Children & Youth Behavioral Health Work Group Annual Report

Part 1: 2025 Recommendations

Letter from the Co-Chairs

Governor Inslee and Members of the Legislature,

The Children and Youth Behavioral Health Work Group is pleased to share its prioritized list of recommendations for the 2025 legislative session.

New data from our Healthy Youth Survey shows that depressive feelings and contemplation of suicide significantly decreased from 2021 to 2023, suggesting an improvement in the wellbeing of our children and youth since the pandemic. At the same time, suspected opioid overdoses continue to increase among youth in Washington. We are ahead of most states when it comes to child and youth health by some measures, but in the latest national ranking we have dropped to 48th in the nation. Young people, their caregivers, and other stakeholders continue to report mental health and substance use as top concerns. As needs increase, our system continues to have gaps in care that lead to long waitlists, workforce burnout, and stressed families.

The Work Group recognizes that the state is facing a substantial budget deficit. While we understand that not every recommendation can be satisfied in this context, we feel it's important to continue illuminating areas of need and opportunities for improvement. The Work Group considered the urgent need to meet current demand for services as well as the opportunity to make changes to the system that – over time – will reduce crisis-level demand by increasing promotion of wellbeing and early intervention. As always, our recommendations consider these important factors, as well as recent legislative action, initiatives being advanced across the sector by a diverse set of actors, current state agency priorities, and national best practices.

This year's priority recommendations include **Overarching** recommendations which are relevant across the range of ages and developmental stages from prenatal through age 25 and aim to reinforce the system serving their behavioral health. Our **Legacy** recommendations build on important actions the Legislature has taken in the past and suggest critical next steps to maintain momentum and widen the impact of these efforts. Our **New** recommendations address emerging priorities. Recommendations that the Work Group chose not to prioritize are offered as Additional recommendations.

This year's recommendations:

- Aim to increase the **effectiveness of current capacity** and **expand access** to proven models of support for a range of needs, including **during early childhood** when children may not have a specific diagnosis, **through schools** where kids spend so much of their time and where behavioral health challenges can impede educational outcomes, and **during the transition to adulthood.**
- Continue to **strengthen the workforce,** by preparing and attracting **new and more diverse practitioners,** by **building their capacity** to meet the unique needs at every stage of development, and by **ensuring they are sustained** through rate increases and alternate payment models.
- Provide **parents, caregivers, and families** the support they need to provide an environment where children, youth, and young adults can thrive.

We are grateful to the numerous stakeholders who participated in and informed the development of these recommendations. We deeply appreciate the commitment so many individuals and organizations make every day to improving access to quality behavioral health services for all Washingtonians.

We look forward to working with the 71st Legislature to make continued progress in improving behavioral health and well-being for all our children, youth, and those who care for them.

Representative Lisa Callan, CYBHWG Co-chair
Washington State Representative, 5th District

Jason T. McGill, JD, CYBHWG Co-chair
Assistant Director
Health Care Authority

Summary List of Recommendations

Brief summaries of the recommendations are presented below. A detailed write-up of each recommendation is available as Appendix D.

Overarching Recommendations

Overarching recommendations address cross-cutting challenges, have the potential for system-level impact, and/or support the development of the Washington Thriving P-25 behavioral health strategic plan. The five Overarching recommendations are listed below in no particular order.

Overarching Recommendations

Enhance substance use disorder prevention services and quality substance use disorder and co-occurring mental health care for youth, young adults, and families

The CYBHWG requests the legislature allocate additional staffing and financial resources for the Washington State Health Care Authority in the 2025-2027 biennium to stabilize community and school substance use disorder prevention and mental health promotion services, increase the ability to detect behavioral health trends in youth, young adults and pregnant and parenting people, and enhance quality substance use disorder care for adolescents and transition-age youth. The CYBHWG aims to achieve this through:

- Supporting state opioid settlement priorities;
- Supporting the ASAM-4 package to incorporate and integrate MOUD care and co-occurring MH/SUDcare;
- Supporting the prevention package enhancing the capacity of the Community Prevention Wellness Initiative (CPWI) and Healthy Youth data collection initiatives

Maintenance funding expansion for Partnership Access Line (PAL) & Referral Service

Maintenance funding expansion for Partnership Access Line (PAL) and Washington's Mental Health Referral Service for Children and Teens. To keep PAL and Referral Service both operating at full capacity with no service cuts over the upcoming biennium, we request budget increase for those two programs together to be a total of $2.211 million dollars over the biennium [$370K GF-S].

Ensure viable and appropriate implementation of the CCBHC model

CCBHC = Certified Community Behavioral Health Clinic

The Legislature should take necessary steps to provide legislative and budgetary support to ensure implementation of the CCBHC model by FY2027, including participation in the federal demonstration and/or executing a State Plan Amendment.

Extend the timeline of House Bill 1580 (2023)

Extend the timeline of House Bill 1580 (2023 State Session) to ensure the team can fully build a process to support children who remain hospitalized unnecessarily due to barriers to discharge. HB1580 was passed with a timeline that ran only for the 2023-2025 biennium and will expire in June 2025 if not extended. We recommend extending both the positions and flexible funding elements of the bill for at least another biennium.

Ensure pediatric CHWs are a sustained and viable workforce for patients insured in Medicaid through WA State seeking adequate Medicaid rates from CMS

Ensure Pediatric Community Health Workers (CHWs) are a sustained and viable workforce for patients insured in Medicaid through WA State seeking adequate Medicaid rates from Centers for Medicare & Medicaid Services (CMS). Seeking Medicare rates for CHWs in Medicaid's state plan amendment proposal to CMS.

Prioritized Recommendations

Legacy Recommendations

These recommendations build on important actions the Legislature has taken in the past and suggest critical next steps to maintain momentum and widen the impact of these efforts. The seven Legacy recommendations are listed below in order of priority.

Legacy Recommendations

1. Expand Early (birth to three) ECEAP

Early ECEAP = Birth to three Early Childhood Education and Assistance Program (ECEAP) (pronounced e-cap)

Expand Early (birth to three) ECEAP service provision by adding 200 slots ($5M). We recommend an expansion of the Birth to Three ECEAP program, a comprehensive childcare partnership model for high-need children 0-3 who need both classroom and family support services. Early ECEAP is modeled after the federal Early Head Start childcare partnership program that has been shown to reduce families' involvement with child protective services (CPS), combining robust trauma-informed approaches with children and parents with high quality early learning.

Legacy item of the Prenatal-through-Age-5 Relational Health Subgroup

2. Behavioral Health Teaching Clinic designation & enhancement rate

The Legislature should enact legislation codifying the Behavioral Health Teaching Clinic Designation & Enhancement Rate into law; appropriate funds necessary to enact and adequately fund the enhancement rate; and direct the Health Care Authority (HCA), during the FY26-27 biennium, to take necessary steps to submit the Behavioral Health Teaching Clinic Designation & Enhancement Rate for approval by the Centers for Medicare and Medicaid Services (CMS).

Legacy item of the Workforce & Rates Subgroup

3. Increase investment in IECMH-C (Holding Hope program)

IECMH-C = Infant and Early Childhood Mental Health Consultation

Increase investment in IECMH-C by $1.5 million annually to address unmet needs and increase equitable access to IECMH-C for Washington's children, families, and adult caregivers in child care. Funds would be used to (1) expand capacity to provide individualized mental health consultation services to child care providers, children and families; (2) provide IECMH-C services by linguistically and culturally matched consultants, and (3) initiate a community-engaged program evaluation and planning effort to determine access and effectiveness of consultation approach in diverse communities.

Legacy item of the Prenatal-through-Age-5 Relational Health Subgroup

4. Conditional Scholarships (TIED in prioritization)

A policy change is needed to direct WSAC to work with a UW-led consortium of 13 institutions of higher education statewide to recruit a diverse cohort of master's level candidates. Funding is needed for: 1) conditional scholarships ($50k/student; 180 students); 2) three concentration areas: community behavioral health, K-12 public and tribal schools, and crisis serving agencies, to provide skills training to candidates in alignment with employers' needs ($10k/student); and 3) continuing program evaluation ($150K per year). The School-Based Behavioral Health and Suicide Prevention Subgroup also supports this recommendation.

Legacy item of the Workforce & Rates Subgroup

5. Expand the ECEAP Complex Needs Funds (TIED in prioritization)

In FY23-25 ECEAP Complex Needs Received $15M (including $5.8M in one-time funds). We support reallocating the $5.8M in one-time funds for the 25-27 biennium.

Legacy item of the Prenatal-through-Age-5 Relational Health Subgroup

6. Mental Health Literacy Coordinator

Maintain OSPI budget allocation, originally allocated in the 2024 supplemental budget, funding mental health literacy coordinator charged with facilitating the addition of mental health literacy in schools. Expand the role to include national collaboration with other state education agencies and the US Department of Education. [$360K 25-27 biennium]

5950-S.SL.pdf (wa.gov) – pg. 660, Sec. 501 (1)(m), $150,000 for FY24

Legacy item of the School-Based Behavioral Health & Suicide Prevention Subgroup

7. Fund the supervisor stipend program

Monitor the budget to ensure that the funding necessary for DOH to implement HB2247's supervisor stipend program in July of 2025 is retained. These funds are currently included in DOH's maintenance level budget.

Legacy item of the Workforce & Rates Subgroup

New Recommendations

These recommendations are emerging priorities for the Work Group. They may have previously been recommended by a subgroup and not prioritized by the CYBHWG. The eleven New recommendations are listed below in order of priority.

New Recommendations

1. RUBI parent training program pilot expansion

$250,000 in funding to conduct a one-year Pilot Site implementation project of the RUBI Parent Training program with behavioral health providers embedded in primary care settings at 10 pilot sites across WA State. The focus is on enhancing primary provider skills in providing care for families of youth with autism/intellectual disabilities (ASD/IDD) and co-occurring behavioral health needs as well as expanding family access to evidence-based care.

New recommendation of the Behavioral Health Integration Subgroup

2. Strengthen statewide guidance and direction for behavioral health in schools

Require the Office of Superintendent of Public Instruction (OSPI), in partnership with state, regional, and local entities, to define minimum expectations for behavioral health supports provided and/or coordinated by Washington's schools and establish strategic direction for state-wide programming to strengthen the capacity of schools to implement meet those supports and reduce system barriers. Total for FY25-27 biennium: $500K.

New recommendation of the School-based Behavioral Health & Suicide Prevention Subgroup

3. Expand the Bridge Residential housing program

Expand the number of Bridge Housing programs that serve young people exiting inpatient behavioral treatment. The Bridge Housing are 6-10 bed, 90-day, residential programs that provide mental health and substance use disorder support onsite and in the community. Cost is $1.5M annually per additional house.

New recommendation of the Youth and Young Adult Continuum of Care Subgroup

4. Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates

Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates. Includes rates for individual and family psychotherapy, group psychotherapy and PCP behavioral-health related patient visits, as well as primary care pediatrics. It is the BHI Subgroup's understanding that with the Health Plan Assessment we would draw down enough Federal dollars to allow for Medicaid:Medicare parity without additional GFS dollars.

New recommendation of the Behavioral Health Integration Subgroup

5. Support expansion of recovery high schools

Convene an advisory committee to establish a statewide network of recovery high schools. Work may include reviewing strategies used by other states, reading the Association of Recovery Schools Toolkit for starting a school, conducting outreach and needs assessments, identifying potential long-term funding sources, and developing a structure for evaluation and communication of student characteristics and outcomes. This recommendation is based on Oregon's demonstrated success in designing a strategic plan outlining the path forward. Initial investments would likely include a portion of an FTE to staff the proposed advisory committee and stipends for some committee members.

New recommendation of the Youth and Young Adult Continuum of Care Subgroup

6. Develop and pilot a dyadic benefit to allow mental health professionals to provide BH supports to young children who may present with symptoms that do not merit a diagnosis

We recommend partnering with the HCA to develop a dyadic benefit on Medicaid in state budget year 2025 that would emphasize prevention and support healthy emotional development, including for children who have symptoms that do not merit a diagnosis, and pilot the benefit in at least one urban and one rural primary care clinic serving significant proportion of children insured on Medicaid in state budget year 2026.

New recommendation of the Behavioral Health Integration Subgroup

7. Expand access to peer supports in school settings & professional peer pathways for youth and young people

Expand access to peer supports in school settings by coordinating statewide integration of Peer Learning Curriculum; and expand existing and future peer service provision (especially youth and family peer services) by increasing in-school peer training, creating and enforcing network adequacy standards, lowering barriers to insurance billing, maximizing billing for current programs to expand services and ensure sustainability, and investing in wellness programs and professional development for the peer workforce.

New recommendation of the Youth and Young Adult Continuum of Care Subgroup

8. Expand Maternity Support Services (MSS) regional coverage and provision of wraparound supports (TIED in prioritization)

Expand Maternity Support Services (1) provision to all counties; and (2) programming to incorporate individualized, intensive, coordinated, comprehensive, culturally competent, and trauma-informed wraparound services to better meet the needs of pregnant and post-pregnancy individuals with behavioral health conditions.

New recommendation of the Prenatal through Age Five Relational Health Subgroup

9. Establish a Technical Assistance & Training Network (TATN) (TIED in prioritization)

The Legislature should establish and fund a Technical Assistance & Training Network (TATN) to provide schools with the support, resources, and training necessary to coordinate comprehensive supports across the behavioral health continuum for their students. Total for FY25-27 biennium: $2.5-3.5 million

New recommendation of the School-based Behavioral Health & Suicide Prevention Subgroup

10. Increase family psychotherapy reimbursement rate

Increase all family psychotherapy rates to reflect the complexity of providing relationship-focused treatment that includes parents and caregivers, which is best practice in clinical Infant-Early Childhood Mental Health treatment. Current family psychotherapy rates are up to 36% lower than individual psychotherapy rates for services of equivalent duration, which disincentivizes provision of and billing for these essential services.

New recommendation of the Prenatal through Age Five Relational Health Subgroup

11. Fund youth-focused curriculum for Behavioral Health Support Specialists (BHSS)

A Behavioral Health Support Specialist will be a new bachelor level provider type with a scope of practice that includes mental and behavioral health interventions delivered under clinical supervision. UW Seattle is a catalyst for this workforce project and received funding from Ballmer Group to develop an adult curriculum. If the University of Washington Department of Psychiatry and Behavioral Sciences receives state support, it would help fund the inclusion of subject matter experts in youth mental and behavioral health to develop appropriate curriculum for the bachelor level programs. Previous legislation has helped create the structure for credentialing. [$900K]

New recommendation of the Workforce & Rates Subgroup

Additional Recommendations

Six additional recommendations are listed below in no particular order. These are recommendations that, although important, the Work Group prioritized lower than the priority recommendations presented above.

Additional Recommendations
Fund administration of CAPS and streamline pathway to First-Episode Psychosis care CAPS = Central Assessment of Psychosis Services Despite the increased availability of First Episode Psychosis services across our state, pathways to FEP care remain difficult for families to navigate and teams are often under-equipped to meet the need. The Central Assessment of Psychosis Service (CAPS) seeks to streamline the pathway to FEP care in Washington State and address obstacles to early detection of psychosis by creating one front door for young people as well as their families and practitioners who have a psychosis-related concern. A stable source of funding is needed to launch and sustain this statewide service in FY2026. Budget request: $1.1M New recommendation from the Youth and Young Adult Continuum of Care subgroup
Improve ratio of social workers in Washington schools To improve the ratio of school social workers available support student behavioral health needs in schools, the legislature should increase the allocation for school social workers in the state funding formula, provide matching grants to rural and remote districts to hire school social workers, and refine the definition of school social workers in state statute. Budget request: Grants: 4.65M for FY25-27; Funding Formula Increase: 29M for FY25-27. New recommendation from the School-Based Behavioral Health and Suicide Prevention Subgroup
Behavioral health funding for school districts Provide funding directly to local education agencies (LEAs) to plan, coordinate, and/or provide school-based supports that address the emergent mental health crises in their student populations and meet the requirements of RCW 28A.320.127. Budget request: $4.35 million for FY25-27. Previous recommendation from the School-Based Behavioral Health and Suicide Prevention Subgroup

Well-Being Specialist designation

Policy ask: State adopts a plan to incentivize referral to wellness services from primary care, details forthcoming. Funding for FY25 ($780,000):

I. Scholarships to support OJT pathways subsidized by the state for 50 Well-Being Specialists: $100,000

II. Clinic incentives to participate in wellness specialist training program that help pay for step increases in pay, supervision and ongoing training costs for 10 participating agencies. $300,000 (if the agency rates vary in cost, we will look to expand the number of participating agencies)

III. Continued funding for agency culturally responsive and leadership training for 10 agencies. $130,000

IV. Administration, evaluation and technical assistance. $250,000

New recommendation from the Workforce & Rates Subgroup

Sustainable funding to enhance behavioral health capacity among home visiting providers

Provide sustainable funding to enhance behavioral health capacity among home visiting providers to support the whole family unit following a Neonatal Intensive Care Unit (NICU) stay and/or diagnosis of developmental delays. This capacity building will focus on training providers to support the emotional well-being of parents and caregivers while providing developmental support for infants. [$500K annual]

New recommendation from the Prenatal-through-Age-5 Relational Health Subgroup

Infant & Early Childhood Mental Health (IECMH) Alternative-payment model (APM) pilot

IECMH Alternative-payment model pilot. Create an Apple Health (Medicaid) methodology for reimbursement, moving from fee-for-service reimbursement methodology, which is setting-agnostic, supportive of the workforce without adding administrative burden, and provides a pathway for expanding service provision. Estimated costs to implement a pilot within the biennium, not inclusive of implementation costs post-pilot: $1.25m GF-S; $1.25m Federal.

New recommendation from the Prenatal-through-Age-5 Relational Health Subgroup

Appendix A: Recommendation Prioritization Process

The process of developing, reviewing, and prioritizing this year's recommendations occurred over the course of seven months from April through October. Each of the five subgroups ran unique processes with their membership to identify issues of concern, develop recommendations to address them, and determine what recommendations to present to the CYBHWG. The subgroups' recommendations were then submitted to the Work Group for consideration over the course of two meetings.

Five recommendations were put forward by Work Group members as "Overarching." These are recommendations which address cross-cutting challenges and have the potential for system-level impact.

Seven "Legacy" recommendations were considered. These are recommendations that relate to established legislation where further advancement is required to achieve the goals.

Seventeen "New" recommendations were considered. These recommendations are either newly emerging or may have previously been put forward by a subgroup but not prioritized by the CYBHWG in the past.

September 5th CYBHWG meeting

The objectives of this meeting were for the Work Group to take a first look at the 33 recommendations that the five subgroups were in the process of developing, to ask questions to better understand the recommendations, to provide input to strengthen the recommendations, and to identify intersections across the recommendations and with other work being undertaken outside the Work Group.

Each subgroup had 15 minutes to present their draft recommendations, followed by two rounds of breakout discussions organized first by subgroup and then by theme. The systems expert who had introduced a framework last year to help the Work Group think more critically about the impact each recommendation will have on the broader system returned to review the various levers that each recommendation might act on to impact children and youth behavioral health – whether immediately or over the longer term.

October 14th CYBHWG meeting

This meeting was dedicated to the presentation and discussion of the final proposed recommendations, as well as voting to determine their prioritization. 31 of 38 members attended this meeting. 26-29 members participated in the votes throughout the day. Each year, some members choose to abstain from voting based on their agency affiliation.

The Work Group considered 29 total recommendations across three categories: Overarching, Legacy, and New.

Overarching. Behavioral Health Catalyst (the organization providing strategic support and staffing to the CYBHWG) summarized the five Overarching Recommendations and invited questions. After discussion, Work Group members were asked via Mentimeter whether they supported advancing them. The response was: Yes (26), Yes with discussion (3), and No (0).

Legacy. Behavioral Health Catalyst summarized the seven Legacy Recommendations and invited questions. After discussion, Work Group members used Mentimeter to rank the recommendations in order of priority. Detailed results of this vote are reflected in this report and summarized in Figure 1 below.

After discussion, Work Group members were asked via Mentimeter whether they supported advancing them as prioritized. The response was: Yes (29), Yes with discussion (0), and No (0).

New. The Work Group members first rated and ranked the New Recommendations for the purposes of discussion. Using Mentimeter, members were asked to rate each of the 17 new recommendations on 1) their actionability and 2) their potential impact on equity. The results were presented by Behavioral Health Catalyst. Next, members were asked to rank the new recommendations in order of priority. Due to technical limitations in the voting software, the recommendations had to be broken into two groups. The members ranked the seven recommendations with an estimated cost of <$1M separately from the ten recommendations with an estimated cost of >$1M.

After these first votes, members broke into small groups to discuss the results. Each small group shared key discussion points with the larger group.

Another ranking vote with the recommendations organized into two groups was conducted before reducing the total number of recommendations under consideration. To reduce the number of recommendations to less than twelve, Behavioral Health Catalyst identified the recommendations that had been ranked 1st, 2nd, or 3rd by the greatest number of members. This led to eleven recommendations being prioritized, and seven recommendations being moved into the "Additional Recommendations" section of this report.

26 members ultimately voted to determine the prioritization of the 11 Priority New Recommendations. The results of the final votes are reflected in this report and summarized in Figure 2 below.

Additional recommendations. The six recommendations that were prioritized by subgroups and not adopted by the CYBHWG at this time are presented in this report to honor the deep work conducted in developing these recommendations, and the support of subgroup participants for pursuing action in each of the recommendations' target areas.

Figure 1. Voting results to prioritize Legacy recommendations

LEGACY RECOMMENDATIONS	($$$) Increase investment in IECMH-C (Holding Hope program)	($TBD) Conditional Scholarships	($TBD) Behavioral Health Teaching Clinic designation & enhancement rate	($TBD) Fund the supervisor stipend program	($) Mental Health Literacy Coordinator	($$$$) Expand the ECEAP Complex Needs Funds	($$$) Expand Early (birth to three) ECEAP
How many voters ranked this recommendation in this position?							
1st	2	3	8	1	3	2	10
2nd	5	5	3	1	2	5	8
3rd	7	4	4	3	0	9	2
4th	6	6	5	1	3	4	3
5th	2	5	7	6	4	2	1
6th	6	3	2	4	9	2	0
7th	1	2	0	11	6	3	3
Not ranked	0	1	0	2	2	2	2
Vote count	**29**	**29**	**29**	**29**	**29**	**29**	**29**
How many points did this recommendation receive based on voters' rankings?							
	14	21	56	7	21	14	70
	30	30	18	6	12	30	48
	35	20	20	15	0	45	10
	24	24	20	4	12	16	12
	6	15	21	18	12	6	3
	12	6	4	8	18	4	0
	1	2	0	11	6	3	3
	0	0	0	0	0	0	0
Total score	122	118	139	69	81	118	146
RANKING	**3**	**4**	**2**	**7**	**6**	**4**	**1**

Figure 2. Voting results to prioritize New recommendations

	($) RUBI parent training program pilot expansion	($$-$$$) Increase family psychotherapy reimbursement rate	($$) Fund youth-focused curriculum for Behavioral Health Support Specialists (BHSS)	($TBD) Develop and pilot a dyadic benefit ...	($TBD) ... assessment to fund Medicaid mental health counseling ...at Medicare rates	($$$) Expand the Bridge housing program	($$$) Expand Maternity Support Services (MSS)...	($) Strengthening statewide guidance and direction for schools	FINAL: ($) Support expansion of recovery high schools	FINAL: ($$$) Establish a Technical Assistance & Training Network (TATN)	($TBD) Expand access to peer supports in school settings & professional peer pathways...
How many voters ranked this recommendation in this position?											
1st	7	2	0	3	5	5	0	1	0	3	0
2nd	8	2	0	2	1	2	2	4	2	1	1
3rd	2	0	2	1	2	2	2	5	4	4	1
4th	5	2	0	0	2	3	2	2	3	0	5
5th	2	1	1	2	4	3	2	2	1	2	4
6th	2	2	3	2	3	1	1	3	1	2	2
7th	0	3	0	3	0	1	5	1	5	1	3
8th	0	0	4	6	1	0	2	3	3	0	1
9th	0	2	5	2	2	3	2	2	1	0	1
10th	0	4	3	0	2	0	4	1	1	3	2
11th	0	4	3	1	0	2	1	0	2	6	1
Not ranked	0	4	5	4	4	4	3	2	3	4	5
Vote count	**26**	**26**	**26**	**26**	**26**	**26**	**26**	**26**	**26**	**26**	**26**
How many points did this recommendation receive based on voters' rankings?											
	77	22	0	33	55	55	0	11	0	33	0
	80	20	0	20	10	20	20	40	20	10	10
	18	0	18	9	18	18	18	45	36	36	9
	40	16	0	0	16	24	16	16	24	0	40
	14	7	7	14	28	21	14	14	7	14	28
	12	12	18	12	18	6	6	18	6	12	12
	0	15	0	15	0	5	25	5	25	5	15
	0	0	16	24	4	0	8	12	12	0	4
	0	6	15	6	6	9	6	6	3	0	3
	0	8	6	0	4	0	8	2	2	6	4
	0	4	3	1	0	2	1	0	2	6	1
	0	0	0	0	0	0	0	0	0	0	0
Total score	241	110	83	134	159	160	122	169	137	122	126
FINAL RANKING	1	10	11	6	4	3	8	2	5	8	7

Appendix B: Understanding the system

The recommendations put forward by the subgroups each year touch on many different aspects of Washington's behavioral health system. Some will have an impact immediately, some over the long term. Some focus on a specific population along the developmental continuum from prenatal through age 25, some are relevant to everyone. Some provide funding for services, some aim to change policy. Ultimately, the Work Group's aim is to move the behavioral health system out of crisis mode and into a proactive stance of supporting children, youth, young adults – and their families and caregivers – to thrive.

