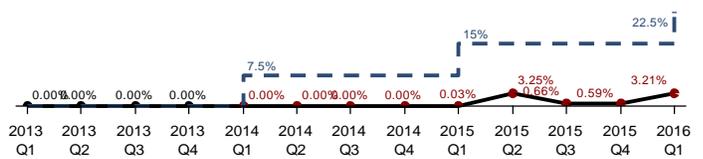
### Southwest Washington Behavioral Health RSN



### Thurston-Mason Regional Support Network



### OptumHealth



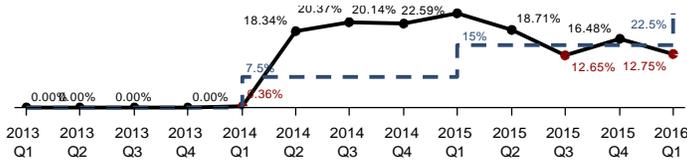
### Grays Harbor Regional Support Network



### Chelan Douglas RSN



### Timberlands Regional Support Network



Source: ProviderONE data warehouse, paid claims.  
 (Note: The trend line is reflective of an entire year, and does not step to the next benchmark indicated in Table A, until the first day of the month following the close of the calendar year)

While there have been improvements in the amount of usage among the RSNs, challenges still remain with reporting and BHSIA continues to hear the following as obstacles in reporting E/RBP data within service encounters:

- **Provider consistency in reporting** — Challenges still exist in reporting the use of E/RBPs when entering encounters into the reporting platform. Continued training, clarification, and follow-up need to be built into the reporting structures. This will allow for a more consistent and reliable source of E/RBP information being reported to the RSN and State level. DBHR continues to work with RSNs on reporting instructions and concerns expressed to continually ensure that this work is improving.
- **Fidelity**—Messaging around fidelity monitoring and the need to certify practice fidelity remains as a barrier to reporting. BHSIA has taken the necessary step in communicating the current removal of fidelity within the SERI handbook while the greater topic of fidelity is being addressed in collaboration with RSNs and their provider agencies.
- **Funding** — RSNs are concerned about reporting E/RBPs without additional legislative funding and they do not see E/RBPs as sustainable at current funding levels.

### Contract Language

Partnership and contract language have been the approach used by BHSIA in moving this work forward. However, there are still challenges in getting reports on the practice we know are occurring within provider networks. In order to more rapidly increase the reporting of the use of E/RBPs and hold contracted entities to the commitments made to the legislature, BHSIA has modified the Interlocal Agreement's contract language in both the Prepaid Insurance Health Plan (PHIP) and State Mental Health Contract (SMHC) with the RSNs.

The contract language modifications are intended to make the deliverable more specific: an anticipated usage percentage for E/RBPs and the date by which that percentage is expected to be met. The language in the current contract reads:

*Evidence/Research-Based Practices: The Contractor will participate with DSHS to increase the use of research and evidence-based practices, with a particular focus on increasing these practices for children and youth as identified through legislative mandates. This includes:*

*Participation in DBHR sponsored training in the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT/CBT) and CBT-Plus (TF-CBT/CBT+) evidence/research-based practices. The contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice within the Contractor's service area.*

*At a minimum, 17 percent of the children/youth enrolled in treatment services will receive an evidence/research-based practice by March 31, 2016.*

*The Contractor shall track evidence-based and research-based practices identified by the Washington State Institute of Public Policy (WSIPP) and report the services as specified in DBHR's Service Encounter Reporting Instructions (SERI).*

Following the addition of clarifying language in the July 2015 contract amendment, a memo was sent to the RSN Administrators in August 2015, clarifying in detail the process for monitoring E/RBPs.