Beginning in 2023, the Work Group engaged a systems expert, Chris Soderquist, to introduce how systems thinking can help us make sense of the diverse recommendations it has to consider. Chris helped the Work Group develop a framework (a systems map with seven key levers) for exploring the impact of its recommendations on the broader system. These concepts of system dynamics and leverage are also being incorporated into Washington Thriving, the effort to develop a P-25 Strategic Plan. Eventually, we expect the P-25 Strategic Plan to focus the Work Group's efforts on the highest-leverage recommendations we can make.

This year, the CYBHWG continued building its collective understanding of the concepts underpinning systems, as well as exploring the importance of "adaptive leadership." Adaptive leadership involves anticipating likely future needs, trends and options, articulating these needs to build collective understanding and support for action, adapting so that there is continuous learning and the adjustment of responses as necessary, and accountability, including maximum transparency in decision making processes and openness to challenges and feedback. The CYBHWG is constantly assessing new information and recognizes the need to continuously iterate and adapt interventions as more is learned. The latter is important because we are dealing with what experts describe as a "wicked system." Wicked is used here not to say the system is bad; rather, wicked is used to describe the complexity of the system. Wicked problems require adaptive leadership.

In June and July, Chris joined Work Group meetings to review the ideas introduced last year. In August, members of the Work Group met voluntarily to further develop the systems map introduced last year, which is presented in Figure 1 below.

At the September meeting, after seeing the draft recommendations for the first time, Chris discussed with the group how they could use the systems map and its levers as they considered the draft recommendations. He hosted four optional office hours where members and subgroup leads could consult with him to build their understanding and explore the recommendations using the framework.

To continue pushing the Work Group's collective thinking about how our recommendations impact the larger system, we asked Behavioral Health Catalyst (the organization providing strategic support and staffing to the CYBHWG) to review the list of proposed recommendations against the levers. Although time did not allow for discussion of this in the October meeting, we are sharing this analysis in Figure 2 below, which shows, for each proposed recommendation, the primary levers that the recommendation acts on.

Figure 1. Map of system dynamics and key levers

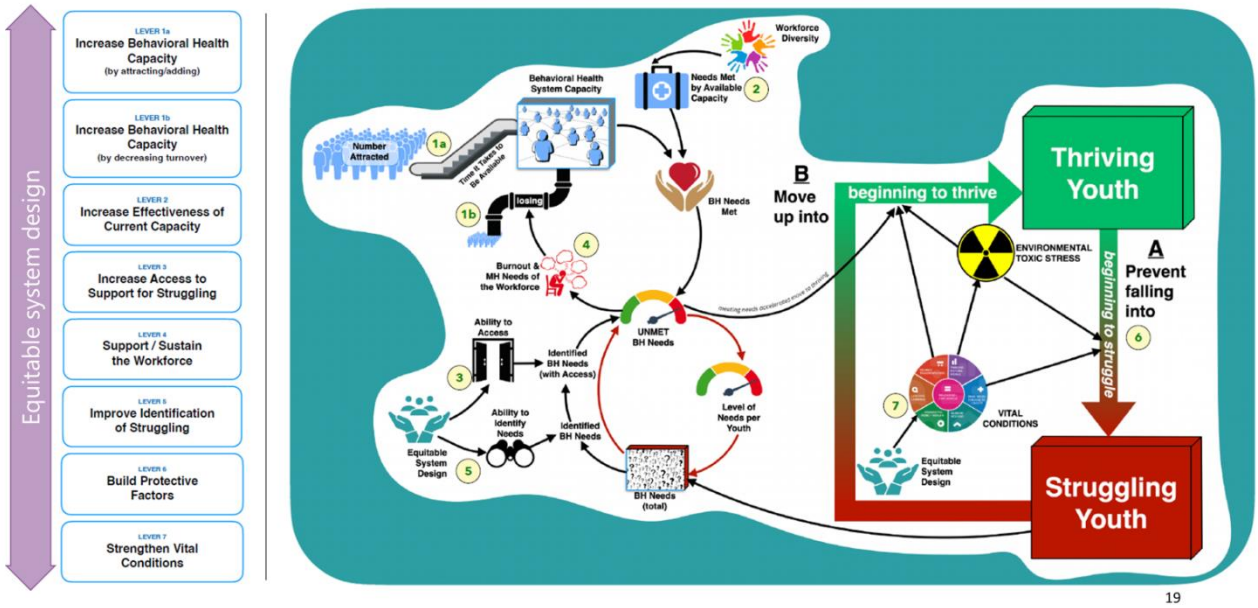
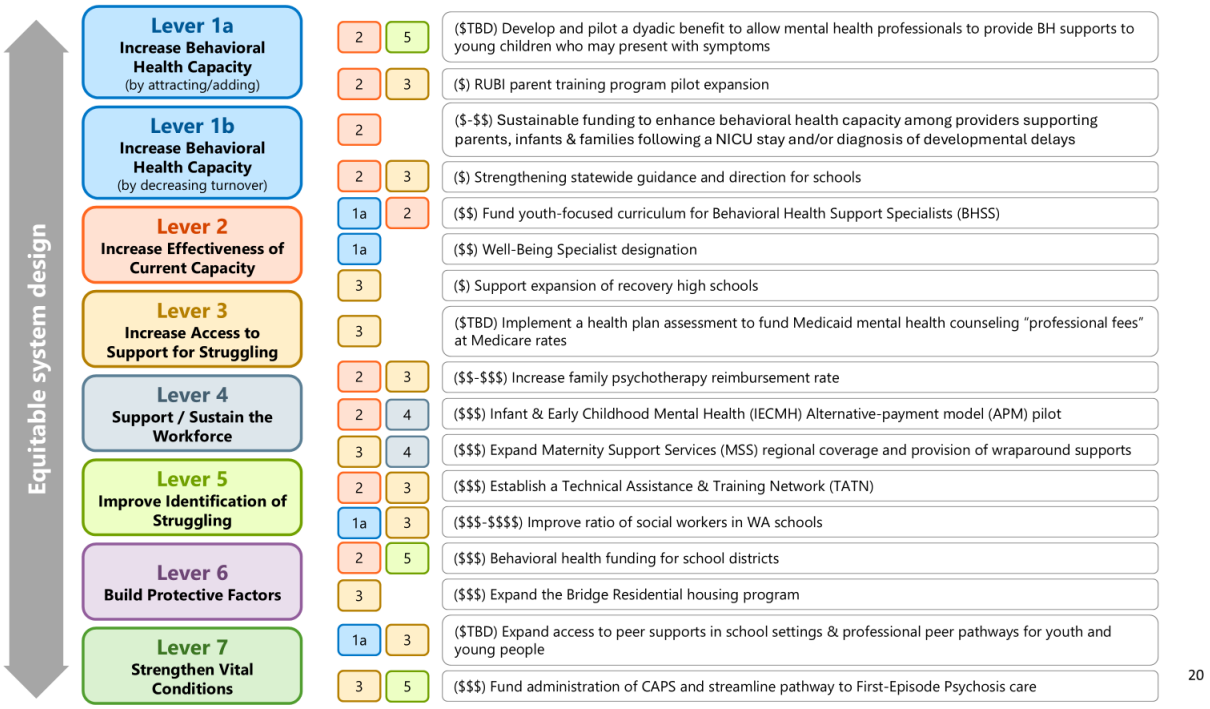


Figure 2. Relationship between proposed recommendations and system levers



Appendix C: Contributors

Representatives from the following organizations participated in Work Group meetings and subgroup meetings in 2024, thus informing the 2025 recommendations.

Advocates and Community Organizations

A Common Voice

Asia Pacific Cultural Center

Behavioral Health Workforce Investment

Catholic Community Services of Western Washington

Center for Early Relational Health

Chad's Legacy Project

Child Care Aware of Washington

ChildStrive

Children's Alliance

Committee for Children

Communities in Schools of Washington State Network

DadsMOVE

Equity in Education Coalition

Empower Next Generations

Family, Youth & System Partner Round Tables (FYSPRTs)

First 5 FUNdamentals

Full Frame Initiative

Greater Health Now

Health Commons Project

HopeSparks

Institute for Family Development

Justice for Girls Coalition

Kindering

MomsRising

North Sound Behavioral Health Administrative Services Organization

National Council for Mental Well-being

NorthStar Advocates

Partners for Our Children

Prenatal Support Washington

Program for Early Parent Support

Ryther

Save the Children Action Network

Shine Light on Depression / Erika's Lighthouse

Start Early Washington

Southwest Accountable Community of Health

SPARK Program – Washington Youth Network

TeamChild

The Arc of King County

Treehouse

Thriving Together

Voices of Pacific Island Nations

Washington Association for Community Health

Washington Association for Infant Mental Health

Washington Association of School Social Workers

Washington Autism Alliance

Washington Chapter of the American Academy of Pediatrics

Washington Council for Behavioral Health

Washington Disability Rights

Washington Education Association

Washington Head Start and ECEAP Association

Washington Mental Health Counselors Association

Washington National Alliance on Mental Illness (NAMI)

Washington Occupational Therapy Association

Washington Partnership for Action, Voices for Empowerment (PAVE)

Washington Psychiatric Association

Washington School-Based Health Alliance

Washington School Counselor Association

Washington State Alliance of Boys and Girls Clubs

Washington State Allied Health Center of Excellence

Washington State Association of School Psychologists

Washington State Community Connectors

Washington State Council of Child and Adolescent Psychiatry

Washington State Hospital Association

Washington State Medical Association

Washington State Parent Teachers Association (PTA)

Washington State Psychiatric Association

Washington State School Districts Association

Washington Student Association

Washington Youth Alliance

Education and Research

Burlington-Edison School District

Educational Service District 113

Educational Service District 114

Educational Service District 189

Granger School District

Highland School District

Interagency Recovery Academy

Monroe School District

North Central Educational Service District

Pasco School District

Puget Sound Educational Service District

Quillayute Valley School District

Renton School District

Richland School District

Seattle Public Schools

Spokane Public Schools

University of Washington Co-Lab

University of Washington Evidence-based

Practice Institute

University of Washington Department of Psychiatry

University of Washington School of Social Work

University of Washington SMART Center

University of Washington SPIRIT Lab

University of Washington Youth Care

Vancouver Public Schools

Washington Association of Educational Service Districts

Washington Association of School Principals

Washington Education Association

Washington State School Directors Association

Washington State University

Western Washington University

Whitworth University

Philanthropic Organizations

Ballmer Group

Health Career Fund

Perigee Fund

Behavioral Health Catalyst

Managed Care Organizations & Commercial Insurers

Community Health Network of Washington

Coordinated Care

Kaiser Permanente

Molina Healthcare

MultiCare

Premera Blue Cross

United Healthcare

Providers

Akin

Atlantic Street Center

Beacon Health System

Carelon Behavioral Health of Washington

Catalight: Quality Care & Access for Behavioral Health

Center for Human Services

Child and Adolescent Clinic

Columbia River Mental Health Services

Community Youth Services

Community Health Systems

Crisis Connections

Excelsior Wellness Center

Foundation for Health Care Quality

Greater Columbia Behavioral Health

Harborview Medical Center

Hospital to home

Island Health

Kids Mental Health Washington

Kitsap Mental Health Services

Madrona Recovery

Mary Bridge Children's Hospital

Northwest Pediatric Center

New Port Healthcare

North Urban Human Services Alliance

Pediatrics Associates of Whidbey Island

Pediatric Health Integration

Pierce County Early Childhood Network

Providence Health Services

Seattle Children's Hospital

Seneca Family of Agencies

Somerset Counseling Center

Spark Behavioral Associates

Spokane County Regional Behavioral Health

The Practice NW

University of Washington

Yakima Valley Farmworkers Clinic

State and County Agencies

Clark County Juvenile Justice

Department of Children, Youth and Families

Department of Commerce

Department of Health

Department of Justice

Department of Social and Health Services

Health Care Authority

King County Behavioral Health and Recovery

King County Health Department

Office of Developmental Disabilities Ombuds

Office of Homeless Youth

Office of the Attorney General

Office of the Governor

Office of the Insurance Commissioner

Office of the State Auditor

Office of the Superintendent of Public Instruction

Tacoma-Pierce County Health Department

Tulalip Tribes

Workforce Training and Education Coordinating Board

Appendix D: About the Children & Youth Behavioral Health Work Group

In 2016, Engrossed Second Substitute House Bill 2439 established the Children's Mental Health Work Group (renamed the Children and Youth Behavioral Health Work Group [CYBHWG]), bringing together legislators, state agencies, health care providers, tribal governments, and other stakeholders to identify and address issues related to mental health access for children, youth, young adults and families, and make recommendations to the Legislature.

Originally the CYBHWG was established for a one-year period and since then (2018, 2020, 2024) it has been reauthorized, most recently in 2024 with Engrossed Substitute House Bill 2256 now to run through 2029. In 2022, the legislature passed Second Substitute House Bill 1890, authorizing the Children & Youth Behavioral Health Work Group to convene an Advisory Group to develop and draft a statewide strategic plan for prenatal-through-age-25 behavioral health. This effort is now referred to as Washington Thriving. A progress report on the development of the strategic plan is provided in a companion report to this one (Part 2).

The Work Group has 38 members, listed below.

Additional information about the CYBHWG, including past recommendations and meeting notes can be found on the CYBHWG webpage.

2024-25 Work Group Members

Member	Represents
Representative Lisa Callan (D) Jason McGill, Health Care Authority (HCA)	Co-Chairs
Representative Carolyn Eslick (R) Representative My-Linh Thai (D) (alternate) Representative Michelle Caldier (R) (alternate)	Washington State House of Representatives
Senator Claire Wilson (D) Senator Judy Warnick (R)	Washington State Senate
Diana Cockrell	Health Care Authority
Judy King	Department of Children, Youth and Families
Shelley Bogart	Department of Social and Health Services - Developmental Disabilities Administration
Michele Roberts	Department of Health
Kim Justice (through September 2024) *To be appointed*	Office of Homeless Youth Prevention and Protection Programs
Amber Leaders	Office of the Governor
Delika Steele	Office of the Insurance Commissioner

Anna Marie Dufault	Office of the Superintendent of Public Instruction
Andrew Joseph, Jr., Confederated Tribes of the Colville Reservation Summer Hammons, Tulalip Tribes (served through March 2024)	Tribal governments
Erin Wick, ESD 113 (beginning June 2024)	Educational Service District representative
Michelle Karnath	Statewide Family, Youth and System Partner Roundtable (FYSPRT)
Val Jones, North Sound Behavioral Health Organization (beginning June 2024)	Behavioral Health Administrative Services Organization (BH-ASO)
Noah Seidel, Developmental Disabilities Ombuds	Organization representing the interests of individuals with developmental disabilities
Libby Hein, Molina Healthcare	Medicaid Managed Care Organization (MCO)
Maureen Sorenson, Coordinated Care	Medicaid MCO serving child welfare
Mary Stone-Smith, Catholic Community Services of Western Washington	Community mental health agency
Laurie Lippold, Partners for Our Children	Advocate for children and youth behavioral health issues
Dr. Eric Trupin, University of Washington	Evidence Based Practice Institute
Preet Kaur, Regence Blue Shield	Private insurance organization
Dr. Avanti Bergquist, Child and Adolescent Psychiatry	Child psychiatrist
Jim Theofelis, NorthStar Advocates	Regional provider of co-occurring disorder services
Dr. Larry Wissow, Seattle Children's Hospital	Pediatrician or primary care provider
Dr. Thatcher Felt, Yakima Valley Farm Workers Clinic	Pediatrician located east of the crest of the Cascade Mountains
Kelli Bohanan, Akin	Provider specializing in infant or early childhood mental health
Cindy Myers, Yakima Valley Farmworkers Clinic (served through March 2024) *To be appointed*	Provider of culturally and linguistically appropriate health services to traditionally underserved communities
Joel Ryan, Washington State Association of Head Start and Early Childhood Education and Assistance Program (WSA)	Early learning and childcare providers
Jackie Yee, Educational Service District 113	Substance use disorder professional

Dr. Bob Hilt, UW Department of Psychiatry	Education or teaching institution that provides training for mental health professionals
Hannah Adira Javiera Barria-Opitz (served through March 2024) *To be appointed*	Youth representatives (2)
Angela Cruze (beginning June 2024)	Parent or caregiver of child under the age of 6 who has received behavioral health services
Kristin Houser	Parent or caregiver whose child or youth has received behavioral health services
Mary McGauhey	Foster parent

CYBHWG Subgroups

Five subgroups meet regularly to develop recommendations in key issue areas. Each of these subgroups is described below.

Workforce and Rates (W&R)

Leads: Hugh Ewart (Adduna Health), Laurie Lippold (Partners for Our Children), & Renee Fullerton (Washington Workforce Training & Education Coordinating Board)
Supported by Representative Mari Leavitt (28th district)

The Workforce and Rates subgroup was formed in 2019 and with subgroup meetings held throughout the year. This subgroup is open to anyone who wants to participate, with a mailing list of over 100 people and at least 30 people attending each meeting, the work group benefits from the participation of many individuals who draw on their professional expertise and personal experience. The group coordinates with others doing related work, including the Workforce Training and Education Board, the Behavioral Health Institute, University of Washington, managed care organizations (MCOs), community behavioral health agencies (CBHAs) and the philanthropic community. Their recommendations reflect their findings that:

- There is a significant shortage of behavioral health providers for children and youth, at a time when behavioral health needs are expected to grow;
- The greatest shortages are among providers who are reflective of the communities and people they serve; and
- provider rates do not currently cover costs and this dynamic feeds into the workforce shortages and thus access problems.

Prenatal through Five Relational Health (P5RH)

Leads: Kelli Bohanon (Akin) and Sandra Diaz (Washington State Association of Head Start & ECEAP)
Supported by Representative Debra Entenman (47th district)

Prenatal through Age Five Relational Health subgroup was established in 2019 and is open to anyone that would like to participate. The subgroup focuses on the CYBHWG's vision for infants, young children, and their families, including pregnant people. This subgroup continues to do outreach to engage stakeholders of diverse races, income, and family needs to have a community-informed policy development approach. This outreach includes parents and caregivers of children with behavioral health needs to share their perspectives and lived experience regarding barriers and solutions. Today, the group of stakeholders

includes parents/caregivers, behavioral health clinicians, early learning professionals, policymakers, advocates, physicians, regulators, and payors. This subgroup remains open to anyone who wants to participate. The subgroup holds a set of defined principles, introduced in 2019 and refreshed in 2024, that frame recommendation development. These principles are:

- Hear the voices of families and proactively embed family voice in recommendations where possible;
- Close health disparities, fueled by systemic oppression and institutional racism, for families of color;
- Provide immediate relief for behavioral health needs for families, especially those who are most vulnerable; and
- Focus on the needs of children and their families particular through the prenatal through age five phase of life, during this time of great potential and vulnerability.

Additionally, the group focuses on crafting recommendations considering the following criteria:

- The size and scope are realistic and achievable given the state budget and policy landscape (which dramatically evolved during the 2021 legislative session);
- have capacity to be implemented;
- Advance equity by closing gaps in health access and outcomes utilizing anti-racist and anti-oppressive measures;
- Strengthens/transforms foundational systems; and
- Fits within the work group scope.

Today, the group is focused on evolving a shared understanding of the scope, depth and breadth of the issues that encapsulate early relational health and developing robust recommendations that represent a holistic conceptualization of early relational health, inclusive of both prenatal and maternal/parental health.

School-based Behavioral Health and Suicide Prevention (SBBHSP)

Leads: Representative My-Linh Thai (41st district) and Christian Stark (OSPI)

The School-Based Behavioral Health and Suicide Prevention subgroup was established in 2019. The subgroup has grown from an initial 25 appointed members to 45 on this subgroup, representing families and students; behavioral health providers and agency representatives; school district and educational service district staff and administrators; and stakeholders from health care organizations, higher education, and advocacy groups. Non-members are encouraged to attend the group's meetings and share their perspectives during the public comment period. They identified the need for increased staffing to support children's social, emotional, and behavioral needs, and a system for ensuring all students receive universal supports. Since inception, the subgroup has evolved to include leadership opportunities for parents, youth, and advocacy professionals, to help guide development of the subgroup's priorities, and to implement a culture of multi-collaboration and consideration of diverse perspectives. Over the years, the group found that the pandemic has highlighted existing gaps in support for students' behavioral health and emotional well-being, leaving Washington schools at a disadvantage to serve students' academic and emotional needs without an established multi-tiered system of support (MTSS), which would have provided the systems, structures, and practices to respond more effectively. As a result, the subgroup determined support for OSPI's decision packages funding MTSS and enhanced staffing levels of professionals are the most effective tools to meet students' behavioral health needs now and in the future.

Youth and Young Adult Continuum of Care (YYACC)

Leads: Representative Lauren Davis (32nd district), Representative Carolyn Eslick (39th district), Michelle Karnath (Parent), and Taanvi Arekapudi (Young Adult)

The Youth and Young Adult Continuum of Care subgroup was formed in 2020, and open to anyone that would like to attend. In addition to addressing the unique behavioral health needs of youth and young adults, ages 13-25, this group explores problems and proposed solutions from the regional network of Family, Youth and System Partner Round Tables (FYSPRTs) which identify access problems in local communities. With a mailing list of over 100 individuals, the group includes mental health providers, advocates, health plans, agency representatives, and youth – and parents of children and youth – who have received behavioral health services. In developing its initial recommendations, the YYACC group brought in providers from every stage of the continuum of care – from prevention to inpatient treatment – to present and consult; the group also held listening sessions with youth and young adults, and family members. Of concern to everyone was the increase in psychiatric distress in youth due to the pandemic, including an increase in lethality of suicide attempts and acuity of symptoms in youth with no previous behavioral health history. The group continues to centralize youth and family voice and features presenters across the continuum of care to develop robust recommendations.

Behavioral Health Integration (BHI)

Leads: Kristin Houser (Parent) and Sarah Rafton (Washington Chapter of the American Academy of Pediatrics)

The Behavioral Health Integration subgroup was established in 2021 and is open to anyone who would like to participate. It includes representatives from behavioral health and primary care providers from various types of communities, Medicaid managed care organizations and commercial carriers, behavioral health providers and state agencies. The development of recommendations is grounded in the subgroup's mission and vision. Its mission is to:

- Support the implementation of integrated care for children and youth in Washington State to promote behavioral health and early identification and treatment for behavioral health issues
- Support the development of best practices in integrated care for children and youth with consideration of national and local, culturally-appropriate, evidence-based practices
- Identify barriers to implementing integrated care in WA State and create equity-centered policy recommendations to remove barriers
- Support the development of an integrated system of care, in which primary care is foundational and helps ensure that behavioral health care is accessible, effective, and patient and family-centered

Its vision is to create an integrated system of behavioral health care for children and youth in Washington State that is:

- Sustainably funded;
- Accessible in primary care, in an environment that is free from stigma and promotes engagement with children, youth, and families;
- Coordinated with other providers of behavioral health care, including behavioral health centers, schools, and hospitals;
- Supportive of a diverse and well-trained workforce;
- Considerate of relational needs of children, youth, and their families;

- Able to provide adequate and evidence-based care for children and their families, beginning in early childhood; and
- Advancing equitable services and outcomes for the most under-resourced and historically marginalized communities.

Appendix E: Recommendation Detail

Below are detailed descriptions of each recommendation. The descriptions address four key questions: 1) what is the issue, 2) what is recommended, 3) why is this a smart move now, and 4) what outreach informed the recommendation.

All recommendations include rough budget estimates, using the scale below. For the most part, these were developed by the subgroups and not by agency staff. They reflect best guesses from those involved. It is understood that the actual fiscal impact is highly dependant on the language and scope of legislative action. Where specific dollar amounts are provided, the information was gleaned from state agency decision packages or actual program costs as presented by the provider.

Finally, each recommendation indicates whether it requires new funding, legislative action, and/or agency action.

Key definitions used in recommendation descriptions

Type
New: New recommendations, either previously recommended by a subgroup and not prioritized by the CYBHWG or not recommended previously.
Legacy: Related to established legislation that requires further advancement to achieve its original aims.

Cost
$TBD: Scalable or unknown cost
$: <$500,000
$$: $500,000-$999,999
$$$: $1 million-$10 million
$$$$: >$10 million
N/A: No cost

Action
Budget ask: Requires new funding be allocated.
Legislative policy: Requires legislative action.
Agency policy change: Requires agency action

Overarching Recommendations

Overarching recommendations address cross-cutting challenges and have potential for system-level impact. The Overarching recommendations are presented in no particular order.

Enhance substance use disorder prevention services and quality substance use disorder and co-occurring mental health care for youth, young adults, and families

New, $37.4M (ASAM-4/ATAY: $27.5M, CPWI, HYS, YAHS: $9.9M), **Budget ask**

Recommendation

The CYBHWG requests the Legislature allocate additional staffing and financial resources for the Washington State Health Care Authority in the 2025-2027 biennium to: Stabilize community and school substance used disorder prevention and mental health promotion services, increase the ability to detect behavioral health trends in youth, young adults and pregnant and parenting people, and enhance quality SUD care for adolescents and transition-age youth.

- Supporting state opioid settlement priorities;
- Supporting the ASAM-4 package to incorporate and integrate MOUD care and co-occurring MH/SUD care; and
- Supporting the prevention package enhancing the capacity of the Community Prevention Wellness Initiative (CPWI) and Healthy Youth data collection initiatives.

What is the issue?

The CYBHWG supports enhancing provider training and program implementation particular to co-occurring conditions and whole-family supports that aim to improve health equity by increasing community access, awareness, and care coordination across the prenatal through age 25 continuum of care.

Building off 2SSB 6228, in 2026 an updated ASAM Criteria for Adolescent and Transition Age Youth (ATAY) will be released and will require Washington State's ATAY substance use disorder (SUD) services to transition to a cooccurring model of care (SUD and mental health treatment). HCA received some funding in the 2024 Supplemental budget to support the additional training needs driven by 2SSB 6228. However, HCA has identified that implanting certain components of Adult ASAM Criteria 4 will have additional impacts requiring ongoing program management support and dedicated funding for enhanced Medicaid Rates, training, technical assistance, and implementation support. In addition, preparation for the upcoming systemic changes to ATAY SUD services requires dedicated funding to advance those efforts.

The rollout of updated ASAM Criteria for Adult and ATAY, in tandem with appropriate training, technical support and strategic planning supported by this ask, will be a significant support in identifying needs to implementation to a co-occurring model of care that incorporates more prevention, early intervention approaches. An updated ASAM ATAY is anticipated to be released in 2026 and will require Washington State's ATAY substance use disorder (SUD) services to incorporate significant changes to the care continuum. These include:

- Transition to a co-occurring model of care (SUD and mental health treatment) at every level of treatment, including low-level intensity outpatient services to address the need of early-intervention services in ATAY behavioral health

- An emphasis on Home and Community based services to increase accessibility and better include family/caregiver involvement
- ATAY developmentally focused care which includes 'family services' to be provided at every level of care and an increase of clinical service hours for residential programs

By preparing appropriate training, technical support, and strategic planning, the Washington State Health Care Authority will be ready to submit a decision package in 2026 that incorporates fiscal projections for rate increases and funding to support new levels of care and associated requirements for ATAY. This timeline is intentional with the anticipated release of the ATAY volume and coordinated planning efforts.

The Community Prevention and Wellness Initiative (CPWI) aims to improve health equity by directing services to communities with higher need and reducing barriers for engaging diverse voices; decrease stigma, strengthen communities and schools, and respond to locally identified needs; enhance assessment of critical health indicators and future need and increase accessibility of data to increase evidence based decision making in the community and schools; and decrease pressure on overburdened treatment and clinical services.

CPWI focuses interventions on communities at higher risk based on mental health, truancy, substance use, and other risk factors.

- Of CPWI communities: Nearly half are rural; 41 percent have over 60 percent of children and youth utilizing Medicaid services; and about a third have over 40 percent BIPOC children.
- Opioid overdose rates for adolescents nearly tripled from 2016 to 2024.
- Despite a high need demonstrated by Medicaid utilization, the prevention services are not eligible for Medicaid match funds.

To perform this work effectively, providers will need significant program support and training in the updated ASAM and ATAY criteria and increased access to and education of HYS and YAHS data. These recommendations address findings from the Washington Thriving discovery sprint and the need to provide services in home and community settings, to increase equitable and sustainable service access for individuals who use drugs.

What do you recommend?

Based on recommendations from the Washington Thriving P-25 Strategic Plan initiative, the CYBHWG recommends the following approach:

- Stabilize whole-family, community and school SUD prevention and mental health promotion (MHP) services, particularly for pregnant and parenting individuals and transition-age youth.
- Increase program supports, provider training and care coordination for co-occurring mental and behavioral health and SUD conditions.
- Enhance data collection, integration and education to bolster prevention efforts.
- Center services supporting culturally-appropriate community behavioral health and wellness.

This recommendation seeks to address these recommendations through enhancing essential coordinated mental and behavioral health service provision particular to populations experiencing co-occurring conditions, by:

- Building off 2SSB 6228, allocate funds to HCA to implement Adult ASAM4 and future ASAM Criteria which impact the adult population, and mechanisms to mobilize implementation of ATAY edition impacting transition-age youth with co-occurring needs.

- Sustaining and increasing investment in CPWI, Healthy Youth Survey (HYS) and Young Adult Health Survey (YAHS) to stabilize community and school SUD prevention and mental health promotion (MHP) services, increasing the ability to detect behavioral health trends in youth and young adults and empower local solutions to local problems.

Building off 2SSB 6228 for people experiencing co-occurring conditions

Preparation for the upcoming systemic changes to ATAY SUD services requires dedicated funding to advance those efforts.

ASAM-4 ATAY edition implementation: $27.486M
Key target areas for implementation of ASAM-4

- Program-specific funding: $607K GF-S FY26-27; $607K GF-S 28-29. These funds will continue support for Adult ASAM4 implementation as well as the upcoming Correctional Settings and Reentry (CSR) and Behavioral Addictions (BA) population-specific ASAM criteria; and support education and communication/media campaigns through contracts.
- Workforce considerations: $374K FY26-27; $374K 28-29. These funds would support 1.0 FTE MAPS3 to oversee Adult ASAM4 implementation and future ASAM Criteria which impact the adult population, including CSR and BA, and costs to attend ASAM and other related SUD trainings.
- Services funding: $6.192M FY26-27 GF-S, $10.919M FY 26-27 Federal. These funds will support a new level of services and requirements, or a standard of care associated with the change in criteria for the ASAM4.
- Provider start-up costs: $2.1M GF-S. These funds would support providers transitions to the new ASAM criteria.

Key target areas for implementation of ATAY:

- Program-specific funding: $2.764M GF-S FY26-27; $2.364M GF-S FY28-29. These funds support training and technical assistance through contracts, including:
    - Co-occurring training for organizations and providers statewide
    - Ongoing implementation support and monitoring for providers, agencies, and organizations to successfully integrate co-occurring models of care for ATAY populations.
    - Supporting and increasing awareness of behavioral health employment campaigns to specialize in co-occurring care
    - Provider listening sessions
    - Training coaching calls/drop-in support
- Workforce considerations: $974K GF-S FY 26-27; $1.574M GF-S FY 28-29.
    - FTE support: $374K GF-S 26-27; $374K GF-S 28-29. These funds support 1.0 FTE MAPS3 to oversee ATAY implementation inclusive of critical strategic planning to onboard service providers and increase service delivery to home and community-based settings and program costs to attend ASAM and other related SUD trainings.
    - ATAY Edition Implementation Analysis Strategic Partner: $600K GF-S FY27; $1.2M GF-S FY28-29. These funds support ongoing assessment of whole system redesign, including:
        - Research to identify service gaps in providing co-occurring care.
        - Community engagement and stakeholder sessions to determine needs for ATAY SUD services per region.
        - Analysis of findings, creation of statewide strategic plan for increased ATAY service delivery

Sustaining and increasing investment in CPWI, HYS & YAHS

Fund $9.93M in operating support to the Health Care Authority, inclusive of 4 FTEs to expand the current CPWI program, increase administrative support and data collection capabilities to detect behavioral health trends in youth and young adults, disseminate data in an accessible format, and empower local solutions to local problems through the HYS and YAHS. FTE will support HCA workforce through increased capacity and more balanced workloads to effectively support services thus positively impacting staff wellness and retention.

Funding allocations breakdown:

- Workforce: 4 FTEs $1.17M; & $696K operating support GF-S 26-27.
- CPWI Rate Increase: $3.34M GF-S
- HYS/YAHS Stabilization & Enhancement: $4.6M GF-S. Provides an increase of 67 percent for HYS and a 100 percent increase for YAHS due to increased inflation since 2016 and for essential data collection.

With additional funding, this approach would stabilize community and school substance used disorder (SUD) prevention and mental health promotion (MHP) services. It would also increase the ability to detect behavioral health trends in youth and young adults through the HYS and Young Adult Health Survey (YAHS), disseminate the data in accessible formats, and empower local solutions to local problems.

This systems approach through the Community Prevention and Wellness Initiative (CPWI) program[1] will:

- Improve health equity by directing services to communities with higher need and reducing barriers for engaging diverse voices,
- Decrease stigma, strengthen communities and schools, and respond to locally identified needs,
- Enhance assessment of critical health indicators and future need and increase accessibility of data to increase evidence-based decision-making in the community and schools, and
- Decrease pressure on overburdened treatment and clinical services.

Why is taking the recommended action a smart move now?

CPWI is an established framework with proven outcomes[2,3,4] in drug and alcohol use prevention by slowing the trajectory of drug use initiation and closing the equity gap between high and low need communities. It focuses resources in nearly 100 diverse communities and schools with higher risk and need to maximize the impacts of funds. Years of level funding, increased costs, and service reductions now present an opportunity. CPWI providers and schools supporting this decision package (DP) are requesting additional funding. Similar federal initiatives receive up to 50 percent more funding per site. Bolstering these services with increased funding would quickly stabilize the initiative.

Currently, only a small portion of Adult and ATAY SUD services meet the anticipated ASAM changes. Changes to services under the adult ASAM4 and the ATAY Edition will require updated treatment approaches and system redesign. Additionally, ATAY SUD treatment has historically focused on individuals coming to organizations, health care settings, and other institutions for treatment, which are inclusive of family and caregiver involvement specifically for ATAY populations. The updated ASAM Criteria for Adult

[1] https://www.hca.wa.gov/assets/program/factsheetcommunitypreventionwellnesscoalitions.pdf
[2] https://theathenaforum.org/sites/default/files/public/prsc_policy_brief_shared_rp_factors_opioid_misuse_published_3.19.24.pdf
[3] Community Prevention and Wellness Initiative: Impact Over Time Report Technical Report No. 20. July 25, 2023
[4] Prevention and Wellness Initiative: Developmental Trend Analysis; 2020

and ATAY outline the need to provide services in home and community settings, to increase equitable and sustainable service access for individuals who use drugs. This will require adjustments to service codes and fiscal assumptions at minimum, and a major adjustment to service delivery for Washington providers as they adopt the new criteria. This DP would ensure adequate resources to support transition by 2026 to the Adult edition and begin preparation for the ATAY version. Successful implementation of the Adult and ATAY edition would increase developmentally and culturally appropriate treatment and supports across the continuum of care, that are geographically accessible and readily available. Implementing the updates in the ASAM4 will allow us to improve the effectiveness of care and treatment for our system. With intentional planning and support, it will have lasting positive impacts on social determinants of health, health care system costs, and most importantly, improving the wellbeing of young people and their families.

What outreach has informed this recommendation?

This budget request stems from conversations and requests from the community as well as schools through CPWI, research from the Washington Thriving strategic plan initiative, and learnings from evidence-based approaches to harm reduction.

CPWI providers/school and partners have consistently asked for aspects included in this proposal, including increased funding and more accessible data products.

CPWI Stakeholders and funded groups are diverse and include intergovernmental ESDs, counties, school districts, cities and community not-for-profit organizations. There are currently:

- Eight CPWI funded not-for-profit organizations;
- Over 2,600 members, partners and organizations; and
- WSU contracts with DBHR to provide evaluation of CPWI efforts and support identification of evidence-based best practices.

HYS/YAHS Stakeholders are in support of this DP and have informed the requests for increased survey funding. They include:

- HYS participants include 227 school districts and over 900 schools.
- HYS is a collaborative effort between DOH, HCA, LCB, and OSPI. The agencies support this DP for increased HYS support, indicating interagency interest in increasing support for this survey.
- Community and school partners, local providers and youth are involved in providing input for HYS.

UW Department of Psychiatry and Behavioral Sciences (PI Kilmer) contracts with DBHR to support YAHS efforts.

Maintenance funding expansion for Partnership Access Line (PAL) & Referral Service

Legacy, $370k GFS, Budget ask

Recommendation

Maintenance Funding Expansion for Partnership Access Line (PAL) and Washington's Mental Health Referral Service for Children and Teens

What is the issue?

PAL and the Mental Health Referral Service are funded by the state based on the cost-of-service positions set at 2018 salary levels. However, due to cumulative inflation and mandatory cost of living adjustments to salaries over the past 6 years, these programs now operate in a significant deficit.

Without a funding level expansion for these service's operating budgets in the next biennium, significant service delivery cutbacks in staffing will be forced to occur. For instance, the Referral Service would no longer be able to maintain the current 7- to 9-day turnaround on making matched available referral recommendations for parents (when the service was understaffed in the past, this would take a month), and the timeliness of PAL consults will also suffer for primary care.

What do you recommend?

To keep PAL and Referral Service both operating at full capacity with no service cuts over the upcoming biennium, we request a budget increase for those two programs together to be a total of $2.211 million dollars over the biennium.

Because HCA receives large contributions of funding for PAL and the Referral Service from the state's commercial insurers (due to previous legislation) and from Federal matching dollars, we understand that the state commitment component of that amount would be on the order of ~$370,000 state general funds over the biennium (subject to HCA's final confirmation)

Why is taking the recommended action a smart move now?

If this is not passed now, the Referral Service staffing will drop, and parents can end up waiting a month or longer again for assistance. Primary care providers would no longer be able to reliably expect to reach a child psychiatrist on demand when calling PAL.

What outreach has helped develop this recommendation?

Seattle Children's, HCA, and the PAL Team have all consulted together on this, with PAL and Children's advancing this as a recommendation to the committee.

Extend the timeline of House Bill 1580 (2023)

Legacy, N/A, Legislative policy

Recommendation

Extend the timeline of House Bill 1580 (2023 State Session, sponsored by Rep. Callan) to ensure the team can fully build a process to support children who remain hospitalized unnecessarily due to barriers to discharge.

What is the issue?

In 2023, the Washington State Legislature passed House Bill 1580 to codify a new approach to addressing the issue of patients remaining hospitalized unnecessarily. This was a top recommendation of CYBHWG during the 2023 session. HB 1580 created a position in the Governor's Office to lead a multi-disciplinary team as well as dedicated positions at the child-serving state agencies (DCYF, DDA, and HCA). The team was intended to be ready to receive referrals of patients "stuck" in hospitals as of Jan 1, 2024; however, the Governor's Office did not hire their lead until May 2024 and as of August 2024 the 1580 Team is working to establish permanent processes.

The biggest issue is that we still have children facing these dire situations and we have not yet seen this bill serve its intended purpose. The 1580 Team has immense promise to revitalize how we as a system

support children and families who remain hospitalized without medical necessity, and we need to give them the time to implement it thoroughly.

What do you recommend?

HB1580 was passed with a timeline that ran only for the 2023-2025 biennium and will expire in June 2025 if not extended – recommend extending both the positions and flexible funding elements of the bill for at least another biennium.

Why is taking the recommended action a smart move now?

This remains an urgent issue facing our most vulnerable youth and families – there are still too many children who are stuck boarding in hospital emergency departments and inpatient units who are ready for discharge but whose families cannot access the services/supports they need to feel safe/confident in taking them home. Taking action now to extend 1580 prevents the team from sunsetting before it can build permanent processes that improve the lives of children, youth, and families.

What outreach has helped develop this recommendation?

There was extensive stakeholdering conducted in preparation for the original ask in the 2023 State Legislative Session. Since the bill's implementation, Seattle Children's has discussed this issue with other hospitals, with the 1580 team and other state agencies, with frontline workforce at SCH, and with parents who have lived experience. There is broad agreement that we cannot continue in status quo and that a new approach – like the one possible through 1580 – is a dire necessity.

Is there any additional collaboration needed to further develop this recommendation?

Seattle Children's has already communicated to Reps. Lisa Callan and Tana Senn that the timeline for 1580 sunsets at the end of the biennium and that an extension feels critical. I (Kashi Arora with SCH) suspect this will need to be a bill rather than just a budget item and will flag that it does not have a prime sponsor yet – happy to work with YYACC and/or CYBHWG leads. Kashi is very willing to collaborate on advocacy here and SCH will have this be one of its focus areas for the 2025 State Legislative Session.

Ensure viable and appropriate implementation of the CCBHC model

CCBHC = Certified Community Behavioral Health Clinic

Legacy, $TBD, Budget ask and Legislative policy

Recommendation

The Legislature should take necessary steps to provide legislative and budgetary support to ensure implementation of the CCBHC model by FY2027, including participation in the federal demonstration and/or executing a State Plan Amendment.

What is the issue?

Certified community behavioral health clinics (CCBHCs) provide critical care for people with mental health and substance use disorder (SUD) challenges. Launched in 2017, the CCBHC model is now operating in 46 states, while 17 CCBHC expansion grant sites have operated in Washington (of those, 12 grants are currently active). CCBHCs dramatically increase access to mental health and SUD treatment, diverting individuals in crisis from already-burdened systems such as hospitals and jails. The CCBHC model also helps to alleviate the impact of the ongoing crisis-level workforce shortage we face in community behavioral by enabling participating agencies to increase hiring; on average, 41 new jobs per clinic are

created. As a conduit for integrated behavioral and physical health, CCBHCs are responsible for engaging in care coordination and developing partnerships with primary care providers to ensure clients' access to services that meet their full range of health care needs.

CCBHCs are funded either through the federal Medicaid demonstration program or via two-year SAMHSA grants. In Washington, all of our CCBHCs are funded via these SAMHSA grants, including initial two-year expansion grants and subsequent two-year extension grants. CCBHCs in the Medicaid demonstration are paid using a Prospective Payment System (PPS), which supports the actual cost of care, including expanding services and increasing the number of clients served, while improving flexibility to delivery client-centered care.

A growing number of states are moving to implement the model independently, including via a state plan amendment (SPA) or a Medicaid waiver, including Washington. In 2022, the Legislature funded a CCBHC budget proviso to support the Health Care Authority (HCA) in planning for this statewide implementation process. That same year, the Legislature also appropriated $5 million for CCBHC bridge funding to help sustain CCBHC grantees while the state began this planning process. HCA applied for, but did not receive, a $1 million CCBHC planning grant from SAMHSA; this planning grant is a prerequisite to be able to apply to become a demonstration state. In 2023, the Legislature appropriated $1 million to replace the assumed federal funding that would have resulted from receiving a SAMHSA planning grant; this work will culminate in a report to the Legislature by December 2024. In 2024, the Legislature again appropriated $5 million for CCBHC bridge funding to support CCBHC grantees while the state continues its planning and implementation process and directed HCA to implement the model statewide by FY2027, either via participation in the federal demonstration or through a SPA. In September 2024, HCA will submit a new application for a $1 million SAMHSA planning grant; the outcome of this application is anticipated in early 2025.

What do you recommend?

Specific recommended action will depend on two factors: the report issued by HCA to the Legislature as part of its current $1 million planning proviso and the outcome of the new application for a SAMHSA-issued CCBHC planning grant. As we await these steps, the Workforce & Rates subgroup and the Children & Youth Behavioral Health Workgroup (CYBHWG) should continue to strongly encourage Washington to join the federal demonstration when able and should recommend the Legislature take necessary action to ensure HCA's adherence to the FY2027 implementation timeline.

Why is taking the recommended action a smart move now?

For the past three sessions, the Legislature has made investments to develop and implement the CCBHC model statewide, including both fiscal support for existing CCBHC expansion grantees and programmatic planning efforts at the state level. The Legislature's most recent action, directing HCA to implement the model statewide by FY2027, is a clear statement of support for this model and its role in the future of Washington's community behavioral health system and workforce. Depending upon the outcome of the upcoming planning grant application, the Legislature should take steps to ensure HCA is able to comply with this directed timeline and that providers are supported throughout this implementation process.

The CYBHWG has been a strong supporter of expanding the CCBHC model in Washington for the past several years, with the Workforce & Rates Subcommittee frequently and consistently identifying CCBHCs as a priority item. Not only does the CCBHC model allow for greater recruitment and retention of a well-qualified workforce, it provides significant value to the broader behavioral health system by relieving strain on other systems, like law enforcement and emergency departments.

What outreach has helped develop this recommendation?

The Washington Council for Behavioral Health (the Council) is a consistent presence in both subgroup meetings and at the full workgroup level and has shared regular updates at subgroup meetings throughout the interim and for several past years. Additionally, the Council is a core member of HCA's CCBHC Technical Provider Workgroup, which is currently engaged in a stakeholder process including:

- Designing Washington's CCBHC model
- Conducting actuarial analysis to model budget impact
- Providing cost information from prospective CCBHCs

This workgroup's efforts will inform a legislative report submitted in December 2024. Any relevant action stemming from that report will likely be considered for incorporation into this recommendation. Additional outreach may be necessary depending upon the outcome of HCA's upcoming application and forthcoming legislative report.

Is there any additional collaboration needed to further develop this recommendation?

Additional collaboration should be considered following the submission of HCA's newest application for a SAMHSA planning grant, as well as following the publication of the legislative report related to its current $1 million state planning proviso.

Council policy staff are working closely with HCA and its actuarial partner, Milliman, as part of the CCBHC Technical Provider Workgroup (the $1 million state planning proviso work). Council staff will continue to share updates with subgroup members, as well as meet with subgroup leads as needed to develop any further recommendation/advocacy strategies. We anticipate this will remain part of the Council's legislative advocacy for the upcoming 2025 session, but do not feel this should negate the need for support and advocacy from both the subgroup and the full workgroup.

Ensure Pediatric Community Health Workers (CHWs) are a sustained and viable workforce for patients insured in Medicaid through WA State seeking adequate Medicaid rates from CMS

Legacy, $TBD, Budget ask

Recommendation

Ensure Pediatric Community Health Workers (CHWs) are a sustained and viable workforce for patients insured in Medicaid through WA State seeking adequate Medicaid rates from CMS.

What is the issue?

The Washington State Legislature invested in the Pediatric CHW workforce through a 2-year grant program beginning in January 2023 and has directed the HCA to submit a state plan amendment to CMS to make CHWs a Medicaid benefit beginning in July 2025. The HCA has indicated that the rates they seek will not cover CHW salaries. Today, pediatric CHWs serve in over 40 clinics, including 10 tribal clinics, making meaningful impacts in behavioral health and health related social needs for children, teens and families. If the rate WA seeks from CMS does not cover the cost of employing CHWs, clinics will no longer employ the workforce, nor will it grow. This would be an enormous lost opportunity for workforce extenders, a culturally congruent workforce, more timely access to BH care, and support for Health-Related Social Needs.

What do you recommend?

Seeking Medicare rates for CHWs in Medicaid's state plan amendment proposal to CMS.

Why is taking the recommended action a smart move now?

Clinics with CHWs have already seen significant impacts in their ability to address the health-related social needs of children ages 0-18 and their families, help kids access behavioral health services, and build trusting, collaborative relationships with families. Recent research also found that incorporating CHWs in primary care improved children's receipt of preventive care services, further demonstrating the importance of the CHW role in closing healthcare access gaps and achieving health equity (Coker et al., 2023).

CMS and the Biden Administration have prioritized Community Health Workers and a new code for reimbursement for Community Health Workers was released in November 2023 (G0019 for community health integration services.)

As the HCA applies for a state plan amendment to sustain and scale CHWs it is of critical importance that Washington:

- maximize federal reimbursement for these services, seeking Medicare rates for CHWs;
- ensure no gap in payment for the existing pediatric CHW workforce; and
- ensure that funding mechanisms on Medicaid are sufficient for clinics to employ CHWs.

What outreach has helped develop this recommendation?

Broad-based support from CYBHWG, BH Integration and P-5 Subgroups, First Year Families, Champions for Youth and others.

Is there any additional collaboration needed to further develop this recommendation?

Primary care clinics would be happy to help HCA model rates and services in light of salaries needed to employ CHWs.

Legacy Recommendations

These recommendations build on important actions the Legislature has taken in the past and suggest critical next steps to maintain momentum and widen the impact of these efforts. The Legacy recommendations are presented in order of priority.