August 2015

**Evidence & Research Based Practice for Children/Youth receiving Behavioral Health Services**

DATE Range (calendar)	Run Date	Distribution/available Date*	Expected E/RBP Percentage
July--September 2015	11/1/2015	11/15/2015	13.13%
October--December 2015	2/1/2016	2/15/2016	15%
January--March 2016	5/1/2016	5/15/2016	16.88%
April--June 2016	8/1/2016	8/15/2016	18.75%
July---September 2016	11/1/2016	11/15/2016	20.63%
October--December 2016	2/1/2017	2/15/2017	22.50%
January--March 2017	5/1/2017	5/15/2017	24.38%
April--June 2017	8/1/2017	8/15/2017	26.25%
July--September 2017	11/1/2017	11/15/2017	28.13%
October--December 2017	2/1/2018	2/15/2018	30%
Januaray--March 2018	5/1/2018	5/15/2018	31.88%
April--June 2018	8/1/2018	8/15/2018	33.75%
July--September 2018	11/1/2018	11/15/2018	35.63%
Oct--Dec 2018	2/1/2019	2/15/2019	37.50%
January--March 2019	5/1/2019	5/15/2019	39.38%
April--June 2019	8/1/2019	8/15/2019	41.25%
July--Sept 2019	11/1/2019	11/15/2019	43.13%
October--December 2019	2/1/2019	2/15/2019	45%
January 2020--Forward	Run 1 month and one day after the calendar quarter	*15th of month or Monday Directly after a weekend	minimum of 45%

As indicated in HB 2536 Report to the Legislature

**Behavioral Health Organizations—Moving Forward**

As of April 1, 2016, BHSIA will have completed the legislatively mandated integration of Mental Health and Substance Use Disorder services to Behavioral Health Organizations (BHOs), by means of integrated contracts, services, and funding. This combined contract will continue to carry forward the mandate of increasing the use of evidence-based and research-based practices by including the above-mentioned contract language and milestone deliverable dates and percentages.

Partnership with the University of Washington

BHSIA has collaborated with the University of Washington to establish a statewide implementation plan for E/RBPs that began in July 2015. This work entails a survey of RSNs to ascertain their most pressing needs in E/RBP implementation and then encapsulating that information into areas of technical assistance and a statewide strategic plan to enhance and grow the use of these practices in the behavioral health system. The identified areas of technical assistance (TA) will be offered to the RSNs at no cost. The survey is expected to be completed by January 2016.

Next Steps

A great deal of work remains to grow toward the next benchmark of 15% and beyond of youth receiving E/RBPs and to develop an infrastructure that is prepared and able to sustain these changes moving into the future. BHSIA plans to continue to work with RSNs and upcoming BHOs to move toward the goal of 45% of youth receiving E/RBPs by the end of calendar year 2019.

**CHILDREN’S ADMINISTRATION (CA)**

In the 2014 Report to the Legislature on Evidence-based and Research-based Practices Children's Administration (CA) anticipated a potential downward trend in the use evidence-based services (EBP). This downward trend was forecasted because CA was not able to meet the increased training needs. As CA increased the locations where EBPs could be accessed, the fiscal resources needed to continue expansion and maintain the statewide infrastructure became too large. As identified in the table below from the December 2014 report, it was assumed that the reduction in trainings would result in fewer providers being able to deliver services and a corresponding reduction in the number of families receiving evidence based services.

	<b>FY2014 Families Receiving an EBP</b>	<b>Percent Change</b>	<b>FY2015 Project Target</b>
<b>Total</b>	<b>2,541</b>	-20%	<b>2,033</b>

*Data Source: FamLink September 2014*

During FY 2015, CA leadership held discussions with social service specialists and supervisors around the benefits of using evidence-based services. These continued practice discussions appear to have impacted the use of EBPs in FY 2015 as seen in the table below. The increase in the use of EBPs in FY 2015 was matched by a 53% reduction in the use of Family Preservation Services (FPS).

<i>Practice</i>	<i>FY2014 Families</i>	<i>FY2015 Families</i>	<i>Total Percent Increase</i>
<i>Functional Family Therapy</i>	277	587	112%
<i>HomeBuilders</i>	752	840	11%
<i>Incredible Years</i>	452	571	26%
<i>Multi-Dimensional Treatment Foster Care*</i>	N/A	N/A	
<i>Parent Child Interaction Therapy</i>	138	220	59%
<i>SafeCare</i>	364	604	66%
<i>Triple P</i>	552	1,558	182%
<b>Total</b>	<b>2,541</b>	<b>4,380</b>	<b>76%</b>

*Data Source: FamLink September 2015*

\*The one contractor for this service chose to not renew their certification.