1. Expand Early (birth to three) ECEAP

From the Prenatal-through-Age-5 Relational Health Subgroup

Early ECEAP = Birth to three early childhood education and assistance program (pronounced e-cap)

Legacy, $5M (200 slots, scalable), **Budget ask**

Recommendation

Expand Early (birth to three) ECEAP service provision by adding 200 slots.

What is the issue?

Lack of access to high intensity, family-supportive services for children 0-3 in center-based settings Birth to Three ECEAP is our state's intersection between early childhood mental health and early learning. Birth

to Three ECEAP targets low-income children (100%) with CPS involvement (11.3%), experience with homelessness (14.6%), on Individualized Family Service Plan (IFSP, this is an early intervention plan) (7.9%), and other priority factors such as substance abuse (10.8%), family violence (11.3%), loss of a parent (7.1%), mental health issues in family, etc. We currently serve less than 7% of eligible children in Early ECEAP and Early Head Start combined.

What do you recommend?

We recommend an expansion of the Birth to Three ECEAP program, a comprehensive, childcare partnership model for high-need children 0-3 who need both classroom and family support services. Early ECEAP is modeled after the federal Early Head Start childcare partnership program that has been shown to reduce families' involvement with child protective services (CPS) combines robust trauma-informed approaches with children and parents with high quality early learning.

Why is taking the recommended action a smart move now?

Families who need an early learning approach that incorporates intensive family support and mental health services have very little to choose from, and our ECEAP classrooms are seeing far more children arrive when they are 3 or 4 with significant developmental delays and behavior challenges.

The legislature has signaled support for Birth to Three ECEAP with a significant rate increase in 2023, and there is high demand (as shown in ECEAP Request for Application) for B-3 ECEAP expansion in child care deserts and areas with high incidence of CPS involvement, substance use disorder, homelessness and 0-3 child care deserts. This item was a high priority item of the CYBHWG in the 2024 legislative session but was not funded.

What outreach has helped develop this recommendation?

Washington State Head Start and ECEAP (WSA), the state ECEAP and Head Start association, worked closely with parents and early learning providers around what needs are unmet in the 0-3 space. In their assessment, the need for center-based comprehensive 0-3 services has greatly increased over the last few years. It is strongly supported in the WSA 2024 state advocacy survey; among Spanish-speaking respondents it was the top-rated advocacy goal (out of 14 options).

2. Behavioral Health Teaching Clinic designation & enhancement rate

From the Workforce and Rates Subgroup

New, N/A, Legislative policy

Recommendation

The Legislature should enact legislation codifying the Behavioral Health Teaching Clinic Designation & Enhancement Rate into law; appropriate funds necessary to enact and adequately fund the enhancement rate; and direct the Health Care Authority (HCA), during the FY26-27 biennium, to take necessary steps to submit the Behavioral Health Teaching Clinic Designation & Enhancement Rate for approval by the Centers for Medicare and Medicaid Services (CMS).

What is the issue?

Community Behavioral Health Agencies (BHAs) are the essential safety net providers for adults, children, youth, and families experiencing mental health and/or substance use disorders (SUD) in Washington State. Decades of underinvestment, including chronically low Medicaid rates, have left BHAs unable to offer competitive compensation packages to their employees. In addition to providing clinical services and care coordination, BHAs are the training ground for students and new graduates pursuing behavioral

health careers across sectors and settings, bearing the cost for the essential training and supervision infrastructure that sustains this crucial workforce development pipeline. This role, however, is an unofficial and uncompensated one. A Behavioral Health Teaching Clinic Designation & Enhancement Rate is an innovative solution to recognize and compensate our BHAs for training the broader behavioral health workforce in cutting-edge, critical behavioral health treatment modalities.

What do you recommend?

To sustain our community BHAs and to incentivize providers to remain in the field, both of which are critical to the mental health of Washingtonians, the Legislature should invest in enacting and funding a Behavioral Health Teaching Clinic Designation & Enhancement Rate, with the ultimate goal of receiving a federal Medicaid match to sustain the model in perpetuity. This solution will be achieved through a partnership between the Washington State Legislature (to codify and fund the model), the Department of Health (as the certifying body) the Health Care Authority (as the contracting body), and a wide array of community behavioral health providers and advocates who are dedicated to improving the lives of people living with serious mental illness and/or addictions disorder.

In the 2024 legislative session, three crucial steps should be taken:

1. The Legislature should enact the Behavioral Health Teaching Clinic Designation & Enhancement Rate into law in Washington State.
2. The Legislature should appropriate funds to enact the enhancement rate.
    - This should include amounts adequate to fund the payment of a Behavioral Health Teaching Clinic Enhancement Rate to qualifying BHAs throughout the state, as well as amounts necessary to fund the administration and oversight conducted by DOH and HCA.
3. The Legislature should direct the Health Care Authority, during the FY2026-2027 biennium, to take the necessary steps to submit the Behavioral Health Teaching Clinic Designation & Enhancement Rate for approval by the Centers for Medicare and Medicaid Services (CMS) in order to secure federal investment and matching necessary for long-term sustainability.
    - HCA should seek CMS approval for direct payments and amend MCO contracts to include language that requires MCOs to pass the enhanced rate funding through to approved teaching clinics.

Why is taking the recommended action a smart move now?

The Workforce & Rates subgroup, and the CYBHWG as a whole, has included the teaching clinic concept as among its priorities for multiple years now, throughout the development process. Each successive year has built upon existing work to culminate in the final demonstration project report and the development of a formal Behavioral Health Teaching Clinic Designation & Enhancement Rate.

The findings of the data collection conducted during the demonstration were conclusive: BHAs expend resources to train and supervise behavioral health workers that are not sufficiently recouped through current reimbursement rates. This one-way investment continues to put a strain on our community behavioral healthcare system and will continue to increase as our population's needs grow. The Behavioral Health Teaching Clinic Designation & Enhancement Rate offers a solution, one that should be enacted now in order to further reverse decades of underinvestment in our community system. Codifying this model and funding the enhancement rate offers an opportunity for thousands of new therapists, counselors, substance use disorder professionals, and more to join the workforce in the coming years, with strong incentives to remain and serve our most vulnerable populations.

What outreach has helped develop this recommendation?

The Washington Council for Behavioral Health (WA Council) developed this concept with the intent to formally identify and compensate BHAs for the true cost of this teaching role. A multi-part process was developed to recognize, describe, and test the concept, which utilized a public-private resource development path, including legislative appropriations and philanthropic grant funding.

- In 2021, the Legislature funded a workgroup led by HCA to develop preliminary standards and rate estimates for the concept, which resulted in a preliminary report that the WA Council demonstration project utilized as a starting point.
- In 2022, the WA Council formally launched the demonstration project, funded via a $1.1 million grant from the Ballmer Group, with six participating volunteer BHAs from across Washington State, representing a wide array of populations and communities served, as well as service provision and workforce types.
- In 2023, the Legislature funded a 0.5 FTE at HCA to ensure the agency would participate in these efforts to ensure BHAs are compensated for their role as teaching clinics for students seeking professional education in behavioral health disciplines and for new graduates working toward clinical licensure and certification.

Data was collected from participating BHAs, analyzed to accurately capture the true cost of the hours of investment put into supervising, training, and preparing clinicians to administer behavioral healthcare across the spectrum of patient needs. Teaching clinic standards and billing eligibility requirements, as well as a calculated projected enhancement rate were developed from this data.

In addition, the WA Council has been an active and consistent participant in the Workforce & Rates subgroup, providing presentations and regular progress updates on the teaching clinic development process since 2020. The subgroup's support, as well as that of the full CYBHWG, has been instrumental in achieving the legislative successes to date.

3. Increase investment in IECMH-C (Holding Hope program)

From the Prenatal-through-Age-5 Relational Health Subgroup

IECMH-C = Infant and Early Childhood Mental Health Consultation

Legacy, $3M, Budget ask

Recommendation

Budget Request: Increase investment in IECMH-C by $1.5 million annually to address unmet need and increase equitable access to IECMH-C for WA's children, families, and adult caregivers in childcare. Funds would be used to:

- Expand capacity to provide individualized mental health consultation services to childcare providers, children and families;
- provide IECMH-C services by linguistically and culturally matched consultants; and
- initiate a community-engaged program evaluation and planning effort to determine access and effectiveness of consultation approach in diverse communities.

What is the issue?

More funding is needed to help children, families, and caregivers in Washington. Child Care Aware of WA (CCA of WA) Holding Hope IECMH-C currently employs a diverse and talented team of Mental Health Consultants statewide, with 14 of 16 consultants representing various communities of color and 9

consultants fluent in languages other than English, including Spanish, Somali, Tagalog and French. We are also currently hiring additional consultants to fill positions created though new FY 2025 funds. As of August 2024, there are 5,994 licensed child care providers statewide with a licensed capacity of 200,239 children. At current funding levels, including new funding this year, we have one MHC for every 240 licensed childcare providers or one MHC for every 8,010 children in care. With full caseloads, the team of MHCs can typically serve roughly 4% of licensed providers at any given point in time. Most childcare sites served have multiple child/family concerns and classroom/programmatic needs which consultants are supporting in partnership with Early Achievers Coaches. MHC caseloads are currently full and even as we are hiring and onboarding new staff, there are 86 providers waiting for services, and referrals continue to come in. Additional investment will allow us to serve more of our waitlisted providers, which is a critical short-term goal. Additionally, based on the data below, we know that the actual need for Mental Health Consultation in the childcare community is much greater, and our long-term goal is to have enough IECMHC funding to serve 10% of childcare providers at a time.

Childcare providers in WA report critical need for IECMH-C services. Per the 2022 survey of all licensed childcare providers statewide:

- 41% of providers report that 50% or more of the children in their care could benefit from additional support with behavioral or social emotional concerns. 9% of providers reported that ALL of their children need additional support.
- 59% of providers report that they do not have sufficient access to a childcare health or mental health consultant to support children's health, developmental or behavior concerns.
- 60% of childcare providers report that they need social/emotional, behavioral, inclusion for special needs, or mental health supports.
- 67% of providers reported that they have seen an increase in social/emotional challenges with children.

High and disproportionate rates of suspension and expulsion impact Black and dual language learning students as well as students with disabilities. Black children's preschool expulsion rate is nearly two times as high as Latino and white children. And while Black children represent 19% of preschool enrollment, they account for 47% of preschool children receiving one or more out-of-school suspensions. In comparison, white children represent 41% of preschool enrollment, but 28% of preschool children receiving one or more out-of-school suspensions. Federal data indicates that a disproportionate number of male students representing minority populations are expelled, along with English Language Learners and students with disabilities, all of whom could benefit from daily attendance in preschool programs. Because Holding Hope IECMHC is built on a national evidence-based model that is proven to reduce suspension and expulsion, we are asking for expansion funds to serve underserved communities, assure fidelity to the national model and disrupt expulsion practices and trends here in WA.

What do you recommend?

We recommend increased investment in IECMH-C, which addresses concerns stated above. IECMH-C is an evidence-based prevention-oriented, multilevel intervention that results in improved caregiver social-emotional support for young children and improved children's social-emotional well-being. It is also an effective practice to interrupt bias and disproportionate expulsions and suspensions of young children of color in child care and early learning, providing more equitable opportunities for children to participate in high-quality child care and early learning experiences. IECMH-C leads to many positive results for children and families including increased social-emotional skills and self-regulation, reduced challenging behavior, and reduced expulsion rates. For caregivers, it increases positive interactions with children,

reduces stress and turnover, and improves caregiver self- efficacy and knowledge, among other positive results.

Why is taking the recommended action a smart move now?

The pandemic and aftermath have taken a substantial toll on children, families and the child care community. Fourteen percent of parents report that their children had developed more serious mental health and behavioral challenges since the start of the pandemic. During the pandemic, verbal, motor and social-emotional development for the youngest children has been negatively impacted by the following: the number of words spoken by parents to children was lower than in the past two years, restricted opportunities for physical play and interaction with peers, high parental stress, depression, anxiety, social isolation and reduction of personal and family interaction. Additionally, rates of social-emotional and behavioral challenges were one to four times higher among racial and ethnic minorities.

Rates of caregiver depression are extremely high, and caregivers report significant increases in young children's behavioral challenges. A 2023 national study revealed that 55% of Washington child care providers screened positive for symptoms of clinical depression. These symptoms among caregivers result in less responsive and attuned interactions with young children and indicate a need for increased caregiver support. This same study also revealed an alarming increase in young children's challenging behaviors. 65% of ECE professionals in Washington reported that they had children with increased externalizing and internalizing behaviors in their classrooms or programs since the Pandemic. Further, there was significant staff turnover of child care providers during the pandemic, resulting in a less experienced, newer workforce that needs training, professional development and ongoing support to offer quality social emotional learning experiences and environments for young children. As the Holding Hope IECMH-C model is built on the national model with evidence of reduced staff stress and turnover and reductions in children's challenging behaviors, we believe that increased investment will have a positive impact on these trends in WA.

The need for mental health support for Washington's caregivers, children and families is significant, and IECMH-C is an evidence-based prevention-oriented, multilevel intervention that results in improved caregiver social-emotional support for young children and improved children's social-emotional well-being.

What outreach has helped develop this recommendation?

In years past, the Prenatal through 5 Relational Health Subgroup has had extensive exploration and outreach on IECMH-C which involved learning from a national expert, several subgroup conversations involving diverse perspectives, and outreach to non-members like ECEAP and childcare providers, parents, and caregivers with lived experience with children with complex and relational health needs. Further, CCA of WA regularly solicits direct feedback from providers and families served through Holding Hope IECMH-C, showing high levels of satisfaction with services, positive changes for staff/children and recommendations from providers for increased funding for IECMH-C services.

4. [W&R] Conditional Scholarships

From the Workforce and Rates Subgroup

Legacy, $TBD, Legislative policy

Recommendation

A policy change is needed to direct WSAC to work with a UW-led consortium of 13 institutions of higher education statewide to recruit a diverse cohort of master's level candidates.

Funding is needed for:

- Conditional scholarships ($50k/student; 180 students);
- Three concentration areas: community behavioral health, K-12 public and tribal schools, and crisis serving agencies, to provide skills training to candidates in alignment with employers' needs ($10k/student); and
- Continuing program evaluation ($150K per year).

The School-Based Behavioral Health and Suicide Prevention Subgroup also supports this recommendation.

What is the issue?

A shortage of qualified behavioral health professionals persists in many communities and among critical service providers in Washington state.

To address this issue, Masters-level candidates are needed to serve children and adults with behavioral health challenges in the public mental health system, in community mental health centers, in crisis care settings, and within and in partnership with K-12 public and tribal schools. The range of high-need public behavioral health settings could be expanded in the future.

With the philanthropic support of Ballmer Group, the University of Washington School of Social Work has partnered with 12 universities across the state to address the workforce shortage. Launched in 2021, more than 250 graduate students have received Ballmer Behavioral Health Scholarships; an additional 13 MSW students have participated in UW's initiative to train K-12 school social workers. It is estimated that over 600 graduates will have been funded by the summer 2027, with an estimated 95% joining the public Behavioral Health workforce Washington schools and communities.

What do you recommend?

We recommend funding for:

- Conditional scholarships ($50k/student; 180 students);
- Three concentration areas: community behavioral health, K-12 public and tribal schools, crisis serving agencies, to provide skills training to candidates in alignment with employers' needs ($10k/student); and
- Continuing program evaluation ($150K/per year).

The School-Based Behavioral Health and Suicide Prevention Subgroup also supports this recommendation.

Why is taking the recommended action a smart move now?

There is a great need to increase the number, diversity, and skills of the behavioral health workforce across our state. In addition to receiving private and federal funds, UW School of Social Work and its partners have successfully implemented a statewide behavioral health workforce development initiative. We want to continue to build on the momentum created by universities working in partnership; the implementation of HB1946 – creating the Washington Behavioral Health Corps; and ongoing learning sessions with public policy makers.

What outreach has helped develop this recommendation?

In addition to the 13 universities that have received and distributed private funds to their Master's candidates, discussions have taken place with Washington state legislators representing Eastern and Western Washington.

Is there any additional collaboration needed to further develop this recommendation?

Additional collaboration is needed with Washington Student Achievement Council to share lessons-learned and to manage the financial transactions for conditional scholarships. There are also public entities, such as Washington Employment Security Department, to map the Washington state workforce including the impact of this initiative relative to the existing workforce and monitor Washington state utilization of behavioral health services in these three specialization areas (behavioral health, school mental health, and crisis response). Continued collaboration with the Office of the Superintendent of Public Instruction is needed to understand the landscape of the school mental health workforce. Continued affiliation with the Children & Youth Behavioral Health Work Group via the Workforce & Rates Subgroup and the School-based Behavioral Health and Suicide Prevention Subgroup, as well as statewide and national organizations and professional associations, remain important.

5. Expand the ECEAP Complex Needs Fund

From the Prenatal-through-Age-5 Relational Health Subgroup

Legacy, $5.8M, Budget ask

Recommendation

Expand the ECEAP Complex Needs Funds.

What is the issue?

Additional Supports for ECEAP providers to meet the needs of children with trauma and special needs.

The legislature has recognized the need for additional resources for programs serving children with special needs and physical and behavioral health challenges. Programs use these funds to support extra staff in the classroom, mental health specialists, training for staff around trauma and behavior support, and necessary curriculum or equipment.

What do you recommend?

In FY23-25 ECEAP Complex Needs Received $15M (including $5.8M in one-time funds). We support reallocating the $5.8M in one-time funds for the 25-27 biennium.

Why is taking the recommended action a smart move now?

Early learning providers will attest to the huge challenges they are facing with a combination of more children arriving developmentally behind and without age-appropriate social emotional skills and staff turnover and burnout. The Complex Needs Fund has been critical in providing extra support to staff by increasing their skills to meet the new challenges and providing help in the classroom by reducing the adult-child ratio. Stabilizing the early learning workforce is critical, and this is a key piece.

What outreach has helped develop this recommendation?

The Complex Needs Fund is hugely popular with both childcare and ECEAP providers, making serving very high needs children possible. For ECEAP, the Complex Needs Fund was one of the top 3 priorities from providers and staff.

6. Mental Health Literacy Coordinator

From the School-Based Behavioral Health and Suicide Prevention Subgroup

Legacy, $360k, Budget ask

Recommendation

Maintain OSPI budget allocation, originally allocated in the 2024 supplemental budget, funding mental health literacy coordinator charged with facilitating the addition of mental health literacy in schools. Expand the role to include national collaboration with other state education agencies and the US Department of Education.

5950-S.SL.pdf (wa.gov) – pg. 660, Sec. 501 (1)(m), $150,000 for FY24

What is the issue?

Washington schools need to provide strong prevention support for students, and the foundation of prevention support is dedicated instruction to students on mental health literacy and suicide prevention. Mental health education is more proactive and cost-effective than waiting for needs to arise to the level of concern where treatment is required. Education on Social Emotional Learning and Mental Health Literacy helps create newly informed students who understand and respond to concerns they notice in themselves and in their peers. It is foundational to an effective school multi-tiered system of supports as a critical piece of Tier 1 (universal) supports.

When schools do choose to provide mental health literacy and suicide prevention instruction to students, there is no state oversight to ensure that the curriculum they use is culturally-responsive and research-informed and that those tasked with teaching it have the competency to do so effectively. Schools need more support in connecting with appropriate curriculum.

Data from the 2019-21 Behavioral Health Navigator Survey indicated that only 68% of district surveyed were proving any form of student instruction on mental health or substance use at the time they were surveyed. Only a portion of those were evidence-based. Overall, there are several evidence-based options for schools to refer to and use for mental health curriculum already available; however, many schools don't know about them.

What do you recommend?

The legislature should allocate $360,000 per biennium to the Office of Superintendent of Public Instruction (OSPI) to continue funding a full-time equivalent (FTE) staff position to serve as a mental health literacy lead responsible for aiding in the implementation of mental health literacy instructional curriculum for the P-12 education system. The staff member in this state lead position should work to connect and support the ongoing the work of the Mental Health Instruction Library, and act as a proactive liaison providing implementation support to education service districts (ESDs) and school districts looking to provide effective curriculum for students. The staff member should leverage state and national collaborators already connected to mental health education work and ensure K-12 Learning standards in mental health align with best practices nationally.

Original state budget investment: 5950-S.SL.pdf (wa.gov) – pg. 660, Sec. 501 (1)(m), $150,000 for FY24

Why is taking the recommended action a smart move now?

This state-wide coordination position is a critical piece to leveraging existing resources and partnering with ESD's, districts and schools and creating a system of schools using Tier 1 education to prevent more expensive needs in Tier 2 and especially Tier 3 efforts.

The onboarding began in mid-August (2024) and the new coordinator is already embedded with state and national resources and partners with tremendous promise. That said, the implementation support for schools is just beginning to ramp up and will not be fully realized by the time the current funding ends on June 30th, 2025. This position should be a permanent position within OSPI. It would provide long-term benefit to school-age youth and represent a long-term, statewide investment in preventative (Tier 1) support in WA schools. At the very least, it should be renewed for the 2025-27 biennium to allow enough time to evaluate the impact of the approach. It should also be noted, this leadership position is now being modeled in other states, with Delaware as an example.

Mental health education is key to eliminating stigma, empowering peers to support each other, and reducing the behavioral health services burden on schools, allowing the school to focus on all aspects of a well-rounded education. The Mental Health Curriculum Library effectively summarizes the importance of strong student instruction on mental health literacy:

Studies show including Mental Health Literacy (MHL) in an education program leads to decreased stigma and a stronger mental health knowledge base. In turn, that leads to robust peer support amongst youth, decreased delays to care, improved student productivity and more effective interventions for students at risk of suicide (Kutcher et. al, 2016). Regardless of the availability of SEL programs, MHL is likely a key support for addressing today's youth mental health crisis and eliminating mental illness stigma for a generation.

What outreach has helped develop this recommendation?

If applicable, describe any outreach that you did to develop the recommendation. This could include talking to stakeholders, conducting research, or reviewing data. Is there additional outreach needed?

The original recommendation for this position at OSPI was developed by the SBBHSP Subcommittee in 2023. At the time, the SBBHSP consisted of 37 members, including family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations, and a Youth Advisory Committee consisting of 11 youth and young adults with lived experience interacting with behavioral health supports in WA K12 schools. The Subcommittee developed recommendations across five Zoom workshops and three Zoom Youth Advisory Committee meetings. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here is a combination of the group's fourth and seventh ranked priorities in the survey.

The SBBHSP Subcommittee voted to priority this item again for the 2025 legislative session as a legacy item. Results of the SBBHSP priorities survey this year indicated continued support for the recommendation by this year's membership group.

ESD Behavioral Health Navigators collected the data reference above through interviews with school district staff from 2019-2021. The dataset includes 219 districts, representing all 9 ESDs, and 37 of 39 counties in the state. The interview protocol included questions covering behavioral health services in schools, community referrals, behavioral health screening, Medicaid, and more.

7. Fund the supervisor stipend program

From the Workforce and Rates Subgroup

Legacy, $TBD, Budget ask

Recommendation

Monitor the budget to ensure that the funding necessary for DOH to implement HB2247's supervisor stipend program in July of 2025 is retained. These funds are currently included in DOH's maintenance level budget.

What is the issue?

As identified by individuals and organizations over multiple years, a significant barrier to moving from receiving a degree in one of the behavioral health professions and working in the field is the cost associated with the requirement that most professions have for a certain number of supervised hours post-graduation. This is true for social workers, mental health counselors, and marriage and family therapists. Unless the individual's employer is providing supervision at no cost, payment to the supervisor is likely coming from the supervisee. Wages for behavioral health professionals are often lower than those of other professions requiring a master's degree. As a result, recent master's-level graduates, who are beginning to repay their student loans, may struggle financially with the additional cost of paying for the supervision hours needed to achieve full licensure.

In order to help address the barrier, HB1724, passed in 2023, directed the DOH to establish a stipend program to support some of the costs of supervision. While well intended, the model included in the legislation raised questions and concerns about implementation (e.g. who would actually benefit from the stipend) and therefore, in 2024 a new model for the stipend program was included in HB2247.

What do you recommend?

The legislature included funds (approximately $1.8m for FY26 and $1.8m for FY27) in the budget in 2024 to begin implementation of the stipend program on July 1, 2025. If all goes according to plan, funds will be available and an estimated 900 stipends can be issued each year of the biennium. While this is potentially not enough to cover all associate licensees, it is a reasonable allocation given the program is new and will just be getting off the ground.

It is imperative that the funds remain at maintenance level in DOH's budget. It is recommended that the CYBHWG monitor the budget process, as well as implementation and the potential need for additional funds in FY27. A subsequent recommendation could be forthcoming in the WG's prioritization process for the 2026 session.

It is also recommended that we leave the door open for modification of this request in the event our legislative champion has a different perspective on next steps.

Why is taking the recommended action a smart move now?