The expanded use of EBPs has resulted in unintended consequences. CA learned from service providers and the fidelity consultants that there was an increase in referrals for family situations that do not match the EBPs CA has available. For example, many families have safety concerns outside of the EBPs model parameters or have multifaceted high priority needs that cannot be addressed by an EBP.

CA explored adding additional EBPs to address this gap but was informed of Chorpita and Daleiden's 2009<sup>1</sup> research demonstrating diminishing returns when adopting multiple EBPs. The researchers argued that as most EBPs have shared or related core service foundation, the targeted service populations do not vary greatly.

In FY 2015 CA worked with contractors, stakeholders, national researchers, courts, Tribes, and families to move FPS to an evidence-informed and family driven service to enhance the capacity to meet family needs. CA successfully implemented the new evidence-informed FPS in July 2015.

### **REHABILITATION ADMINISTRATION (RA) JUVENILE JUSTICE (JJ)**

In the 2014 HB 2536 Legislative Report, Juvenile Rehabilitation (JR) reported on the following areas in juvenile justice. These did not require any additional funding and were areas of focus that could be accomplished within existing resources:

- Functional Family Therapy (FFT) in the Juvenile Rehabilitation system
- Juvenile Drug Courts

<sup>1</sup> Chorpita B. & Daleiden E.. (2009). Mapping Evidence-Based Treatments for Children and Adolescents: Application of the Distillation and Matching Model to 615 Treatments From 322 Randomized Trials. *Journal of Consulting and Clinical Psychology*, Vol. 77, No. 3, 566–579<sup>1</sup>

The following program update will provide information on FFT in the Juvenile Rehabilitation and Juvenile Drug Courts.

## **Program Update**

### *Functional Family Therapy*

<b>EBP</b>	<b>SFY 2014 Participants</b>	<b>SFY 2015 Participants</b>	<b>Actual Increase</b>
FFT	58	70	20.69%

Beginning in SFY 2013, JR reallocated funding to expand its delivery of FFT by funding an additional 1.5 FTE to provide FFT to youth on parole. Since that time, the amount of youth that have started FFT has increased each year. In SFY 2014, 58 youth started FFT. That number increased to 70 starts in SFY 2015. Those additional 12 starters represent a 20.69% increase in FFT starters in JR.

### *Juvenile Drug Courts*

The juvenile courts, in conjunction with JR, are continuing to develop the process for juvenile drug courts to become an evidence-based program. In August 2014 a Drug Court Summit was held. Researchers from Washington State University, University of Washington, Washington State Institute for Public Policy, and Administrative Office of the Courts (AOC), as well as members from the juvenile drug courts, JR, AOC, Division of Behavioral Health and Recovery (DBHR), and other evidence-based program quality assurance specialists were in attendance.

The goal of the summit was to begin to identify a programmatic approach for all juvenile drug courts in Washington State to follow. This would involve mechanisms to collect, gather, and disseminate data on program participants; develop quality assurance measures; and enable the programs to be researched.

A Juvenile Drug Court Steering Committee formed in 2015 to continue the work from the Summit. The first order of business was to create and implement a survey to be sent to all of the juvenile drug courts in Washington State. The purpose of the survey was to begin gathering baseline information on all elements of each program—referral, assessment, court engagement, treatment, and continuing care.

The results of the survey will drive the next step in the process, which is to hold a 2-day workshop in March of 2016. The goal is to have the drug courts send a team of staff to work together throughout the workshop on the different core elements of the program.

The Juvenile Drug Court Steering Committee will continue to meet until the process of unifying the Washington State Juvenile Drug Courts under a common model approach is achieved.

## Next Steps

### *Juvenile Justice Programs—Continuous Quality Improvement*

Implementation of evidence-based and research-based programs requires a commitment to maintaining a program's integrity by working to remain adherent and competent in the delivery of those programs. In order to effectively increase the utilization of evidence-based and research-based programs the following core elements must be present:

- Quality Assurance
- Program Research and Analysis
- Promising Programs

### *Quality Assurance*

In December of 2003, the Washington State Institute for Public Policy (WSIPP), as directed by the Legislature, published a report titled [\*Recommended Quality Control Standards: Washington State Research-Based Juvenile Offender Programs \(page 2\)\*](#). In their review of the implementation of research-based programs, WSIPP concluded the following:

*Since the late 1990s, Washington has been recognized as a leader in implementing research-based juvenile justice programs. After evaluating Washington's experiences to date, one conclusion is clear: these programs work, but with one vital qualification. When the programs do not adhere to the original design, they can fail. In fact, we found that the programs can increase the recidivism rates of participants when they are poorly delivered.*

This report was the catalyst for the juvenile justice system's current quality assurance structures. Every program that was listed in the juvenile justice baseline report has some form of quality assurance. Quality assurance is an ever-evolving process where data and information assist with decision making and change.