It is essential that individuals who have completed their degree and are working toward licensure are retained. Financial obligations can be significant, and we must do what we can to address them. Offsetting the cost of supervision is a strategy that has been identified by those impacted and others who are deeply connected to and knowledgeable about behavioral health professionals.

Additionally, the past 2 legislative sessions focused on the issues of having to pay for supervision. Ensuring that the program can go into effect in July of 2025, as a result of maintenance-level funding in DOH's budget, is essential in order to reduce debt burden, incentivize associates to continue on to full licensure, and retain a critically needed behavioral health workforce.

What outreach has helped develop this recommendation?

The DOH has done considerable outreach and has consistently held community meetings to get input on implementation of HB1724 and HB2247 – including the sections creating the supervisor stipend program. Further, this topic has come up repeatedly in the Workforce/Rates subcommittee meetings and we have had DOH presenting at those meetings about the issue/model. Impacted individuals have weighed in, including those who are providing (or could provide) supervision.

Is there any additional collaboration needed to further develop this recommendation?

It is recommended that this be a priority item to monitor. Currently this priority does not appear to need funds, other than those included in DOH's maintenance level budget, to begin implementation in 2025. Additional funds may be needed in FY27, depending on how FY26 implementation goes.

It will also be important to assess the effectiveness of the program through qualitative and quantitative efforts. This should include obtaining feedback from beneficiaries of the stipend – supervisors and supervisees – to help determine effectiveness, and what, if any, adjustments need to be made. This should help guide if/how the program should grow or shrink as future action is in great part a result of its effectiveness.

New Recommendations

These recommendations are emerging priorities for the Work Group. They may have previously been recommended by a subgroup but not prioritized by the Work Group at the time. The New recommendations are presented in order of priority.

1. RUBI parent training program pilot expansion

From the Behavioral Health Integration Subgroup

New, $250K, Budget ask

Recommendation

We propose $250,000 in funding in order to conduct a one-year Pilot Site implementation project of the RUBI Parent Training program with behavioral health providers imbedded in primary care settings at 10 pilot sites across WA State. The focus is on enhancing primary provider skill in providing care for families of youth with autism/intellectual disabilities (ASD/IDD) and co-occurring behavioral health needs as well as expanding family access to evidence-based care.

What is the issue?

Delivering the required specialized treatments to individuals with autism spectrum disorder and related intellectual and developmental disabilities (ASD/IDD) is an area of increasing challenge for our current mental health systems of care. While Applied Behavior Analysis is the standard of care recommended for youth with ASD/IDD, its complex, resource-intensive nature (personnel, intensity of hours) has created significant issues with accessibility, resulting in families waiting for months, if not years to receive care. While waiting, families are turning to their front-line care teams (primary care providers) for needed resources, support, and guidance.

This need for support is elevated for families of ASD/IDD youth with co-occurring challenging behaviors, such as meltdowns or shutdowns, self-injury, as well as verbal and physical aggression, as these behaviors can have safety implications and reduce overall quality of life. These behaviors are frequently exacerbated by delays in obtaining services and lack of caregiver training in how to address these challenging

behaviors. Not addressing these through early intervention can impact the youth's ability to engage in self-care, educational activities, community activities and peer relationships. Unfortunately, they also increase the risk of needing more intensive services at school and in the community. Uncertainty on how to navigate these behavioral challenges amplifies caregiver stress and affects broader family functioning.

To try and address this service access gap, there is a need to expand the accessibility of evidence-based, low intensity service models that can work in primary care settings and are effective in supporting ASD/IDD youth needs and be delivered by non-specialty providers embedded in primary care.

The RUBI Parent Training program is a time-limited, evidence-based, and manualized parent training program for families of youth with ASD/IDD and co-occurring challenging behaviors. Grounded in behavior analytic principles, RUBI creates a structured approach for providers to support caregivers in the building of a behavioral management "toolbox." It has been found to be acceptable to caregivers, reliably delivered by providers, and effective in reducing youth challenging behavior.

RUBI has been studied extensively (over 20 published pilot and randomized clinical trials) and is now demarked an evidence-based treatment (Level 2 rating from the California Evidence-Based Clearinghouse for Child Welfare).

What do you recommend?

We propose $250,000 in funding in order to conduct a one-year Pilot Site implementation project of the RUBI Parent Training program with behavioral health providers imbedded in primary care settings at 10 pilot sites across WA State. The focus is on enhancing primary provider skills in providing care for families of youth with autism/intellectual disabilities (ASD/IDD) and co-occurring behavioral health needs as well as expanding family access to evidence-based care. Deliverables include (1) providing high-quality training in the RUBI intervention that is tailored to the needs of providers serving families at one of 10 selected primary care settings, (2) facilitating pilot site delivery of RUBI with a minimum of 10 families. The goal is to improve the ability of community-based providers to accommodate and support individuals with intellectual and developmental disabilities and maximize treatment benefits and supports for caregivers and youth in their community setting. Providing access to evidence-based interventions at this initial point of care creates points of action for families while they are waiting for more intensive services and may reduce the need for more intensive services.

Why is taking the recommended action a smart move now?

Research has proven early intervention is the key to reducing costs and improve outcomes for children with intellectual and/or developmental delays. RUBI empowers the caregiver to incorporate the principles of ABA into the ongoing to development needs of their child. Targeting RUBI training with providers imbedded in primary care embraces the provision of integrated care with physical health and behavioral health, focusing on whole person care.

What outreach has helped develop this recommendation?

This proposal is built off prior pilot funding of RUBI provider training by the MolinaCares Foundation (initial 40k proof-of-concept feasibility trial of RUBI training for behavioral health providers imbedded in primary care) and the Washington State Health Care Authority (RUBI training for WISe Team providers). In both of these training efforts, there was high provider acceptability of the intervention, endorsing the appropriateness of RUBI in front-line care settings and with non-specialty care providers. This proposed funding initiative would support an effort to scale up dissemination, with a targeted focus on elevating access to care (i.e. deliverables move beyond provider training to include implementation of RUBI by a minimum of 10 families per pilot site).

2. Strengthen statewide guidance and direction

From the School-Based Behavioral Health and Suicide Prevention Subgroup

New, $500K, Budget ask and Legislative policy

Recommendation

Require the Office of Superintendent of Public Instruction (OSPI), in partnership with state, regional, and local entities, to define minimum expectations for behavioral health supports provided and/or coordinated by WA schools and establish strategic direction for state-wide programming to strengthen the capacity of schools to implement meet those supports and reduce system barriers.

What is the issue?

When kids/families need help with behavioral health issues (anxiety, depression, substance use) that interfere with learning/academic success, many access behavioral health services (counseling, treatment) through local school nurses, school counselors, school social workers, or other mental health professionals.

Unfortunately, school staff face significant barriers to coordinating/delivering behavioral health services to kids/families:

- Confusing state/federal policies and guidance
- Lack of standardized frameworks and best practices
- Limited funding
- Legal and regulatory challenges
- Technology, security, and compliance issues
- Coordination issues
- Training and capacity issues
- Language and cultural barriers
- Siloed efforts competing for LEA/School/Staff time

Behavioral health and wellness supports for K-12 students in Washington are fragmented and uncoordinated. The Office of the WA State Auditor's 2021 Performance Audit on K-12 Student Behavioral Health in WA provided the basis for this recommendation. Their audit found that:

The state's current approach [to school-based behavioral health] is fragmented, with roles and responsibilities assigned across several local and state agencies. Washington's decentralized approach has relied on school districts to develop behavioral health plans without oversight. Furthermore, educational service districts can only provide limited support to school districts as they develop those plans. Gaps in the current oversight and guidance structure requires improved state-level coordination to help schools better identify and connect students to behavioral health supports. Insufficient state-level direction and oversight results in students having uneven access to behavioral health supports. Leading practices suggest greater state-level direction and coordination can help schools and districts better address students' needs.

The SBBHSP Subcommittee spent significant time discussing these issues over the last three years. Members emphasized that the state does not have a comprehensive, unified working plan for school-based behavioral health with corresponding organizational oversight. No state agency is accountable or responsible for ensuring, facilitating, or supporting student access to school-based behavioral health services. As a result, WA youth are being left underserved in a critical time of their development.

What do you recommend?

Require the Office of Superintendent of Public Instruction (OSPI), in partnership with state, regional, and local entities, to:

- Utilize a shared framework, in alignment with other WA state-wide initiatives, for coordinated student behavioral health supports;
- Define minimum expectations for establishing a comprehensive set of behavioral health supports, in partnership with community-based organizations and
- Establish strategic direction and goals for state-wide programming to strengthen the capacity of schools to implement supports and reduce system barriers and a review process to assess statewide process toward those goals over time.

Minimum expectations established should address, among other things:

- Prevention efforts, including instruction on Social-Emotional Learning (SEL), Mental Health Literacy (MHL), substance use prevention, and suicide prevention, in partnership with community-based organizations.
- The school's role in supporting screening, recognition, and response to emotional and behavioral distress, as required by **RCW 28A.320.127**.
- Staffing to support needs along the school behavioral health continuum, including guidance for supporting coordination between Education Staff Associate (**ESA**) roles.

Why is taking the recommended action a smart move now?

The 2021 Performance Audit on K-12 Student Behavioral Health in WA provides further impetus for pursuing this recommendation now:

Addressing the broader issue of behavioral health disorders goes beyond what schools can reasonably solve. Nonetheless, because schools are a hub for the vast majority of children who might begin to exhibit symptoms, schools are a natural setting for prevention and early intervention efforts.

The National Assembly on School-Based Health Care emphasizes the role state leadership can play in it's 10 Critical Factors to Advancing School Mental Health brief2 as such – "State leaders across child-serving public sectors must establish a cohesive and compelling vision and shared agenda for school mental health that can inspire localities to act."

What outreach has helped develop this recommendation?

The SBBHSP Subcommittee is made up of 44 members, including youth and family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations. The Subcommittee developed priorities across a series of monthly meetings and four workshops on Zoom. SBBHSP staff put out a request for recommendation proposals that were aligned with the identified priorities and members subsequently ranked the proposals submitted through that process via a survey. This recommendation and the 'Technical Assistance & Training Network' recommendation were presented as one proposal in the member survey. That proposal was the top ranked priority. We chose to split them into two separate recommendations, but they are intended to complement each other.

The proposal this recommendation was based off of was created through a collaborative effort that includes staff representing three school districts (one in eastern WA and two in western WA), a non-profit that supports with extensive experience working with schools around equitable access to health and social are, and several representatives from two academic centers of excellence that provide training and

technical assistance to schools focused on behavioral health. The proposal also incorporates several elements of the recommendations included in the results of the BloomWorks K-12 Behavioral Health Discovery Sprint which was done as part of the WA Thriving strategic plan effort.

3. [YYACC] Expand the Bridge Housing program

From the Youth and Young Adult Continuum of Care Subgroup

New, $TBD, Budget ask and Legislative policy

Recommendation

Expand the number of Bridge Housing programs that serve young people exiting inpatient behavioral treatment. The Bridge Housing are 6-10 bed, 90-day, housing programs that provide mental health and substance use disorder support onsite and in the community.

What is the issue?

This is an issue that was a Support Item for the most recent CYBHWG agenda and is related to Young Adults 18-24. The request is to add 2-6 more Bride Housing programs across the state. The current situation is according to DSHS data that those most likely to be homeless within 3-12 months of exiting a state system are the 18- to 24-year-olds coming from inpatient behavioral health treatment. This is mainly due to them being discharged from the inpatient treatment facility to destinations that are not long-term safe housing with community supports. Instead, they are discharged to emergency shelters, drop-in centers that have no beds or worse.

What do you recommend?

We want to expand the successful SHB 1929 and add 2 more 90-day Bridge Housing programs and 1 long-term housing program. It is estimated to be a $1.5 annual cost for each Bridge House and we would implement them as soon as the HCA could release the RFP and the funding was active. Likely July 2025.

Why is taking the recommended action a smart move now?

This is a fiscal strategy to reduce costs and prevent homelessness and behavioral health crises for young adults. When a young person agrees to get treatment that is an opportunity to be an offramp from homelessness and return to the table of community. Because young people of color and LGBYQ+ young people are homeless at a higher rate this is an equity strategy. Many young people can return to their community and family but given history their families and community supports often require them to be on their meds and/or without substance use for a period of time. The Bridge Housing supports young people in a safe, milieu to get healthy and identify their Return to Community Plan.

What outreach has helped develop this recommendation?

NorthStar Advocates and young people with lived experience have had several focus groups with young people who have had behavioral health inpatient treatment experience. We did this for the SHB 1929 and over the past several months to get input on the design of the 1929 RFP and design of the programs. We heard over and again from young people how they were discharged into unhealthy and unstable living environments which led to immediate relapse and return to homelessness.

Is there any additional collaboration needed to further develop this recommendation?

NorthStar Advocates will take responsibility and the lead for advocating for expansion. It is not clear if we need a bill or if a budget proviso will suffice given the passage of SHB 1929. We are talking with

legislators and others, but it does look like a budget proviso will suffice. We will continue to welcome the support of the YYACC and the CYBHWG for any ideas or support. The main need at this point is to be on either the Priority or Support agenda for the 2025 legislative session. The impact is to leverage both the motivation from young people who entered inpatient treatment and the funding the state already expended by authorizing payment for the inpatient treatment episode.

4. Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates

From the Behavioral Health Integration Subgroup

New, N/A, Legislative policy

Recommendation

Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates. Includes rates for individual and family psychotherapy, group psychotherapy and PCP behavioral-health related patient visits, as well as primary care pediatrics.

Our understanding is with the Health Plan Assessment we would draw down enough Federal dollars to allow for Medicaid: Medicare parity without additional GFS dollars.

What is the issue?

Outside of Collaborative Care (CoCM) billing, Medicaid rates for mental health counseling in primary care is not sustainable. While Collaborative Care billing can cover cost of care (when programs are built intentionally for children and for the associated billing parameters/requirements), not all children and teen's clinical needs match with the Collaborative Care model, nor are all clinics able to implement the CoCM model. Multiple clinics with BH Integration report needing both CoCM and traditional psychotherapy billing in order to meet the varying needs of pediatric patients. In addition, pediatric primary care rates have fallen by 4% and would be brought back to Medicare rates under this Medicaid: Medicare parity financing mechanism.

Raising Medicaid mental health counseling rates by 30% would

- Ensure that existing BH Integration programs are financially viable and can continue,
- BH integration programs can most appropriately serve children and teen's presenting clinical needs, and
- Increase the number of primary care clinics able to provide BH Integration for children and teens.

Furthermore, at these higher, more sustainable rates, some private practice mental health providers who do not currently accept Medicaid may open their doors to children and teens insured on Medicaid.

Restoring primary care pediatric rates to Medicare would ensure more equitable access to preventive primary care for children and teens across the state.

Please note, this proposal for mental health rates would only help a small number of community mental health centers – and does not impact a preponderance of community mental health center funding. Nor does it apply to Federally Qualified Health Clinics

What do you recommend?

We recommend passing a health plan assessment for ultimate Medicaid: Medicare parity for psychotherapy and ARNP visits.

Why is taking the recommended action a smart move now?

Today only about 25-30 primary care clinics across the state are providing BH Integration tailored to the unique needs of children and teens.*

BH Integration is a proven model for breaking down stigma, reducing access barriers for BIPOC, and helping children with mild and moderate needs as soon as a need is identified.

Furthermore, if private practice providers who are currently closed to Medicaid would allow access for Medicaid, it would create some degree of capacity not currently available in the system.

95% of primary care and mental health agencies surveyed report the proposed rate increase would address unmet community need and 85% would expand services with a rate increase of this magnitude. A large majority of practice providers surveyed (69%) who do not currently take Medicaid would open their doors to kids in Medicaid with this rate increase.

**Please note, while many Federally Qualified Health Clinics have BH Integration – oftentimes their service remains a light touch – providing about 2 brief BH interactions per patient. Thus our description of only about 25-30 clinics providing peds BH integration to the best of our knowledge.*

What outreach has helped develop this recommendation?

We conducted 9 key informant interviews with primary care providers, child advocates, community mental health agencies, independent (private practice) mental health counselors, and child & adolescent psychiatrists on the impact Medicaid: Medicare parity for psychotherapy could have on access and their services. We also surveyed primary care, mental health agencies and private practice providers and received 123 survey responses from across the state. All interviews and survey responses indicate a significant potential impact from a rate increase of this size.

The BHI Subgroup and the Workforce and Rates Subgroup have had meetings on this topic in the past three months (at least 3 meetings) including broad-based stakeholders from multiple sectors.

Is there any additional collaboration needed to further develop this recommendation?

The Workforce and Rates and P5RH Subgroups are supportive.

5. Support expansion of recovery high schools

From the Youth and Young Adult Continuum of Care Subgroup

New, $250K, Budget ask and Legislative policy

Recommendation

Convene an advisory committee to establish a statewide network of recovery high schools.

What is the issue?

Currently, Washington has few resources to support adolescents and young adults in returning to the community after they complete substance use disorder treatment. Early recovery supports are essential for young people to sustain the gains they made in treatment and build recovery within the four dimensions of health, home, purpose, and community (SAMHSA, 2012). Recovery high schools are an opportunity for Washington to fill this gap by serving students in grades 9-12 and up to age 21.

Recovery high schools are an evidence-based strategy, with national and Washington data documenting their effectiveness. One federally funded study from Finch, Tanner-Smith, Hennessy, & Moberg (2017)

found that, compared to students in non-recovery high schools who received substance use treatment, students in recovery high schools: (a) have higher graduation rates, (b) report significantly lower absenteeism, (c) have significantly lower odds of dropping out, (d) are more likely to abstain from using substances, and (e) have significantly fewer days using drugs and alcohol.

In 2014, King County Behavioral Health and Recovery Division (BHRD) and Seattle Public Schools partnered to open the only public recovery high school in Washington. It was prompted by a 2013 DSHS report which found only 25% of adolescents in publicly funded SUD treatment graduated from high school. This number dropped to 17% for adolescents with co-occurring disorders (Behavioral Health Needs and School Success, 2013).).

Puget Sound Educational Service District and King County BHRD described the demographics and characteristics of students who attended the Interagency Recovery Campus for more than 90 days between Fall 2015 and Spring 2022:

- An average of 38 students enrolled for at least 90 days annually.
- 63% of students have either earned, or were working toward, a HS Diploma, with another 18% transferring to continue schooling elsewhere.
- More than half of students had more than one year of recovery following initial enrollment.
- Compared to the school district, more students receive Individualized Educational Plan (IEP) and McKinney-Vento services.

Recovery high schools are effective nationally and locally in promoting recovery and guiding youth toward the vital milestone of graduating from high school.

What do you recommend?

Assemble an advisory committee whose work may include reviewing strategies used by other states, reading the Association of Recovery Schools Toolkit for starting a school, conducting outreach and needs assessments, identifying potential long-term funding sources, and developing a structure for evaluation and communication of student characteristics and outcomes. An advisory committee will identify keys to success for potential recovery high school sites across Washington and make the best use of the investment through planful consideration and community engagement. A stepped process would ensure each site had support and guidance before moving on to the next site.

The estimated budget is approximately $250,000 to convene the committee. Initial investments would likely include a portion of an FTE to staff the proposed advisory committee and stipends for some committee members.

Direct the legislature to fund an advisory committee administered by OSPI, whose work may include:

- Staffing the advisory committee with 0.5-1.0(c_) FTE to perform administrative and coordination tasks;
- Review strategies used by other states, such as learnings from **Oregon's** advisory committee and **HB 2767 (2023)** implementation and determine appropriate implementation pathways for WA State;
- Consult with the Association of Recovery Schools and other field experts in Accredited Recovery School implementation;
- Identify long-term funding strategies analyzing existing cost models;
- Develop a structure for interagency coordination, quality assurance, evaluation, and outcomes metrics;
- Perform all activities and produce a report of recommendations by June 1, 2026.

As Oregon demonstrated, the first step to opening state-sponsored recovery high schools is convening a committee tasked with designing a strategic plan outlining a path forward.

Locally, the committee could engage King County BHRD and the Interagency Recovery Campus staff in keys to success.

Why is taking the recommended action a smart move now?

Washington State youth had a mortality rate from drug overdoses nearly twice the national average in 2020-2022 (New England Journal of Medicine article, pp. 99-100). In the 2022-2023 school year, Narcan was used to reverse overdoses 42 times across Washington's schools (Byran, C. The Seattle Times, 2023).

Washington's public schools are facing significant budget deficits, limiting their ability to meet student needs. Primary objectives for the advisory committee would include (a) identifying funding sources for recovery high schools that will not negatively impact Washington's public schools; (b) prioritizing historically marginalized communities and groups with a focus on eliminating racial, ethnic, geographic, linguistic, and socio-economic behavioral health inequities; and (c) developing an evaluation plan to measure success.

What outreach has helped develop this recommendation?

The primary source of outreach has been studying the Interagency Recovery Campus implementation. Additional outreach may include consultation with (a) the state of Oregon regarding their process for establishing a statewide network of recovery high schools; (b) Dr Andrew Finch, co-founder of the Association of Recovery Schools and Professor of the Practice at Vanderbilt University's Peabody College who has published extensive research on recovery high schools; and (c) Paul Bryant with Madrona Recovery.

6. Develop and pilot a dyadic benefit to allow mental health professionals to provide BH supports to young children who may present with symptoms that do not merit a diagnosis

From the Behavioral Health Integration Subgroup

New, $TBD, Budget ask and Legislative policy

Recommendation

We recommend partnering with the HCA to develop a dyadic benefit on Medicaid in state budget year 2025 that would emphasize prevention and support healthy emotional development, including for children who have symptoms that do not merit a diagnosis, and pilot the benefit in at least one urban and one rural primary care clinic serving significant proportion of children insured on Medicaid in state budget year 2026.

What is the issue?

The first years of a child's life are critical for lifelong health and development. During this time, safe, stable, and nurturing relationships are paramount, with family- and community-centered care of particular importance. Pediatric well-baby visits are the most frequent point of contact with the healthcare system for families with young children (up to 12 visits by age 3), and this is where much of the caregiver and family-based intervention to support child development occurs, i.e. "dyadic health care services." Decades of research have shown that dyadic models of care are the most effective form of behavioral health intervention for both preventative and acute, problem-based needs in infants and young children. Given

the frequency of primary care visits for families with children under 5, the mild to moderate, non-specialty mental health system is well-positioned to provide both preventative and mild to moderate behavioral health care to these families.

However, the lack of a payment model for behavioral health dyadic services in primary care prevents providers from effectively serving these families, resulting in needing to wait until a mental health diagnosis emerges before a billable service is provided. Establishing a payment pathway for primary care-based dyadic behavioral health services could empower a workforce to transform how we support babies, young children, and their families.

In Medicaid expansion states, children are often enrolled in the same health plan as their caregivers. This presents an opportunity for Managed Care Organizations (MCOs) to leverage dyadic service delivery and reduce the total cost of care for the entire family. By drawing upon strategies employed by various states, advocating for the opening of health and behavior assessment/intervention codes, and implementing Healthcare Common Procedure Coding System (HCPCS) dyadic codes to support dyadic behavioral health services, policymakers in Washington could provide the necessary financial support to deliver much-needed behavioral health services to families.

What do you recommend?

We recommend partnering with the HCA to develop a dyadic benefit on Medicaid in state budget year 2025 and pilot the benefit in at least one urban and one rural primary care clinic serving significant proportion of children insured on Medicaid in state budget year 2026.

Why is taking the recommended action a smart move now?

The science of early childhood development and early relational health demonstrates upstream evidence-based supports at the earliest juncture can have lifelong impacts. Today, the financial incentive is to treat children and teens only once they warrant a full-fledged diagnosis. This funding would allow us to help children in the first years of life and prevent future mental illness.

What outreach has helped develop this recommendation?

We have met with the HCA and are learning from MN and CA. At the 8.27.24 BHI Subgroup it became clear that the MN approach is not ideal. At the 9.3.24 BHI Subgroup we learned from CA and their approach holds promise.

Is there any additional collaboration needed to further develop this recommendation?

We anticipate the P-5 Subgroup would support this concept and need ongoing partnership and expertise from the HCA and states who already have this benefit.

7. Expand Maternity Support Services (MSS) regional coverage and provision of wraparound supports

From the Prenatal-through-Age-5 Relational Health Subgroup

New, $5M, Budget ask

Recommendation

Expand Maternity Support Services (1) provision to all counties; and (2) programming to incorporate individualized, intensive, coordinated, comprehensive, culturally competent, and trauma-informed

wraparound services to better meet the needs of pregnant and post-pregnancy individuals with behavioral health conditions.

What is the issue?

Maternal mortality remains high in our state, and disproportionately impacts birthing people of color. Most pregnancy-related deaths are in Medicaid-enrolled birthing individuals living in urban areas. Behavioral health is overwhelmingly the leading cause of pregnancy-related deaths; these deaths occur prenatal through one-year post-pregnancy. Pregnancy-related deaths due to behavioral health happen an average 115.4 days from the end of pregnancy. Many of the recommendations from the Maternal Mortality Review Panel center on providing additional support to pregnant and post-pregnancy individuals.

Maternity Support Services (MSS) are preventive health and education services to help individuals have healthy pregnancies, births, and babies. Individuals can receive MSS through the First Steps Program if they are pregnant or up to 60 days post-pregnancy and receiving Apple Health. An MSS team includes nurses, dietitians, behavioral health specialists, and in some cases, community health workers. MSS may include pregnancy and parenting information, screening for possible pregnancy risk factors, brief counseling for identified risk factors, and referral to community resources. However, only 25 counties have MSS providers.

MSS was reduced dramatically during the Great Recession, with a combined 55% funding cut between 2009-2011. Less funding has resulted in lower utilization. This last legislative session saw the first increase to MSS since these cuts. In 2024, SB 5580 was passed to improve maternal health outcomes, with $2.5M of state funding included in the final budget. This bill and associated funding do three things: 1) expanded income eligibility for pregnant and postpartum coverage to 210% of FPL (from 193%), 2) creates a post-delivery and transitional care program for extended post-delivery hospital care for people with a substance use disorder at the time of delivery; and 3) updates Maternity Support Services to increase rates, update screening tools and ensure care coordination. The updates to MSS will be implemented in January 2026. Unfortunately, it is unclear how much of this $2.5M of state funding will be used for different portions of SB 5580.

Numerous levers will be utilized to increase provider participation in MSS and to increase access to MSS services for pregnant and postpartum individuals. These levers include increasing rates by $10 per unit (unchanged since 2006), changing the tier structure from three tiers to two tiers (1) no, low, or moderate risk, and (2) high risk), and increasing the number of service hours guaranteed for each tier. It is unclear which of these levers will make the biggest impact on the incentivizing providers to offer MSS services or impact the outcomes for pregnant and post-pregnancy individuals.

We have two main recommendations related to Maternity Support Services to improve care for pregnant and post-pregnancy individuals:

1. Expand Maternity Support Services. MSS could be expanded either in terms of geographic location (to reach more counties) or to expand beyond sixty days post-pregnancy.

    a) Geographic expansion: MSS is only available in 25 counties after a substantial budget reduction in 2012. MSS needs to be expanded to be available in more counties to provide additional support to birthing individuals on Apple Health. While some counties have a low number of births and MSS services can be provided via audio-only or video telemedicine modalities, having support from providers familiar with the region and the community is important for building a trusting relationship with pregnant Apple Health enrollees.

b) Coverage timeline expansion: Services currently end at 60 days post-pregnancy, despite the fact that general consensus has the perinatal period extending to at least one-year post-pregnancy. Additional services in the post-pregnancy period would ensure more time to support enrollee needs and also address any perinatal mood and anxiety disorders that crop up during the postpartum period. It is crucial for post-pregnancy individuals to have additional support beyond 60 days, and ideally for one year to match up with the post-pregnancy coverage benefit.

2. Expand the Maternity Support Services programming to incorporate wraparound services where the need is greatest to better support pregnant and post-pregnancy individuals with behavioral health conditions. MSS home visitors would be able to better identify the individuals who could benefit from more intensive wraparound services, while also helping to identify additional prenatal and post-pregnancy needs. This wraparound program should extend to one-year post-pregnancy to further impact material health outcomes.

What do you recommend?

Fund Health Care Authority to expand MSS, and/or fund Health Care Authority to develop and implement a model for wraparound services for pregnant or post-pregnancy individuals with documented behavioral health conditions. The model for wraparound services could be tested out in areas of greatest need.

Cost –$5 million (GF-State)

- Annual MSS expenditures in 2020 were $2.2 million. The recent investment from SB 5580 would likely include an additional $4 million, putting the entire program at about $6.2 million total funds.
- The program receives a 50% FMAP for covered services.
- Annual program expenditures in 2008 were $20.5 million.
- If HCA expanded MSS to 12 months postpartum, one could assume a doubling of the units available (32 units or 8 hours for no, low, or moderate risk individuals, and 64 units or 16 hours for high-risk individuals). This would be scalable so that HCA could expand MSS to individuals up to six months post-pregnancy if not 12-months post-pregnancy, for a 50% increase in units. HCA used complex methodology for their decision package in 2023 and could use the same methodology to determine the additional costs of this proposal.
- The increased rates being implemented in January 2026 will increase rates by $10 per unit, which equates to a $40 per hour increase for providers. An additional incentive for providers with maternity care deserts may further increase access.
- Model development and pilot implementation of wraparound services may be feasible with less than $5 million.

Why is taking the recommended action a smart move now?

The Maternal Mortality Review Panel reviews pregnancy-related deaths and makes recommendations every two to three years. While important progress has been made to increase access to doulas for Apple Health enrollees and addressing some needs related to birthing people who are actively using substances, Washington State can do more to provide wraparound support for pregnant Apple Health enrollees with documented histories of mental health or behavioral health needs. The mental health and behavioral health of birthing people has a direct impact on their children. The next report from the panel is expected in October 2025, which will continue to have additional recommendations related to preventable pregnancy-related deaths related to behavioral health. Maternity Support Services is one of the few

programs that was devastated by the Great Recession and still has not rebounded appropriately. Initial steps have been taken to implement improvements, but additional investment is warranted to get the program even remotely back to pre-recession levels.

What outreach has helped develop this recommendation?

We have considered the interests of the P5RH workgroup and the recommendations of the Maternal Mortality Review Panel (2023 report, #3.1, 5.1, 5.2, 5.3, 5.11). We have discussed portions of this recommendation with various HCA staff to help shape understanding and program need. This proposal is aligned with the HCA decision package PL-GD-Maternal Health Improvement, which seeks FTE to ensure full implementation of SB 5580.

Is there any additional collaboration needed to further develop this recommendation?

We have had initial conversation with HCA and others as needed to support these recommendations. Additional conversations would be helpful. Molly could have conversations with people with more knowledge of MSS and wraparound models for feedback, and draft language, Nucha could help provide information around the science supporting reductions in stress and trauma during pregnancy and how it impacts birthing people and their babies in the short-and long term. We could also reach out to other stakeholders because we expect additional support for expanding MSS.

8. Establish a Technical Assistance and Training Network

From the School-Based Behavioral Health and Suicide Prevention Subgroup

New, $2.5M-$3.5M, Budget ask and Legislative policy

Recommendation

The Legislature should establish and fund a Technical Assistance & Training Network (TATN) to provide schools with the support, resources, and training necessary to coordinate comprehensive supports across the behavioral health continuum for their students.

[see recommendation section for more detailed fiscal estimate]

What is the issue?

When kids/families need help with behavioral health issues (anxiety, depression, substance use) that interfere with learning/academic success, many access behavioral health services (counseling, treatment) through local school nurses, school counselors, school social workers, or other mental health professionals.

Unfortunately, school staff face significant barriers to coordinating/delivering behavioral health services to kids/families:

- Confusing state/federal policies and guidance
- Lack of standardized frameworks and best practices
- Limited funding
- Legal and regulatory challenges
- Technology, security, and compliance issues
- Coordination issues
- Training and capacity issues
- Language and cultural barriers

- Siloed efforts competing for LEA/School/Staff time

What do you recommend?

The Legislature should establish and fund a Technical Assistance & Training Network (TATN) to provide schools with the support, resources, and training necessary to coordinate comprehensive supports across the behavioral health continuum for their students.

The structure of the TATN should include:

Coordinating Hub:

The coordinating hub should:

- Create and maintain the network infrastructure
- Provide high-level strategic oversight
- Connection to state frameworks and priorities
- Grant/contract allocation and management
- Evaluation and monitoring for network progress toward goals

The hub should consist of OSPI and a contracted organization(s) with relevant infrastructure and expertise to support and coordinate the work.

Statewide & Regional Network:

The TATN should be comprised of state-wide and regional partners with specific experience and capacity to provide training and technical assistance to schools. Partners should include:

- The Association of Educational Service Districts (ASED);
- The nine Educational Services Districts (ESD); and
- Relevant academic centers of excellence and community-based organizations that use evidence-based practices to provide training and technical assistance to schools around meeting student behavioral health needs.

Direct Support to LEAs:

The TATN should provide direct support to schools for establishing and implementing behavioral health supports in partnership with community-based organizations. Types of support activities may include:

- Conducting, or supporting local administration of, needs assessments to identify behavioral health needs of students, including cultural and contextual factors affecting their mental health
- Providing training and professional development opportunities for district and school staff on topics such as mental health awareness, trauma-informed practices, and effective intervention strategies, including offering specialized certifications for Educational Service Associate (ESA) and other critical school mental health roles, including paraprofessionals such as Student Assistance Professionals
- Assisting districts and schools in designing and implementing evidence-based behavioral health programs tailored to their specific needs and resources, in alignment with the screening, recognition, and response to emotional and behavioral distress requirements of RCW 28A.320.12
- Creating and distributing resources such as guides, toolkits, and intervention materials that schools can use to support behavioral health initiatives, including prevention efforts
- Helping districts and schools develop and revise policies and procedures related to mental health support, crisis intervention, and student well-being

- Analysis of state and local data to identify priorities and evaluate impact of the state's school behavioral health plan and constituent strategies as well as partnership with braided initiatives to look at cooperative efforts and outcomes
- Facilitating connections and partnerships with community-based organizations and state and local agencies to enhance support for students, leverage additional resources, and establish effective referral pathways
- Providing strategies and tools for involving families and communities in behavioral health initiatives, ensuring a holistic approach to student support.
- Offering guidance on crisis response strategies and mental health crisis intervention for staff and students
- Providing ongoing consultation and support as schools implement their behavioral health systems, helping to address challenges and sustain efforts over time

To enhance the effectiveness of the network and build off existing statewide work, the TATN should be deliberately connected to and built off of the existing Inclusionary Practices Technical Assistance Network. The TATN should also support increasing the regional capacity building of Regional Implementation Teams, and the Behavioral Health Navigators at the ESD level.

Initial Timeline & Project Plan (first two years):

Months 1-6:

- Hub organizing activities
- Develop accountability framework connected to relevant "playbooks"
- Initial communications to LEAs
- Statewide needs sensing from state, LEAs, CBOs, etc.
- Requests for Proposals (RFP) for coordinating hub partner organization(s) with specific content expertise
- Initial webinars and events, newsletters, etc.

Months 7-12:

- Cross-train network partners on consistent model
- Distribute state funding to LEAs for training & technical assistance
- Begin solicitation of training & technical assistance needs from LEAs
- Provide universal/targeted, intensive training & technical assistance

Year 2:

- Continue to provide universal/targeted, intensive training & technical assistance to LEAs based on identified needs
- Add network partners as needed
- Evaluate impact on staff, schools, districts, students

Budget Estimate:

- OSPI Hub coordination: $250,000
- Contracted organization(s) hub coordination: $500,000
- Coordinated training and technical assistance provided to LEAs by network providers, in collaboration with AESD (and each ESD) to continue development of regional capacity: $1.5-2.5 million
- Grant program for to LEAs for training and technical assistance: $300,000

Total for FY25-27 biennium: $2.5-3.5 million

Why is taking the recommended action a smart move now?

The effort to add a Behavioral Health Network component to two existing and emerging bodies of coordinated efforts in the state allows the success efforts to be combined. Behavioral Health focuses can leverage existing Technical Assistance Network practices and connections and can additionally make solid use of emerging Regional Implementation Teams at the ESD level that hold potential to support LEA's with PD/TA/Coaching across a multitude of Statewide initiatives (ISS, Attendance, School Improvement, CSCP, etc).

Creating and funding a Training and Technical Assistance Network would establish a coordinated and consistent access point for school districts to look to for support in creating and maintaining comprehensive, multi-tiered system of support that meetings the behavioral health needs of all students, in coordination with community-based partners.

What outreach has helped develop this recommendation?

The SBBHSP Subcommittee is made up of 44 members, including youth and family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations. The Subcommittee developed priorities across a series of monthly meetings and four workshops on Zoom. SBBHSP staff put out a request for recommendation proposals that were in alignment with the identified priorities and members subsequently ranked the proposals submitted through that process via a survey. This recommendation and the 'Strengthening Statewide Guidance & Direction' recommendation were presented as one proposal in the member survey. That proposal was the top ranked priority. We chose to split them into two separate recommendations, but they are intended to complement each other.

The proposal this recommendation was based off of was created through a collaborative effort that includes staff representing three school districts (one in eastern WA and two in western WA), a non-profit that supports with extensive experience working with schools around equitable access to health and social are, and several representatives from two academic centers of excellence that provide training and technical assistance to schools focused on behavioral health. The proposal also incorporates several elements of the recommendations included in the results of the Bloom Works K-12 Behavioral Health Discovery Sprint which was done as part of the WA Thriving strategic plan effort.

This recommendation is informed by the development/publication of a statewide playbook for COVID-19 testing in Washington State schools https://doh.wa.gov/sites/default/files/legacy/Documents/1600/coronavirus/421-018-LearnToReturnPlaybook.pdf) that supported the implementation COVID-19 testing services in almost every public, private, and tribal school in Washington State (https://storymaps.arcgis.com/stories/375107d48f5441699fac33ffc86436b1).

This recommendation is also informed by the development/implementation of Student Health Hub (https://studenthealthhub.org/)- - a coordinated, school-based service/program/system of care that has been co-developed and pilot tested in Renton, Washington in collaboration with schools, city government, behavioral health agencies, philanthropies, corporate sponsors, education service districts, county government, and state government agencies. The Student Health Hub model is now being expanded in Renton and pilot tested in Seattle and Enumclaw.

9. Expand access to peer supports in school settings & professional peer pathways for youth and young people

From the School-Based Behavioral Health and Suicide Prevention Subgroup

New, $TBD, Budget ask and Legislative policy

Recommendation

Expand access to peer supports in school settings by coordinating statewide integration of Peer Learning Curriculum; and expand existing and future peer service provision (especially youth and family peer services) by increasing in-school peer training, creating and enforcing network adequacy standards, lowering barriers to insurance billing, maximizing billing for current programs to expand services and ensure sustainability, and investing in wellness programs and professional development for the peer workforce.

What is the issue?

Substantial evidence exists that peer services are often more effective in health-related behavior changes with alcohol and substance use in addition to improving mental health outcomes[5][6][7] for youth and adolescents, having positive effects for both the peer educators[8] and peer learners[9][10].

Peers are the only profession within the behavioral health workforce where we have not a shortage, but a surplus of willing workers. Access to peer services significantly increases treatment engagement, adherence to treatment plans, and longevity in treatment. Furthermore, peers play a crucial role in conducting outreach to bring people into treatment and services who would otherwise not receive care. Peer services are enormously effective. Given the massive behavioral health challenges our youth and young adults are facing, we cannot afford to have peer services underutilized and to have inadequate access to peer services.

In addition to supporting our existing and future certified peer support professionals, additional informal peer training and supports are needed to equip youth, young adults and their families with the skills foundational to mental health and substance use literacy to create and reinforce community and safe and supportive spaces for social-emotional co-learning, and to prevent crises before they occur.

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SPARK is the home of a Curriculum designed to empower youth and young adults aged 17-26 through a comprehensive 12-week curriculum that focuses on becoming certified Peer Counselors. Participants will learn to create Wellness Recovery Action Plans (WRAP) and develop essential skills such as social and emotional tool-building, coaching, and mentoring in a strength-based environment. The curriculum includes state-approved materials and practical life skills, covering banking, housing, and systems navigation. The program is in the planning phase in the Wenatchee school district at Eastmont Highschool. It will be supported by a team of trainers, including Youth Peer Support Specialists and licensed therapists. The program emphasizes a diverse approach to understanding peer counseling roles. Participants can earn school credit, with ongoing evaluations measuring their progress throughout the course. The SPARK Program seeks to create a supportive environment where youth can discover their strengths and advocate for themselves and others.

What do you recommend?

- Fund SPARK peer learning pilot expansion and education and training in school-settings.
- Create network adequacy standards for youth peers, family peers, and adult peers across Medicaid and commercial insurance carriers and a mechanism to enforce these standards.
- Create a low barrier way for non-behavioral health agencies to bill for the provision of peer services.
- Ensure insurance is being maximally billed for existing peer services programs.
- Increase funding for the Washington Peer Network, the Washington Peer Jobs database, and other initiatives supporting mental health literacy and training for youth.

Why is taking the recommended action a smart move now?

The peer landscape will change radically in July 2025 with the implementation of SB 5555, the creation of the new certified peer specialist, and the ability for individuals with commercial insurance to access peer services for the first time. Any legislation passed in the 2025 session would have an effect date that coincides with SB 5555 implementation.

The SPARK Program, supported by the Washington Behavioral Health Youth Network, currently pilots program delivery in the Wenatchee school district at Eastmont Highschool. The Program utilizes a team of trainers, including Youth Peer Support Specialists and licensed therapists to create a supportive environment where youth can discover their strength and advocate for themselves and others, while offering opportunities for students to earn school credit, achieve a diverse understanding of peer counseling roles and become Certified Peer Counselors. The program also focuses on raising awareness among parents and teachers about the benefits of peer support, including tailored culture and expertise-building for families and educators, while centering youth voice. This strengths-based wraparound approach to youth peer supports is evidenced to create a safe, supportive, empowered and healing environment where youth and families can discover their strengths and advocate for themselves and others, and needs to be widely accessible to WA students statewide.

What outreach has helped develop this recommendation?

This recommendation builds on prior successful YYACC efforts to expand access to youth and family peer services. The need for increased access to peer services was raised again during YYACC meetings in the 2024 interim.

Is there any additional collaboration needed to further develop this recommendation?

Yes, there will be engagement with HCA, OIC, OSPI, the MCOs, SPARK, and other vested parties to further the development of this recommendation.

10. Increase family psychotherapy reimbursement rate

From the Prenatal-through-Age-5 Relational Health Subgroup

New, $1.5M ($645K GF-S), Budget ask and Legislative policy and rule change

Recommendation

Increase all family psychotherapy rates to reflect the complexity of providing relationship-focused treatment that includes parents and caregivers, which is best practice in clinical Infant-Early Childhood Mental Health treatment. Current family psychotherapy rates are up to 36% lower than individual psychotherapy rates for services of equivalent duration, which disincentivizes provision of and billing for these essential services.

What is the issue?

National and Washington-specific data suggest that young children are less likely than older children and youth to receive needed mental health care, and challenges with accessing insurance reimbursement for services likely contributes to families' difficulties accessing care (Ghandour et al., 2019; Health Care Authority, 2022).

IECMH treatment services are highly effective and offer a strong return on investment; every dollar spent on IECMH treatment services can yield $8.00-$15.00 in savings per child (Oppenheim & Bartlett, 2022).

Best practice in clinical IECMH services is to work with the parent/caregiver and the infant/young child together, and family therapy that includes the parent/caregiver is essential in order to achieve optimal treatment outcomes. However, only about 46% of licensed behavioral health agencies reported providing this type of dyadic treatment service (i.e., family psychotherapy) in the 2022 Behavioral Health Provider Survey.

While IECMH specialization is extremely limited in Washington's behavioral health workforce, a 2020 survey found that many of the existing IECMH providers experience challenges being reimbursed for their services (Oxford & Lecheile, 2022).

Currently, the maximum allowable rates for family psychotherapy codes in the Apple Health fee schedules are significantly lower than those for individual psychotherapy services even if the duration and intensity of services is comparable. The current rate gap is up to 36.41% for Fee for Service (FFS) providers (Mental Health Fee Schedule) and up to 15.83% for Community Behavioral Health Agencies (Specialized Mental Health Fee Schedule). This significant difference in reimbursement serves to unintentionally disincentivize provision of and billing for family psychotherapy services. Some providers note that agencies may encourage coding for individual psychotherapy with caregivers present to obtain higher reimbursement, which puts providers in an ethical and potential legal dilemma of using the most appropriate code to reflect care versus optimizing reimbursement.

Other state Medicaid programs have effectively addressed this issue. For example, Oregon's fee-for-service rates are $184.66 for 90837 (individual) versus $175.21 for 90846 and $205.47 for 90847 (family psychotherapy codes) (Oregon Behavioral Health Fee Schedule, August 2024)

What do you recommend?

- Increase family psychotherapy reimbursement for young children birth through 5 years old by 25% for Specialized Mental Health rates and 65% for FFS Mental Health rates. The difference in rates of increase is reflective of the significant disparities in base reimbursement rates by funding stream.
- This would result in an increase in family psychotherapy rates slightly beyond matching individual therapy rates intended to account for the additional complexity of family therapy and to incentivize providers to align their clinical care with best practice and evidence-based treatment models.
- Consistent with prior implementation of **SHB 1325 (2021) (Mental Health Assessment for Young Children, MHAYC),** this effort should align Apple Health policy and reimbursement with national best practices in IECMH.

Why is taking the recommended action a smart move now?

Some longitudinal administrative research has found that family therapy can have a greater impact on reducing health care costs in the years following treatment than individual therapy, making family therapy a cost-effective intervention strategy (Crane et al., 2012)

Adjusting the rates for family psychotherapy could increase the willingness of the limited number of IECMH clinicians whose services are in high demand to contract with Medicaid MCOs, increasing availability of this highly specialized service to Apple Health enrolled infants, young children, and their caregivers.

This rate increase would support the sustainability of current parallel IECMH professional development initiatives in Washington State that are focused on training in dyadic models of therapy (e.g., Child-Parent Psychotherapy, NeuroRelational Framework).

This recommendation is supplemental to the recommendation from the CYBHWG's Behavioral Health Integration (BHI) subgroup of a 30% FFS rate increase to match Medicare rates. The BHI subgroup recommendation would address disparities in reimbursement for behavioral health services by provider type and funding stream, which involve significant reimbursement differences of up to 54%. The P5RH subgroup recommendation would address disparities in reimbursement by service type, closing the gap between rates for individual and family psychotherapy services of similar durations. If both move forward, adjustment of the budget for this recommendation would be necessary to reflect the increased baseline FFS rates.

It is important to note that best practice in IECMH is not dissimilar to best practice in provision of psychotherapy for children of all ages, particularly when considering the importance of including parents/caregivers. While family psychotherapy is essential when working with the youngest children, involving parents and other caregivers in services for children over 6 years old is also best practice and is critical to achieving positive treatment outcomes. Addressing inequitable family psychotherapy reimbursement rates for children birth through 5 years is a valuable first step; however, the potential unintended consequences of failing to extend this rate increase for clients beyond 6 years of age must be recognized.

What outreach has helped develop this recommendation?

This recommendation builds off the work of HB 1325 (2021, Mental Health Assessment for Young Children), which aligned Apple Health policy and reimbursement with best practices in IECMH. HCA recently published a report summarizing the outcomes of a statewide tour (June – October 2023)

including ten listening sessions with 96 mental health providers throughout the state. The report describes newly developed HCA IECMH priorities, which are aligned with HCA's overall strategic plan, and identifies action items for HCA to address barriers highlighted by providers during this statewide tour. One such step is to initiate the internal process for increasing family therapy rates for young children to promote best practices for IECMH.

This year, the P5RH Subgroup engaged stakeholders in a recommendation development process that was followed by a vote during which subgroup participants identified their five highest priorities. The issue of family therapy rates was one of the top three priorities identified through this process. The prioritization of this issue is consistent with clinician feedback through historical stakeholder engagement processes such as the HCA statewide tour.

HCA has submitted a decision package for the 2025 – 2027 budget session that is requests funding to increase family therapy rates for young children. This decision package can be accessed at https://abr.ofm.wa.gov/api/public/decision-package/summary/74869. The background cost modeling behind the numbers in this recommendation are also available upon request.

11. Fund youth-focused curriculum for Behavioral Health Support Specialists (BHSS)

From the Workforce and Rates Subgroup

New, $$, Budget ask

Recommendation

A Behavioral Health Support Specialist (BHSS) is a new bachelor level provider type with a scope of practice that includes mental and behavioral health interventions delivered under clinical supervision. UW Seattle is a catalyst for this workforce project and received funding from Ballmer Group to develop an adult curriculum.

What is the issue?

Increasing the capacity, availability and diversity of the mental and behavioral health workforce is critical to helping children and families thrive in Washington State. SB 5189 (2023) created a certification for a new bachelor-level profession in Washington State called the Behavioral Health Support Specialist or BHSS. The BHSS will deliver, brief, culturally responsive, evidence-informed treatment for common mental and behavioral health conditions such as depression and anxiety under clinical supervision. A competency framework was utilized for the BHSS Clinical Training Program to identify applied skills foundational to generalist practice. A BHSS is not limited to practicing these competencies in the workplace. The language in the BHSS CR102 uses the qualifier "competencies and clinical skills include but are not limited to."