One thing is for certain: quality assurance and monitoring for fidelity takes funding and resources. Since 2004, the juvenile justice field has been building a robust system of quality assurance. This has largely been accomplished without specific funding support from the Legislature. Although the juvenile courts receive state funding from the Legislature, the funding for quality assurance is taken off the top of direct service dollars before they are distributed to the juvenile courts. Juvenile Rehabilitation received some funding to support quality assurance for their residential programs but it was not funded at nearly the capacity at which it needs to be. Currently there are only two FTEs dedicated to providing training and quality assurance to all JR residential staff (approximately 500 FTEs). Despite these challenges, the juvenile justice system understands the immense value of these efforts. However, with specific funding assistance for quality assurance more youth could be better served and the quality of

services received would drastically improve leading to even better outcomes for youth and families.

Fidelity and quality assurance is an integral part of the delivery of evidence-based and research-based programs. Without quality assurance and fidelity monitoring the State's investment in these programs will not meet expectations.

### ***Program Research and Analysis***

It is essential that funding for program expansion include funds necessary to conduct research on those programs that fall into the category of promising or research based. Strong data analysis regarding youth within the juvenile justice system will improve the system's ability to select programs that work for particular types of youth.

A broader array of well-designed and effective programs is necessary in order to respond to the needs of those youth that are not being reached by the current menu of programs. The juvenile justice system is not yet in a position to fully respond with programs designed to meet the needs of youth based on cultural differences or on differences in the complexity of youth needs.

### ***Research Needs and Conclusions***

For nearly 15 years the Washington State Legislature has been committed to the ongoing prioritization of evidence-based programming for the juvenile justice system. More recently, pursuant to House Bill 2536, this effort has been enlarged to include a similar emphasis for different systems of care, including children in the mental health and child welfare systems. With the Legislature's support to date, and the work of juvenile justice agencies, Washington State is perceived as a national leader in the areas of providing evidence-based programs in juvenile justice and for the quality assurance structure created to ensure the programs are implemented and maintained to create positive results for the youth served.

The continued success of this evidence-focused juvenile justice system depends on the willingness of those who govern directional and budgetary decisions to meet the needs of the system so that it can move forward. It is time for Washington State to expand beyond implementation, maintenance, and quality assurance monitoring of our programs. The next phase of our commitment includes the ability to evaluate in detail our current menu of evidence-based and research-based programs and make data driven decisions regarding possible new programs that could meet the needs of those children with whom we have yet to succeed. Without a commitment to full research support for evidence-based programs in juvenile justice the current system of care will become outdated, unresponsive to important new information, and ultimately less successful. To continue to use funding identified for direct service of programs to support this necessary piece of the overall picture translates into fewer and fewer youth getting into programs, completely defeating the purpose of this evidence-based journey.

Currently, the funds allocated for juvenile justice evidenced-based programs are fully dedicated to program delivery and its quality assurance structure. A strong research foundation is needed that will help lawmakers determine if Washington State is maximizing its tax dollars to reduce crime. State professionals in juvenile justice, both juvenile courts and JR, identify this as an important priority.

While the current need for responsive research in juvenile justice is critical, it is only wise to see this as part of a long-term strategy that should be able to serve not only legislators and juvenile justice professionals but also those other systems of care moving down the path of providing evidence-based programs to their consumers. All systems should be able to take advantage of a learned truth: that evidence-based programs cannot thrive on their own and creating positive outcomes for any target population without the underpinning of skilled juvenile justice professionals, competent providers of programs, quality assurance experts and the science of research.

At a minimum, future steps to expand the menu of evidence-based and research-based programs must include funds for evaluation, data analysis and research.

Costs for these items will vary by program. Choosing which programs to prioritize for implementation will require additional data analysis about the risks and needs of youth in the juvenile justice system. Special consideration should be made for youth who appear to have needs that are not met by currently available programs.