UW Psychiatry and Behavioral Sciences through generous funding from Ballmer Group has developed an infrastructure for scaling the BHSS role statewide. One of the primary grant objectives is to develop an evidenced-based curriculum to be shared with any Washington State college or university prepared to integrate the BHSS competency framework into their existing four-year degree program. The approved BHSS educational program will include a practicum to help students develop proficiency in treatment delivery under supervision prior to starting employment.

Current funding focused on the development of a curriculum to serve the adult population. There is a need to identify funding to develop youth focused curriculum and on-going support of this centralized curriculum. UW Psychiatry and Behavioral Sciences requests funding to hire subject matter experts in behavioral health disciplines to develop a youth (13 to young adult) curriculum that will prepare the BHSS

to contribute to service delivery across a variety of settings. These settings include, but are not limited to school-based mental health, crisis services, youth shelters, youth-based community services, integrated primary care, specialty mental health and hospital-based services. BHSS employment in these settings will be sustained through revenue generated from billing for services to Medicaid and third-party insurance.

The UW BHSS Clinical Training Program has engaged seven active partners in delivering BHSS curriculum. Five additional colleges and universities are engaging in self-study to prepare to integrate BHSS training into their psychology or social work programs. It is anticipated that these programs will graduate approximately 100 students per year in the first two years and that the number will increase significantly as more higher education programs join in this workforce development effort.

What do you recommend?

If the University of Washington Department of Psychiatry and Behavioral Sciences receives state support, it would help fund the inclusion of subject matter experts in youth mental and behavioral health to develop appropriate curriculum for the bachelor level programs. Previous legislation has helped create the structure for credentialing.

Estimated Cost

Anticipate a cost of $900 K distributed over two academic years. Expenditures include part time appointments for subject matter experts in child and adolescent psychiatry, psychology, and other mental and behavioral health professions. Additional expenditures may include instructional design, communications and curricular materials. A detailed budget of expenditures will be forthcoming. The UW BHSS Clinical Training Program has been intentional about hiring subject matter experts from both UW and partner colleges and universities to help shape the BHSS curriculum for Washington State.

Why is taking the recommended action a smart move now?

The BHSS professional type helps to supplement previous CYBHWG recommendations such as behavioral health workforce shortages for youth and families; services for young people transitioning to adulthood; need for school-based behavioral health services and supports; and wait lists that create a barrier to care when youth need it.

Washington State has moved forward with developing a bachelor level provider type working under supervision with a scope of practice that includes behavioral health. The BHSS will be able to work across settings helping to create a network of providers in school-based mental health, integrated primary care, community social services for youth and specialty mental health care. These providers will be training in public and private institutions with a common core of competencies. One expectation is that the broadening of higher institutions and pathways into the profession will help diversify the workforce. The youth-based curriculum funding proposal is a one-time request to continue to advance the work initiated by Ballmer Group and UW Psychiatry and Behavioral Sciences to expand the behavioral health workforce and increase access to mental and behavioral healthcare.

What outreach has helped develop this recommendation?

Since 2022, the UW BHSS project team has been engaging with both adult and youth advocacy groups representing providers, payors, community leaders, client/patient populations and higher education programs. Feedback has been to work on educational pathways for the delivery of youth-based services. To prepare this recommendation for legislative action, we need to engage a legislative sponsor.

For additional background information, please see the three-minute read in Psychiatric Services or visit the BHSS website. Please forward any questions to bhsswa@uw.edu and a team member will respond to you. Thank you for your consideration.

Additional Recommendations

Six additional recommendations are listed below in no particular order. These are recommendations that, although important, the Work Group prioritized lower than the priority recommendations presented above.

Fund administration of CAPS and streamline pathway to First-Episode Psychosis care

From the Youth and Young Adult Continuum of Care Subgroup

CAPS = Central Assessment of Psychosis Services

New, $1.1M, Budget ask

Recommendation

Despite the increased availability of First Episode Psychosis services across our state, pathways to FEP care remain difficult for families to navigate and teams are often under-equipped to meet the need. The Central Assessment of Psychosis Service (CAPS) will streamline access to FEP care in Washington State, addressing obstacles to early psychosis detection through a single access point for young people as well as their families and practitioners who have a psychosis-related concern; a stable source of funding is needed to launch and sustain this statewide service in SFY2026.

What is the issue?

Significant progress has been made in increasing access to First Episode Psychosis (FEP) Coordinated Specialty Care services across the state. Although the availability of this evidence-based model has contributed to reductions in Duration of Untreated Psychosis (DUP)—a leading predictor of schizophrenia spectrum disorder prognosis—the DUP in Washington State remains higher than the maximum DUP recommended by the World Health Organization. Furthermore, recent analyses by the Department of Social and Health Services Research Data and Analysis Unit suggest that many young people who meet criteria for FEP are not accessing New Journeys' FEP services (DSHS, 2021).

Currently, each New Journeys team handles its own referrals, screening processes for eligibility, and onboarding timelines. This system creates inefficiencies and is vulnerable to issues such as staffing volatility, training deficits, implicit biases, and unequal access to screening and treatment across the New Journeys Network. Moreover, rural and racially marginalized youth are disproportionately impacted by circuitous pathways to care, diversions from the care pathway to the criminal justice system, and misdiagnosis. In short, existing entryways to the New Journeys Network are difficult to navigate and continue to disadvantage underserved and marginalized communities.

What do you recommend?

The Central Assessment of Psychosis Service (CAPS) will streamline access to FEP care in Washington State, addressing obstacles to early psychosis detection through a single access point for young people as well as their families and practitioners who have a psychosis-related concern. CAPS currently operates as a limited-capacity UW Medicine telehealth service that provides psychodiagnostics assessments for diagnostically complex referrals to the New Journey Network. In 2023, the Health Care Authority invested

in the conceptual and operational development of an enhanced assessment service, which would work to expand equitable and efficient access to FEP screening and care across the State of Washington through the following activities:

- Develop, launch, and operate a health communication campaign to support awareness of psychosis signs and symptoms, the New Journeys Network, and CAPS services.
- Develop the clinical operational, quality management, and data management systems to support a statewide psychosis screening and assessment service.
- Develop and maintain a Health Information Technology system for case level tracking.
- Develop and maintain a referral database to ensure that all families receive timely referrals to right fit care.

A cost analysis projects that the annual operational costs associated with these activities is $1.1 million, inclusive of 10% indirect, beginning SFY2026 (July 2025—June 2026). If funded, a stagewise rollout of the health campaign and corresponding services will be feasible for a SFY26 launch due to readiness activities that were funded by the 1115 IMD Waiver and MHBG Bipartisan Safer Communities Act (BSCA) in SFY2024-25.

Why is taking the recommended action a smart move now?

Expanding CAPS aligns with state and federal efforts to support early and periodic screening, diagnostics, and treatment for high-risk, high-impact health conditions. The activities outlined above are responsive to best practices in early identification, measurement-based care, and public health campaigns, all of which are associated with a reduced Duration of Untreated Psychosis, cost savings, and evidence-based coordinated care at the population level. Furthermore, the statewide CAPS expansion would further the state's mission to enhance equitable access to mental health care by facilitating timely, culturally-sensitive, and psychometrically validated screening and assessment processes. By making CAPS a "front door" through which all individuals would be screened for New Journeys admission, the state can reduce lag times for referrals, and enhance efficient, appropriate, and equitable access to First Episode Psychosis care. Furthermore, CAPS is poised to develop a central registry for New Journeys referents. A central registry enables more accurate estimates of First Episode Psychosis and Clinical High Risk for Psychosis incidence rates, geographic distribution, and service use data across the state, all of which are sorely needed to inform future program and policy decisions for this high-risk population.

What outreach has informed this recommendation?

The conceptual and operational development of the enhanced service has been informed by an extensive stakeholdering process. The UW CAPS team, led by Dr. Sarah Kopelovich in coordination with New Journeys Implementation Lead and Director of the Washington State Center of Excellence in Early Psychosis, Dr. Maria Monroe-DeVita, has co-produced the enhanced model with input from New Journeys program directors, agency administrators, families and service users, the Health Care Authority, DSHS Research and Data Analysis administrators, and UW Medicine administrators. In addition, the CAPS team has presented the model to community members, behavioral health agency peer and clinical staff, and policymakers to ascertain perceptions of the acceptability and feasibility of the statewide service. Anonymous data obtained from the CYBHWG Youth & Young Adult Continuum of Care (YYACC) subgroup committee following a presentation on the proposed expansion of CAPS are presented in Figures 1 and 2, below.

Figure 1: YYACC Subgroup Survey Respondents by Profession

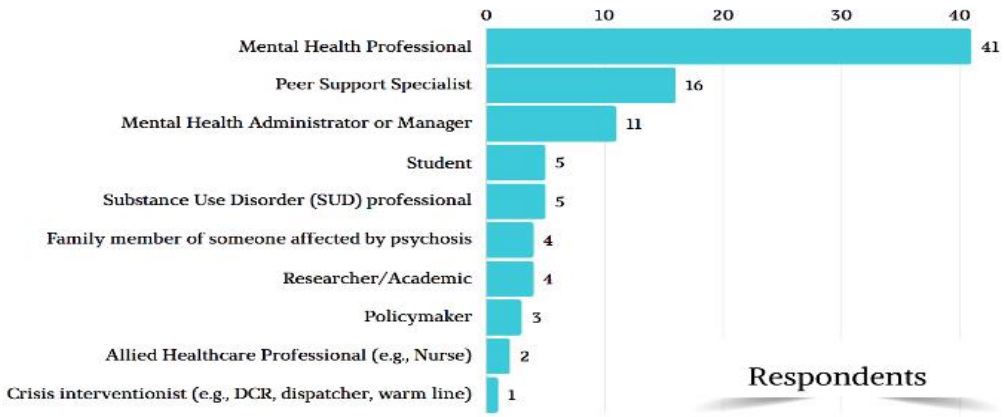
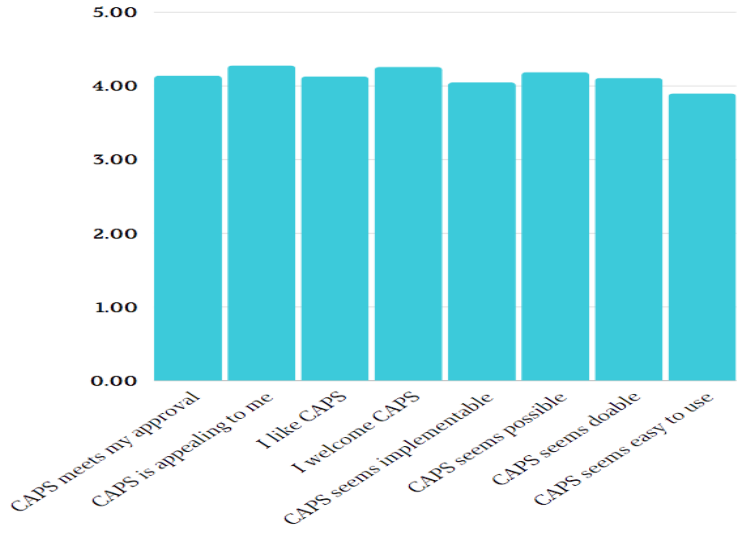


Figure 2: YYACC Subgroup Perceptions of CAPS Acceptability and Feasibility (1—5 Likert Scale)



Aggregated data across three large community and professional events is currently in the process of being analyzed. Results will be submitted for peer-review publication in FFY25.

Is there any additional collaboration needed to further develop this recommendation?

Considerable coordination across programs is needed to support a successful psychosis awareness campaign effort and the statewide screening, assessment, and referral service. The educational, marketing, and promotional materials developed for the campaign will be supplied to New Journeys teams, who can develop adaptations that are indicated for their catchment area (e.g., translations). Furthermore, the UW CAPS team will conduct analytics of campaign activities to detect whether the campaign is having equitable impacts across the state. This data will be triangulated with data from referents about their pathways to CAPS; these analytics can then be used to develop more targeted outreach and social marketing strategies that are indicated in different regions. For instance, a health education effort among clergy, teachers, pediatricians, and family medicine practitioners may be more fruitful in a rural region, whereas targeting law enforcement and correctional staff may be a more fruitful strategy in a larger

metropolitan area. The funding request outlined above would enable both public-facing activities and the continuous quality improvement efforts that are needed to maximize the efficacy of the health campaign.

As is the case with complimentary resources such as the Mental Health Referral Service and the Behavioral Health Toolkit, once launched, families and practitioners will come to rely on CAPS services. A state proviso will help to ensure the stability of the service and enable it to meet its stated objectives. Moreover, the population-level data that will be obtained through this statewide service will complement RDA's efforts to track clinical outcomes and estimate the incidence of FEP and Clinical High Risk for Psychosis, thereby informing future program and policy decisions related to this vulnerable population.

Improve ratio of social workers in Washington schools

From the School-Based Behavioral Health and Suicide Prevention Subgroup

New, $$$$, Budget ask and Legislative policy

Recommendation

To improve the ratio of school social workers available support student behavioral health needs in schools, the legislature should increase the allocation for school social workers in the state funding formula, provide matching grants to rural and remote districts to hire school social workers, and refine the definition of school social workers in state statute.

What is the issue?

There are inadequate staff to address the social, emotional and behavioral health needs of students in K-12 public and tribal schools despite the legislature's investments in 2022. This workforce shortage has an adverse impact on students and staff who are struggling to address the needs of these students in the classroom. Social workers are the Educational Staff Associate (ESA) professional type in schools who are the most likely to work directly with students at multiple tiers of support to address their needs and in conjunction with family/school/community. Yet, they are the most limited in their numbers in schools.

Under the current prototypical school funding model, an elementary school needs 1,818 students to generate a single full-time social worker. At the middle and high schools, it takes even more students, 7,200 and 6,742 respectively. The staffing allocations are simply inadequate to support comprehensive student mental health and well-being, especially when considering the statewide need. The Legislature has made significant progress in boosting school staffing levels to reflect the measures recommended by Washington voters through Initiative 1351 in 2014. However, these recommended staffing ratios were initially developed more than 10 years ago, and these numbers must be revisited and revised to reflect true and adequate support for an educational system that supports the current social, emotional, mental, and behavioral health needs of each and every student. This is especially so for districts in rural and remote communities across the state, which generally have far fewer enrolled students than those in urban and suburban communities. Using enrollment data for the 2023-24 school year, 111 local education agencies (or ~35% of those in the state) had less than 400 enrolled students across all grades, K-12. Further, where districts do have funding, they could use to hire a school worker, many school administrators and districts decision-makers lack understanding of the extent to which school social workers can work with other ESA staff to address student behavioral health needs.

The Workforce for Student Well-being (WSW), funded by the U.S. Department of Education, is a consortium of higher education institutions and statewide schools of social work who are working to increase the number, diversity, and skills of well-trained social workers in schools. It is challenging for recent graduates of the WSW to find positions due to the limited supply of school social work jobs available in our state especially in rural, high need school districts. There are approximately 300 school

social workers across the entire state of Washington with a 93 percent increase needed to align with recommendations from the national model of school social work. Current staffing disparities are the most pronounced for school social work compared to all other ESA types in schools, including counselor, nurses, and psychologists.

What do you recommend?

To improve the ratio of school social workers available support student behavioral health needs in schools, the legislature should:

- Establish a targeted matching grant program for rural and remote school districts to hire school social workers. The grant program should:
    - Provide grants to 30 local education agencies (LEAs)
    - Award $150,000 over 2 years, targeted toward the 126 rural and high-need LEAs across the state
    - Require grantee LEAs to fund the difference between an FTE school social position, and the $75,000/year awarded through the grant
    - Require grantee LEAs to staff a school social worker for two years, the 2026-2027 school year and 2027-2028 school year, and award funding in two $75,000 increments with the second payment contingent on hiring a school social worker
    - Require grantee LEAs to participation in a monthly call during the grant period on the roles of ESA staff and supervision as well as on challenges unique to rural school districts
    - Require grantee LEAs to participate in a short evaluation survey about sustainability regarding the position, the impact of the award, and barriers to providing mental health services to students in schools facing rural school districts

    Budget Impact: 4.65 million for the biennium

    - 30 two-year grants at $150,000 each
    - Grant administration and grantee support activities
- Refine the definition of school social work and their role as school mental health professionals to help to clarify the importance of their role in schools

    Refining the definition will add needed clarification on the role school social workers can play in supporting student behavioral health needs. Additionally, the School Social Work Association of America's national model includes key components related to equity, which are currently missing in Washington state's definition. These revisions aim to align our state's policies with national standards and ensure a more equitable approach to student support.
- **Budget impact:** NegligibleFund OSPI 2025 Budget Request to increase the allocation for school social workers through the state funded prototypical school funding model.

    To support student mental and behavioral health across the state, the OSPI budget request seeks funding to increase the staffing allocation for social workers in the prototypical school funding model. Specifically, OSPI requests to increase the allocation for social workers through the state funded prototypical school funding model by 0.06 FTE per prototypical school. This would increase the social worker allocation for prototypical elementary schools from 0.311 FTE per school to 0.371 per school, from 0.088 to 0.148 per prototypical middle school, and from 0.127 to 0.187 per prototypical high school. Using maintenance level funding as a baseline for calculations and student enrollment as approved by the Caseload Forecast Council, OSPI estimates this

increased allocation will drive an approximately 130 FTE certificated instructional staff allocation through the prototypical funding model statewide.

Budget Impact:

- Fiscal year 2026 = $12,671,000
- Fiscal year 2027 = $16,523,000
- Fiscal year 2028 = $16,842,000
- Fiscal year 2029 = $17,195,000

Why is taking the recommended action a smart move now?

UW, OSPI, and WASSWA have been collaborating on the WSW and discovered the disparity around school social worker staffing levels. This is the ESA type that is most likely to deliver school-based mental health services at multi-tiered levels of support at a time when student needs are at a very high level.

Further investment into the state school funding formula school social workers would provide a system-wide, structural improvement to the way the state funds staffing along the school behavioral health continuum of supports that would impact all WA school districts. However, because that investment would be on a per enrolled student basis, it is not likely to be nearly enough to generate full, or even half time, equivalent increases in school social worker staffing for districts in rural and remote communities. Pairing the statewide investment with a new grant funding specifically for rural and remote school districts in hiring school social workers would address that gap and provide staffing support for districts of all sizes across the state. The new grant funding would also directly align with our state's effort to grow the number of candidates interested and qualified to fill much needed school social work positions through the Workforce for Student Well-being (WSW) initiative.

What outreach has helped develop this recommendation?

Outreach efforts have included conversations with educators and school staff across Washington state, revealing a general lack of knowledge and understanding about the role of school social workers. This feedback highlights the need for a clearer definition to ensure that school social workers' contributions to students, families, and communities are fully understood and recognized.

The SBBHSP Subcommittee is made up of 44 members, including youth and family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations. The Subcommittee developed priorities across a series of monthly meetings and four workshops on Zoom. SBBHSP staff put out a request for recommendation proposals that were in alignment with the identified priorities and members subsequently ranked the proposals submitted through that process via a survey. The recommendation detailed here was tied for the second-highest ranked proposal in the member survey.

Behavioral health funding for school districts

From the School-Based Behavioral Health and Suicide Prevention Subgroup

New (previous subgroup priority)**, $$$, Budget ask**

Recommendation

Provide funding directly to local education agencies (LEAs) to plan, coordinate, and/or provide school-based supports that address the emergent mental health crises in their student populations and meet the requirements of RCW 28A.320.127.

Budget Impact: $4.35M for FY25-27, inclusive of $350K for grant administration and state and regional capacity development; and, grants to 20 LEAs for $100K/year.

What is the issue?

School districts currently lack the funding necessary to coordinate comprehensive supports across the behavioral health continuum for their students. RCW 28A.320.127 requires each school district in Washington to adopt a plan for recognition, initial screening, and response to emotional or behavioral distress (EBD) in students, including but not limited to indicators of possible substance abuse, violence, youth suicide, and sexual abuse. The RCW requires EBD plans to include a list of components - including identifying training opportunities, developing partnerships with community-based organizations, and creating protocols for responding to crisis situations – all of which require significant staff time and resources to complete effectively. However, the state does not provide funding to LEAs, outside of funding allocations for school nurses, social workers, counselors, and psychologists, to do this crucial work. As such, many LEAs lack adequate funding for implementing foundational evidence-based preventative supports, especially those in collaboration with community-based providers, while coordination of intervention supports often relies on navigating challenges with billing student insurance. When community providers are available to support students, schools have difficulty engaging community providers because of access, scheduling, and funding issues, making it difficult to integrate services into school support teams.

OSPI conducted a survey of all 321 Local Education Agencies (LEAs) in the state between March 2022 and February 2023 to gauge compliance with the RCW 28A.320.127. Data collected from the survey found that only 172 LEAs (54%) reported that they had an EBD plan in place. 149 LEAs reported they did not have an EBD plan in place.

The OSPI survey on compliance with RCW 28A.320.127 asked LEAs about barriers they encountered in developing an EBD plan. Lack of time or adequate staff was the most mentioned barrier, cited by 84 LEAs in the survey. Lack of funding and/or resources were the second most commonly cited barrier. Many LEAs mentioned that they needed more funding to ensure proper training and professional development, both to create the plan and train their staff to support the plan once it was created. Several LEAs also mentioned that they would need funding for an additional staff member to create the plan, since they felt their current staff didn't have the time or the proper expertise. Similarly, some LEAs said that they would need funding to hire behavioral health staff to support the plan once it was created. Other LEAs pointed to a lack of behavioral health resources in their community as a barrier to putting this plan in place and/or emphasized, in general, that the EBD RCW, as it stands, is "another unfunded mandate."

What do you recommend?

The legislature should provide funding to all school districts to create and implement a plan for screening, recognition, and response to emotional and behavioral distress in students, as required by RCW 28A.320.127.

To pilot direct funding to support districts compliance with RCW 21A.320.127, the Legislature should allocate $4.35M to establish a statewide grant program for local education agencies (LEAs). Allowable uses of funds should include:

Accessing specialized training, support, and resources to implement elements required by RCW 21A.320.127

Funding to sustain staffing and create/strengthen an EBD plan through a multi-tiered system of supports, and support screening

Centering primary prevention as a meaningful element of EBD work in every school community

Coordination with community-based organizations to support the creation and implementation of the EBD plan, and meet the behavioral health needs of all students

Providing effective training and technical assistance to staff in integrated behavioral health comanaged with pediatric primary care clinics

The grant program should be administered through a cascading support structure (see below) that pairs grantees with state-level and regional support to guide LEA planning, build clear aligned statewide infrastructure, and create consistent, equitable, responsive training, resources, and expert consultation on best practice as it pertains to school district ability to meet the requirements of RCW 28A.320.127. To receive funds, grantees must be willing to submit current plans for feedback and participate in regular consultation around their work to meet RCW 28A.320.127 with state and regional partners.

- Statewide infrastructure and expertise:
    - Across prevention, screening, intervention, and response and created with consultation of expert partners and consultation
    - Identifying and creating consistent training offerings to support district and regional implementation
    - Exemplars
    - Best Practice Resource Repository
- Supports regional partners in implementation, training, and technical assistance:
    - Including ESD Behavioral Health Navigators and other state and nation-wide expert partners with the guidance, training, and resources necessary to provide:
    - Consistent, equitable, and regionally responsive support to their regions
    - Ongoing evaluation of EBD plans and consultation that supports continues improvement of those plans
- LEAs awarded grant funding receive:
    - Feedback and consultation on meeting the requirements of RCW 21A.320.127, including ongoing support for program, policy, and procedure refinement based on district needs AND best practice
    - Specialized training, support, and resources to implement elements required by RCW 21A.320.127.
    - Funding to sustain staffing and create/strengthen an EBD plan through a multi-tiered system of supports, and support screening
    - Support for centering primary prevention as a core element of the EBD work in the school community

Overall, this recommendation seeks to further invest in local capacity to achieve the functions of high-quality school mental health supports that improve student well-being.

Why is taking the recommended action a smart move now?

OSPI survey data from the last 19 months shows a clear picture of where LEAs need support with planning and coordinating for effective screening, recognition and response to emotional and behavioral distress in students. 149 LEAs (46% of those across the state) self-reported that they did not have an EBD plan in place. It is imperative that we address the mental health crisis that WA students are facing by providing crucial funding support for LEAs to use to create and strengthen their EBD plans and mental health

support systems. We acknowledge that the State Legislature made a significant investment in the funding allocations for physical, social, and emotional (PSES) support staff through House Bill 1664 (2022). This funding will move our system towards a longer-term "righting" of the school staff capacity we need for prevention/education. However, schools need dedicated funding right now to address the mental health crisis WA students are facing.

What outreach has informed this recommendation?

The original recommendation for this position by the SBBHSP Subcommittee in 2023. That year, the subcommittee consisted of 37 members, including family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations, and a Youth Advisory Committee consisting of 11 youth and young adults with lived experience interacting with behavioral health supports in WA K12 schools. The Subcommittee developed recommendations across five Zoom workshops and three Zoom Youth Advisory Committee meetings. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here is a combination of the group's fourth and seventh ranked priorities in the survey.