### **Promising Programs**

As mentioned previously, the juvenile justice field has been investing in evidence-based and research-based programs for many years. What this journey has uncovered is that not all youth can be adequately served by the menu of programs that are currently provided. After reviewing the baseline report for juvenile justice it became very clear there are two very specific treatment areas that do not have an evidence-based or research-based treatment available that impacts recidivism: substance abuse treatment and sex offender treatment. In the juvenile courts and JR, these two treatments are the only areas where treatment funding is spent on a non-evidence-based or research-based program.

The juvenile justice field needs to extend beyond what is currently available. As a result, in order to effectively implement promising programs, new funding will need to be made available to provide quality assurance and fidelity monitoring as well as funding for research and data analysis.

A sound investment is critical in order to ensure promising programs are done with fidelity, have a research design, and include a plan for evaluation.

## **Report Amendment**

There was an error reported on page 13 of the June 2013 HB 2536 Baseline Report to the Legislature regarding Juvenile Justice. Please see Appendix 1 (attached) for the correction.

## **HEALTH CARE AUTHORITY**

HCA administers a Medicaid benefit that covers mental health services for all beneficiaries. Although HCA does not require that mental health services provided be evidence- or research-based, several modalities have been embraced by our community mental health providers.

Unlike DBHR, CA, and JJ and RA, Medicaid's relationship with the mental health providers who render these services is not analogous to the employer-employee or contracted model with extensive contractual obligations. Medicaid does not regulate the delivery of care, Medicaid reimburses for service rendered.

### *Implementation and Resources*

HCA developed billing procedures with the managed care organizations (MCOs) to support collecting information on select Evidence/Research-Based Practices (E/RBPs) provided to clients under the age of 21 years. Apple Health Fee-For-Service (FFS) and the MCOs have been tracking the modalities listed below since July 1, 2014. The agency does not reimburse the delivery of services separately from the encounter code. Consequently, there are no additional costs.

### *Progress*

Our goal is to capture data that reflects the practice of E/RBPs in children's mental health, including prevention and intervention services when provided to a child covered under FFS or an MCO. Information to be collected and reported includes:

- Number of children receiving E/RBP services
- Number and percentage of encounters using these services
- Relative availability of these services

In order to accomplish the Legislative mandate, HCA worked with partners across agencies and our providers to identify the modalities utilized to provide mental health services to children in community mental health settings. Data is being collected about each of these targeted E/RBPs.

<b><i>Programs/Coding for Mental Health Professionals*</i></b>
<i>Positive Parenting Program (Triple P) (Level 2)</i>
<i>Positive Parenting Program (Triple P) (Level 3)</i>
<i>Parent-Child Interaction Therapy (PCIT)</i>
<i>Cognitive Behavioral Therapy (CBT)+ for Behaviors, Anxiety and Depression</i>
<i>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)</i>
<i>Bonding and Attachment via the Theraplay model (Promising Practice)</i>
<i>Cognitive Behavioral Therapy (CBT)</i>
<i>Strengthening Families Program</i>

There was a delay in implementation as issues with some MCO IT systems had to be addressed and an infrastructure needed to be created to capture the data. The low numbers in the first reported quarter are evidence of the initial challenges across the board. In the past fiscal year all Apple Health children’s behavioral health funders (MCOs and FFS) have collected encounter data and have been able to increase the E/RBPs offered to youth. Providers have a year to bill so the data is not necessarily captured in real time; however, the number of E/RBP encounters reported for FY 2015 is shown below:

<b>Provider</b>	<b>AMG</b>	<b>CCW</b>	<b>CUP</b>	<b>CHPW</b>	<b>FFS</b>	<b>MHC</b>	<b>UHC</b>
Q3 2014	7	0	N/A	0	127	1	0
Q4 2014	5	1	N/A	85	285	9	62
Q1 2015	0	5	N/A	31	247	16	64
Q2 2015	11	16	4	63	266	175	22
<b>TOTALS</b>	<b>23</b>	<b>22</b>	<b>4</b>	<b>179</b>	<b>925</b>	<b>201</b>	<b>148</b>

The providers above are:

- AMG** - Amerigroup
- CCW** - Coordinated Care of Washington
- CUP** - Columbia United Providers (the newest of the MCOs, began tracking/reporting in April 2015)
- CHPW** - Community Health Plan Washington
- FFS** - Fee-For-Service (traditional “Medicaid”)
- MHC** - Molina Healthcare
- UHC** - United Health Corporation

HCA continues to meet all stated goals described in ESSHB 2536 and will continue to monitor for compliance and increased use of E/RBPs. Contract language has been crafted and included in the MCO agreement with HCA and some of the plans are including specific expectations regarding E/RBP for providers who contract with them.