ESD Behavioral Health Navigators collected the data reference above through interviews with school district staff from 2019-2021. The dataset includes 219 districts, representing all 9 ESDs, and 37 of 39 counties in the state. The interview protocol included questions covering behavioral health services in schools, community referrals, behavioral health screening, Medicaid, and more.

The SBBHSP Subcommittee in 2024 is made up of 44 members, including youth and family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations. The Subcommittee developed priorities across a series of monthly meetings and four workshops on Zoom. SBBHSP staff put out a request for recommendation proposals that were in alignment with the identified priorities and members subsequently ranked the proposals submitted through that process via a survey. This proposal met several of the priorities outlined by the group this year, and therefore was included on the list of proposals in the survey. The recommendation detailed here reflects was tied for the second-highest ranked proposal in the member survey.

Well-Being Specialist designation

From the Workforce and Rates Subgroup

New (previous subgroup priority), **$780K, Budget ask and Legislative policy**

Recommendation

State adopts a plan to incentivize referral to wellness services from primary care, details forthcoming.

What is the issue?

Purpose of continuing to pursue and support the Wellbeing Specialist designation:

- It is an effort that will increase the numbers of individuals in the behavioral health workforce through focused recruitment, on the job training, and support through licensure with a primary focus on Registered Agency Affiliated Counselors (Mental Healthcare Professionals) but with pathways for Certified Peers, Community Health Workers, Behavioral Techs.
- The wellbeing specialists will be trained and supervised to provide direct therapeutic support as either a 1) step 1 services while waiting for Medicaid/Intake diagnosis or 2) an adjunct to a treatment plan. Both approaches would be delivered under the supervision of a licensed mental

health therapist. The workforce role is being developed to receive a living wage while maintaining a focus on delivering culturally grounded care in line with the definition of Wellness Services

- The CARE project is currently scoping the best center to oversee training and is prioritizing a university-based partner to hold a statewide training plan that will engage local colleges and other high education partners to provide training in collaboration with local community mental health agencies.
- The CARE project is currently developing a Wellness Blueprint to identify the billing and payment strategies that will support the delivery of wellness services in community and convenient locations (schools, primary care, faith-based, etc.) for families while strengthening community mental health agencies as workforce training and billing sites.
- Wellness services can be developed and supported across the range of clinical need and care and aligns with and can support many other workforce priorities (IECMH, integration, perinatal, youth mental health).

What do you recommend?

End goal (5-year goal): Sustainable state grant program that provides scholarships and agency subsidies for providing for On-the-Job training (OJT) programs to produce Wellbeing specialists working under multiple licensure and certificate types. Wellbeing specialists will be licensed in an existing workforce type (primary focus on Registered AAC/MHCP) PLUS an additional wellness certificate to become a Wellbeing specialist. Wellness services are part of state/local grant programs that provide community mental health agencies additional incentives for training and employing wellness specialists. Licensed mental health therapists and supervisors receive incentive pay for supervising Wellbeing specialists.

What we have funding for now/is already in the works:

- Creating the blueprint including curriculum pathway with
    - core competency track across Registered AAC, Peers, Behavioral Technicians (B Techs), Substance Use Disorder Professionals (SUDPs), and Community Health Workers (CHWs)
    - licensure track for multiple licenses
    - additional wellness certification
    - eligible/ideal OJT sites
    - for already licensed workforce, pathway for additional wellness certification
- Beginning wellness services in agencies pre-identified for also taking up the OJT recruitment track in 2025.

What we need funding for in the Biennium (low estimate) FY2024/25-25/26 ($780,000) to finish a pilot phase:

- Scholarships to support OJT pathways subsidized by the state for 50 WBS. $100,000
- Clinic incentives to participate in wellness specialist training program delivered by a university partner that help pay for step increases in pay, supervision and ongoing training costs for 10 participating agencies. $300,000 (if the agency rates vary in cost, we will look to expand the number of participating agencies)
- IContinued funding for agency culturally responsive and leadership training for 10 agencies. $130,000
- Administration, evaluation and technical assistance. $250,000

Placements/OJT for wellness specialist track starts early fall 2025.

Regulation policy ask (no money)

State adopts a plan to incentivize referral to wellness services from primary care, details forthcoming.

Why is taking the recommended action a smart move now?

- We need strategies to increase the immediate availability of mental health therapeutic services
- We need strategies that increase the cultural diversity of the public mental health workforce
- We need strategies that increase the availability of holistic, culturally grounded services in mental/behavioral health

Wellness services are supported by a large and growing literature to directly improve mental and behavioral health - these are services that can be delivered with high quality by individuals with natural therapeutic competencies. Higher education credentials are not necessary for the delivery of effective therapeutic services as an adjunct to a program of treatment in specialty behavioral health and as a standalone intervention for prevention services and mild and moderate mental health needs.

Recruitment, screening and on-the-job training will focus on recruiting individuals with natural therapeutic competencies and training will focus on the delivery of group-based programs for their therapeutic benefit and benefits to expanded system capacity.

What outreach has helped develop this recommendation?

Since CARE was first funded, the effort has engaged over 1,000 community sounding board members, statewide, over 40 project amplifier organizations, and a core wellness coalition of 20 multisector leaders of diverse backgrounds and professional experiences.

We also completed a comprehensive literature review of the non-MA workforce and the capacity to deliver therapeutic interventions, which we sent back to our community sounding board for reflection – this was recently published in a high impact peer reviewed journal: Frontiers | Translating research evidence into youth behavioral health policy and action: using a community-engaged storyboard approach (frontiersin.org)

We have ready partners for pilot implementation for both implementing wellness services (agencies) and to recruit, train and manage placements for OJT training including the UW Center for Child and Family Wellbeing (Psychology Department), Workforce Central Pierce County, UW faculty and clinical experts, SPARK peer organization, King County Behavioral Health and Recovery Division, and others. Our advisory group spans multiple sectors including payors, parents, youth, providers, health equity experts, among others.

This project is already rolling and ready to implement, and simply needs continued funding.

Is there any additional collaboration needed to further develop this recommendation?

We are still waiting to consult with HCA to confirm that wellbeing specialists could bill under our hoped-for SERI codes, and that they will adopt ownership over a sustainable state program.

Sustainable funding to enhance behavioral health capacity among providers supporting parents, infants, and families following a NICU stay and/or diagnosis of developmental delays

From the Prenatal-through-Age-5 Relational Health Subgroup

New, $500K annual, Budget ask

Recommendation

Provide sustainable funding to enhance behavioral health capacity among providers supporting the whole family unit following a Neonatal Intensive Care Unit (NICU) stay and/or diagnosis of developmental delays. This capacity building will focus on training providers to support the emotional well-being of parents and caregivers while providing developmental support for infants.

What is the issue?

Providers in Washington state lack the knowledge and training to adequately support caregivers and their babies during the perinatal period resulting in long-term adverse impacts for the infant and increased provider burnout.

We are requesting sustainable funding for training programs to ensure that community providers across the state of Washington can equitably support the behavioral health of caregivers of infants who are discharging from the Neonatal Intensive Care Unit (NICU) and/or have developmental delays. The current funding structure for this workforce development relies on one-time grants, which creates instability and hinders consistent training programs. This has an impact on both the services provided to infants and their caregivers as well as the attrition rates of home visitors and community providers.

While it is challenging to pinpoint exact figures, we know that approximately 10% of all births nationally result in NICU admissions[11] and approximately 13% of children from birth to age three have developmental delays. In Washington State there are approximately 83,000 births annually thus thousands of families are likely impacted.[12]

NICU caregivers often face a journey that significantly diverges from their expectations of life with a new baby, profoundly impacting their emotional well-being. Perinatal mental health challenges are among the most common complications of pregnancy and birth, affecting an estimated 15% - 20% of new parents.[13] Caregivers of NICU infants experience particularly high rates of mental health issues, including PTSD, which ranges from 4.5% to 30%[14] and postpartum depression, which ranges from 18% to 43% of mothers and 15% to 25% of fathers.[15] Anxiety rates among NICU mothers range from 18% to 43%, while 40% to 45% of NICU caregivers experience both depression and anxiety concurrently.[16] Even if an infant has not had a NICU stay, the emotional well-being of caregivers is often significantly impacted when they seek

[11] NICU directory. (2021, February 28). Neonatology Solutions - Committed to Advancing Our Profession. https://neonatologysolutions.com/nicu-directory/

[12] Who Receives Early Intervention Services in Washington State? | Washington State Education Research and Data Center. https://erdc.wa.gov/publications/early-childhood-education/who-receives-early-intervention-services-washington-state

[13] Johnson Rolfes J, Paulsen M. Protecting the infant-parent relationship: special emphasis on perinatal mood and anxiety disorder screening and treatment in neonatal intensive care unit parents. J Perinatal. 2022 Jun;42(6):815-818. doi: 10.1038/s41372-021-01256-7. Epub 2021 Oct 28. PMID: 34711936; PMCID: PMC8552434.

[14] McKeown, L., Burke, K., Cobham, V., Kimball, H., Foxcroft, K., & Callaway, L. (2022). The prevalence of PTSD of mothers and fathers of high-risk infants admitted to NICU: A systematic review. Clinical Child and Family Psychology Review, 26, 33-49.

[15] Segre, L. S., McCabe, J. E., Chuffo-Siewert, R., & O'Hara, M. W. (2014). Depression and anxiety symptoms in mothers of newborns hospitalized on the neonatal intensive care unit. Nursing Research, 63(5), 320–332. https://doi.org/10.1097/NNR.0000000000000039.

[16] Shuman, C., Peahl, A., Pareddy, N., Morgan, M., Chiang, J., Veliz, P., & Dalton, V. (2022). Postpartum depression and associated risk factors during the Covid-19 pandemic. BMC Research Notes, 15(1), 102. https://doi.org/10.1186/s13104-022-05991-8.

developmental support for their baby. Studies show that 67% of mothers with infants experiencing colic or prolonged crying reported symptoms of postpartum depression, highlighting the critical connection between infant challenges and parental mental health.[17] When a caregiver's emotional health is compromised, it can negatively affect their ability to establish secure attachments and respond to their infant's developmental needs, further exacerbating their mental health challenges.[18] Community providers, such as Early Support for Infants and Toddlers (ESIT) therapists and community health workers, are typically involved with these families to support the infant's developmental needs. However, the behavioral health needs of the caregivers often remain unaddressed due to a lack of training of the workforce and significant resource disparities throughout the state with resources concentrated in urban areas. Numerous barriers to care also disproportionately impact marginalized communities, resulting in significant disparities in healthcare access and quality of services based on race, socio-economic status, and disability.[19]

What do you recommend?

To effectively address this issue, there is a critical need for a structured, sustainable approach to training community providers. Currently, trainings are offered on an ad hoc basis, dependent on available funding. A consistent funding structure that supports a comprehensive training program would greatly benefit infants, caregivers, and the workforce. Home visitors and community providers would gain increased competence and confidence in addressing both caregiver behavioral health needs and infant developmental needs. With the primary beneficiaries being the caregivers and infants served by these providers, who will receive enhanced support for their emotional well-being and caregiving abilities. Improved support for caregivers will directly benefit infants by fostering better developmental outcomes and strengthening the family unit.

The Hospital-to-Home Systems Change Training Team has been actively addressing the challenge of community provider confidence and competence in supporting the perinatal mental health of caregivers. This issue was first identified as a significant concern during a Department of Health Nutrition Contract stakeholder convening in 2015, and its importance was further underscored by the Perinatal Mental Health Task Force in 2024.

Since 2021, the Systems Change team has hosted trainings and Project ECHO groups, reaching nearly 300 diverse community providers with representation from 80% of Washington state's counties. The 3-day training program begins with a foundation in perinatal mental health followed by an intensive on infant feeding and development, and a final day focused on special topics such as how to screen caregivers for perinatal mental health concerns and connecting families with resources. The follow-up ECHOs (Extension for Community Healthcare Outcomes) are grounded in the idea that adults learn best through short, focused sessions, followed by case presentations and peer-to-peer discussions. Surveyed attendees have consistently reported a significant increase in their understanding of how to support the complex needs of this population, as well as an improvement in job satisfaction. To briefly summarize key efficacy data:

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[17] Jenny S. Radesky, Barry Zuckerman, Michael Silverstein, Frederick P. Rivara, Marilyn Barr, James A. Taylor, Liliana J. Lengua, Ronald G. Barr; Inconsolable Infant Crying and Maternal Postpartum Depressive Symptoms. Pediatrics June 2013; 131 (6): e1857–e1864. 10.1542/peds.2012-3316

[18] Als, H., Duffy, F. H., McAnulty, G. B., Rivkin, M. J., Vajapeyam, S., Mulkern, R. V., Warfield, S. K., Huppi, P. S., Butler, S. C., Conneman, N., Fischer, C., & Eichenwald, E. C. (2004). Early experience alters brain function and structure. Pediatrics, 113(4), 846–857. https://doi.org/10.1542/peds.113.4.846.

[19] Beck, A. F., Edwards, E. M., Horbar, J. D., Howell, E. A., McCormick, M. C., & Pursley, D. M. (2020). The color of health: How racism, segregation, and inequality affect the health and well-being of preterm infants and their families. Pediatric Research, 87(2), 227–234. https://doi.org/10.1038/s41390-019-0513-6.

- 85% of training participants reported their personal job satisfaction was significantly enhanced by the Hospital-to-Home (H2H) training.
- 87% indicated that the quality of care that they provided to infants and caregivers would be improved because of the training.
- 92% of participants felt that attending the 3-day training significantly improved the consistency of care for infants and families within the ESIT program.

Given the high turnover among ESIT providers in Washington state, the ongoing need for training opportunities is critical to maintaining workforce competence. The Systems Change team frequently receives requests for additional trainings, though funding limitations have constrained expansion efforts.

With more funding, it would be possible to implement a comprehensive capacity building plan that would include offering live sessions tailored to local needs and asynchronous learning modules for flexible access considering the administrative burden that additional trainings impose. These trainings would continue to address geographic and ethnic disparities by targeting underserved areas, integrating cultural competency into training materials, and partnering with local organizations for effective outreach. It would also support ongoing learning initiatives, such as Project ECHO groups, one-on-one mentorship opportunities, and the creation of research hubs. The evidence suggests that expanding these trainings would have a positive impact on young children's' behavioral health across the state, particularly for those at risk due to a NICU stay or developmental delay.

Why is taking the recommended action a smart move now?

Advances in medical care have led to an increase in the survival of infants born prematurely or with other health challenges. Furthermore, improved screening practices have led to a focus on early detection and the identification of potential delays earlier than ever before. As a result, more caregivers are now navigating the uncertainty of bringing home a medically complex child from the NICU or caring for an infant with developmental delays.

In the short term, this action will ensure there are more providers able to provide equitable care to caregivers, helping them navigate the emotional challenges of caring for at-risk infants. By enhancing the capacity of community providers now, we can reduce the future costs associated with untreated caregiver stress and mental health issues, as well as the downstream impacts on child development particularly across diverse communities.

Taking action now also would strengthen and support efforts across different stakeholders represented within the Prenatal to Five Relational Health Subgroup. Some examples of intersections include:

- Expanding perinatal supports per the maternal mortality review;
- Sustaining community-based whole-family supports as part of the Washington Plan of Safe Care;
- Emphasizing and supporting non-birthing caregivers' inclusion and unique needs; per the Fatherhood Council;
- Strengthening connections through community-based navigators and coordinators;
- Increasing number of healthcare providers integrating emotional well-being into routine care and understanding referral options per Early Childhood Comprehensive Systems (ECCS) Integration P-3; and
- Expanding, diversifying, and training within the IECMH workforce with the People Powered workforce project

What outreach has helped develop this recommendation?

To develop the recommendation for sustainable funding for trainings, the Hospital-to-Home Systems Change Training team undertook extensive outreach efforts. The team engaged with a diverse group of stakeholders, including infant and early childhood behavioral health providers, medical providers, community organizations, and caregivers who have experienced the NICU journey or had an infant with a developmental delay. Their insights and experiences were crucial in shaping the recommendation, emphasizing the urgent need for specialized training to support the emotional well-being of caregivers.

Additionally, the Systems Change Training team conducted thorough research on evidence-based best practices, reviewing existing studies and identifying gaps in current support systems. Consultations with experts in perinatal mental health, early childhood development, and NICU care ensured that the training recommendations are grounded in evidence and aligned with best practices.

Outreach has included caregivers with lived experience, hospital-based providers, ESIT providers, other community practice settings, a range of disciplines (e.g., FRCs, SWs, MDs, RNs, RDs, SLPs/PTs/OTs, DHH/TCVI), variety of roles (e.g., direct service providers, administrators, managers), and extensive range of organizations (e.g., Help Me Grow/WithinReach, subgroup of WCAAP, CYSHCN, UW Infant Development Follow-up Clinic, Cherish, IMPACT, Barnard Center, Fussy Baby Network and more). This cross-sector outreach has clearly shown the need to build the capacity of community providers to support the emotional well-being of caregivers and improve infant outcomes.

Infant & Early Childhood Mental Health alternative payment model pilot

From the Prental-through-Age-5 Relational Health Subgroup

New, $1.25M GFS, Budget ask and Legislative policy

Recommendation

IECMH Alternative-payment model pilot. Create an Apple Health (Medicaid) methodology for reimbursement, moving from fee-for-service reimbursement methodology, which is setting-agnostic, supportive of the workforce without adding administrative burden, and provides a pathway for expanding service provision. Estimated costs to implement a pilot within the biennium, not inclusive of implementation costs post-pilot: $1.25m GF-S; $1.25m Federal.

What is the issue?

Washington State residents with Apple Health (Medicaid) are entitled to behavioral health assessment and treatment for qualifying issues, regardless of age. For our youngest Washingtonians, access to assessment and treatment is limited due to inadequate program availability. With the numerous challenges across the public behavioral health system, due to workforce shortage and low reimbursement rates, agencies around the state have no incentive or clear pathway for expanding services to include developmentally appropriate behavioral health treatment for the birth-through-five population. Existing programs are unable to sustain Infant and Early Mental Health (IECMH) treatment programs under current Apple Health reimbursement models due to the significant additional time, support, and training needed to provide this specialty behavioral health model. The isolation and stress of the pandemic, combined with the increased intensity and risk associated with the fentanyl crisis and parental stress being so high it's been identified as a nation-wide public health crisis, mental health professionals working with families with very young children are facing increasingly challenging treatment issues.

Programs that provide this specialty treatment are limited to billing for services as though they are identical to standard behavioral health services for older populations. That is to say, reimbursement is based on a billable unit of direct time providing psychotherapy services to the child and their caregiver. The current reimbursement account for best practices for treatment, such as the therapist traveling to the

client's home and sessions occurring almost exclusively with the parent child dyad together, rather than an individual client. The time, planning, and intensity of the model is a burden for the providers as well as the agency. In addition, specialty training and support is necessary for IECMH therapists, including reflective supervision and consultation as an essential component for sustaining the quality of treatment.

We know the importance of this work- it is a two-generation intervention that strengthens parent-child relationships and reduces negative outcomes for children in the present as well as ongoing throughout the lifespan. We must invest upstream to improve health outcomes in our communities and to do that, we must invest in the systems and direct service providers to be able to sustain this work while conducting services in a best-practice model

Challenges in billing for their services (Oxford & Lecheile, 2022). With these barriers to access, it may be no surprise that both national and Washington-specific data suggest that young children are less likely than older children and youth to receive needed mental health care (Ghandour et al., 2019; Health Care Authority, 2022). Although best practice is to work with the parent/caregiver and the infant/young children in treatment together, only about 46% of licensed behavioral health agencies reported providing any amount of this type of dyadic treatment services in the 2022 Behavioral Health Provider Survey. Research shows that BH provider participation in value-based payment models support a greater return on investment in increased service quality and lower healthcare cost over time.

What do you recommend?

Create a model of payment, moving from fee-for-service, which is setting-agnostic, supportive of the workforce without adding administrative burden, and provides a pathway for expanding service provision. Estimated costs to implement a pilot for FY26, not inclusive of implementation costs post-pilot: $1.25m GF-S; $1.25m Federal. Create a case-rate model that combines oversight of services provided and outcomes achieved as well as the support and training of the specialty providers who conduct the work. The model should account for the cost of preparation, travel, and providing direct service in the community. The model should take into account the complexity of dyadic parent-child work and the impact on direct service providers by requiring both ongoing specialty training and reflective supervision and consultation. There should be quality improvement strategies built into the model to ensure that people providing this model of services have completed appropriate training and that services are being provided primarily to parent-child dyads (vs individual children) and are offered in the client's home. Value-Based metrics should be based on improvements in the parent-child relationship and decrease in any reported symptom presentation in the child. Additionally, metrics should include collateral work, including communication with the child's primary care provider, child care provider, and any early intervention or other system partners.

Why is taking the recommended action a smart move now?

Builds off of the implementation of SHB 1325 (2021) (Mental Health Assessment for Young Children (MHAYC)), which aligned Apple Health policy and reimbursement with best practices in Infant-Early Childhood Mental Health. Washington's behavioral health system advanced dramatically by designing the developmentally appropriate mental health assessment, however services are not equitably accessible across the state. Continuing to build on the improvements from MHAYC are critical. Transitioning to a case-rate model for the ongoing mental health treatment of young children is a smart move now because while we now have a pathway to assess, diagnose, and understand the behavioral health concerns in young children, the treatment of those concerns has not yet been supported. Between the workforce shortage, the reimbursement inadequacy for providing best-practice services, and the importance of ensuring that treatment providers are following best-practice models, our youngest residents do not have

equitable access to the behavioral healthcare they are entitled to. Washington State has worked hard to support early childhood education and early intervention. These systems are critical for preventing lifespan challenges and address developmental concerns; however they are not sufficient in addressing behavioral health interventions. Far fewer families will need behavioral health interventions, so it is critical to have robust early childhood education and prevention/intervention programs that support early childhood development. When trauma, attachment disruption, or other severe stressors do occur, it is important to have mental health treatment that is developmentally informed, and our public behavioral health system is where that system of care lives. Without a sustainable system, our highest needs families will not get the services they are entitled to.

What outreach has helped develop this recommendation?

The Prenatal Through Five Relational Health Subgroup engaged stakeholders in a recommendation development process that was followed by a vote during which subgroup participants identified their five highest priorities. The recommendation for creating an Alternative Payment Model for Medicaid funded IECMH treatment was one of the top three priorities identified through this process.

- The **2022 Behavioral Health Provider Survey** indicates that less than half of current behavioral health agencies provide mental health treatment to children ages birth through five.
- Health Care Authority (HCA) conducted a statewide tour in 2023 with around 100 mental health providers to learn about the state of IECMH treatment. The resulting report shows that many providers do not have access to population specific training in graduate programs and instead have to seek out post-graduate training opportunities. Opportunities for training are often cost and time prohibitive. Combined with the need for reflective supervision and support in developing clinical skillsets, IECMH programs struggle to provide adequate training, support, and training under the current reimbursement model.
- The 2023 statewide tour also found that there is a gap in availability of culturally and linguistically appropriate services. Adequate training, support, and reimbursement are critical in maintaining IECMH Programs with staffing that reflects the cultural and linguistic diversity of Washington residents with young children. The 2023 Statewide tour also found that low wages were widely reported as a barrier to a sustainable staffing of programs. Especially with the specialty skillset required, providers reported that without rate increases it would be unlikely that wages could be adjusted.
- Washington State has dedicated immense time and funding to ensure that children ages birth through five receive developmentally appropriate mental health assessments however the ongoing treatment of issues discovered in those assessments are not currently accessible or sustainable for providers. It is critical that Washington State continues to move forward in ensuring quality, equitable treatment for its youngest residents.
- The 2023 Reporting Guide for Research and Evidence Based Practices in Children's Mental Health, which is formally recognized by the Healthcare Authority and required by Managed Care Organizations in providing evidence-based treatments, includes Child Parent Psychotherapy, which is the best practice treatment model for early childhood trauma. The treatment model is specifically dyadically focused. It is a model for licensed therapists and requires 18 months of training. Instability in staffing limits agency's in maintaining trained therapists to provide evidence-based treatment to young children who have experienced traumatic stress.
- Wraparound with Intensive Services (WISe) is an example of an effective case-rate model in Washington. A 2023 consumer survey published by the HCA and Washington State University

found that 70%-80% of youth who had engaged in WISe reported doing better at school and/or at home. 76% of parents/caregivers reported improvements at school and/or home.

- In August 2024 the US Surgeon General published an advisory, calling on systems that work with parents and families to strengthen policy, funding, and access to services that support reducing the record-high stress level reported by parents.

Is there any additional collaboration needed to further develop this recommendation?

HCA indicates they are conducting a literature review to support a concept like this in the future. Ongoing consultation needed.