HCA is eager to expand the use of E/RBPs, and will endeavor to do so by using a “report card” to identify providers and compliance over time.

### *Identified Barriers*

Feedback from providers has identified potential barriers to the use of E/RBPs. These include workforce development and supervision cost, reimbursement levels, and challenges with retention of E/RBP trained staff. Partnering Administrations have provided more detail about these issues. Other challenges identified by HCA include consistency in use and tracking as there are currently six MCOs in addition to Fee-For-Service to which these expectations are held. Coordination of reporting and clear, timely information about challenges and potential solutions are among the current priorities.

### *Future Considerations*

HCA is exploring the ramifications of identified barriers and gathering information to develop new approaches to support the continued delivery of quality health care using value based purchasing strategies. MCOs are considering maintaining a list the E/RBPs offered by each mental health provider, or seeking contracts with providers based on the needs clients and the availability of E/RBP trained staff in specific geographical locations. There is a national effort underway to endorse the evidence/research-based components of Evidence Based Models in addition to those Models being used to full fidelity. HCA would like to explore the possibilities of this pathway in addition to the feasibility of offering an enhanced rate when E/RBPs are used in service. A final consideration is the use of a standardized measure of functional improvement in children receiving all types of mental health treatment to align with our value-based purchasing initiative.

HCA has every intention of maintaining the high level of commitment and dedication to assure clients are offered appropriate treatment, in the right place and at the right time. Contracted providers are aware that the use of E/RBPs is a top priority for HCA. Working in collaboration as partners across agencies, HCA will continue to review the data and explore all possibilities with the vision of providing the youth of Washington State the highest quality of care so that they can live a full successful life and contribute to their communities.

## **CONCLUSION**

Engrossed Second Substitute House Bill 2536 directed DSHS and HCA to increase the use of evidence-based, researched-based, and promising practices. This came at a time when DSHS and HCA, to varying degrees, had already begun moving in this direction. The increased attention that ESSB 2536 brought to this effort emphasized the need for infrastructure investments to support growth and sustain the use of evidence-based services.

Looking at the successes of RA and CA in implementing and sustaining EBPs highlights the need for resources to support continued gains in the use of E/RBPs. Through directly managing the infrastructure needed to support EBPs RA and CA have, for the most part, been able to offer children, youth, and families' service based in evidence. Continued success in implementing E/RBPs requires additional resources for DSHS and HCA. Additional resources will allow DSHS and HCA to attend to critical areas of E/RBPs implementation such as:

- Fidelity monitoring
- Increased costs of delivering E/RBP services
- On-going training to address staff turnover
- Data/quality assurance
- Addressing the unique needs of Medicaid and Tribal populations

A great deal of work has been done over the last decade to adopt the use of E/RBPs and still more can be done to accomplish the Legislature's intent that Mental Health, Child Welfare, Juvenile Justice and Health Care Authority services delivered to children and youth be primarily evidence-based and research-based. DSHS and HCA are committed to continuing the work with adequate infrastructure funding.

## Appendix 1

### Baseline Conclusions

#### *Juvenile Justice*

Treatment Categories	Treatment Costs
Evidence Based and Research Based Treatment	24,974,745
Other – Non Evidence Based or Research Based Treatment	12,401,870
Total	37,376,615
<b>Percentage of Utilization</b>	<b>67%</b>

TABLE 8

The total amount of state and federal funds spent on evidence based and research based programs in juvenile justice in the State of Washington is \$24,974,745 (see Table 5). Based on all treatment funding spent, this total represents a 67% utilization. This means that out of \$37,376,615 spent on treatment in SFY 2012 in juvenile justice, \$24,974,745 was spent on evidence based or research based programs (67%).