

UPDATED to include Statements of Support (p. 5) – 12/20/2021

October 29, 2021

Members of the Legislature,

The Children and Youth Behavioral Health Work Group (CYBHWG) is pleased to share its final recommendations for the 2022 legislative session.

In March 2021, Governor Jay Inslee declared a youth mental health emergency. While most students are back in classrooms, the number of children, youth, and families (prenatal through age 25) experiencing significant mental health and substance use struggles remains at crisis levels, with limited resources to serve them.¹

This year's recommendations focus on:

- Providing immediate relief for children, youth and families in crisis;
- Retaining and building our behavioral health workforce which is also in crisis, with clinician shortages limiting access even more²; and
- Developing longer term strategies for fundamental fixes to effectively meet the behavioral health needs of young people ages 0-25 and their families, including prenatal services for those expecting, and covering prevention through recovery support services.

The common thread in this year's subgroup discussions was the need for more behavioral health services across the continuum of care. Parents and young people shared their difficulties in getting timely access to services, even in crisis situations. Providers shared their frustration with the reality that they simply cannot serve all the individuals and families that need their services. Every group wrestled with how to address immediate, crisis-level needs and how to move toward longer-term solutions to ensure that every child, youth, young adult, and expecting parent has their behavioral health needs met.

The work group continues to focus on strategies that leverage federal funding sources. Subgroups and participants have a shared understanding that by bolstering and building new services at the less acute end of the continuum of care, we can – in the long-term – reduce the more significant costs of treating young people who need intensive services.

We appreciate the significant investments the Legislature and Governor have made in improving behavioral health services for all of Washington's people and particularly the prenatal through 25 population. We hope that the 68th Legislature and Governor will build on these efforts to address this continuing crisis.



Representative Lisa Callan
CYBHWG Co-Chair
Washington State Representative
5th Legislative District



Dr. Keri Waterland
CYBHWG Co-Chair
Director, Division of Behavioral Health & Recovery
Health Care Authority

¹ Since the start of the pandemic, calls from families requesting referrals to the Mental Health Referral Service for Children and Teens have more than doubled, with 3 out of 4 requests coming from families with commercial insurance. It currently takes an experienced referral specialist 14-20 days to find a provider. (*Dr. Robert Hilt, Washington Mental Health Referral Service for Children and Teens*)

Today more than half of pediatric primary care visits are for behavioral health concerns; up from 25% before the pandemic. (*Washington Chapter of the American Academy of Pediatrics*)

Almost half of Seattle Children's emergency department beds are filled with patients with behavioral health issues, many of whom could not be discharged safely due to inadequate community supports or are "boarding" while they wait for inpatient beds. (*Kashi Arora, 10/19/21 testimony at House Children, Youth and Families Committee*)

Washington was among the 15 states with the highest teen suicide rates, a rate that has been steadily climbing since 2012. ([Explore Teen Suicide in Washington | 2021 Health of Women And Children Report | AHR \(americashealthrankings.org\)](#))

² Vacancy rates for master-level clinicians in community behavioral health average 30%. Over half of surveyed provider agencies have closed or limited access to outpatient services, treatment beds have been taken offline, and branch office sites have closed (*Washington Council, August 2021 provider survey*) Community mental health agencies in some counties are closed to new clients or are asking families to call back in a month. (*Dr. Robert Hilt, Washington Mental Health Referral Service for Children and Teens*)

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Children and Youth Behavioral Health WorkGroup

Recommendations for the 2022 legislative session




Summary




The recommendations in this report were voted on by the work group as the top priorities brought forward from over 200 stakeholders who participated in one or more of the five subgroups. These priorities span the foundational needs impacting every aspect of behavioral health to targeted recommendations addressing specific needs identified as a pivotal issue related to one of the subgroups. The current subgroups include:

- Workforce and Rates
- Behavioral Health Integration
- Prenatal through Five Relational Health
- Youth and Young Adult Continuum of Care
- School-based Behavioral Health and Suicide Prevention

Overarching recommendations

These recommendations were unanimously approved by the workgroup as overarching. The work group recognizes that these top actions are foundational for preserving the behavioral health safety net and provide the groundwork so other recommendations for this year and future years lead to real improvements for children, youth, and families.

	<p>Medicaid rate increase To stabilize the community behavioral health safety net and improve access to care, implement a 7% Medicaid rate increase directed to community behavioral health agencies retroactive to January 1, 2022.</p>
	<p>Prenatal to Age 25 Behavioral Health Strategic Plan Develop a strategic plan to ensure that all Washington’s children, youth, and young adults (prenatal through 25 years), and their families, have timely access to high-quality, equitable, well-resourced behavioral health education, care and supports across the continuum when and where they need it, including prenatal care.</p>
	<p>Compensation for people with lived experience Change RCW 43.330.220 to allow people with lived experience with system services who participate in work groups to be compensated; provide funding to compensate youth and family members who participate in the CYBHWG and its subgroups. <i>Also: Department of Commerce/Office of Homeless Youth agency request legislation</i></p>

Budget proposals:  < \$500,000  = \$500,000 - \$999,000  = \$1 million - \$10 million  > \$10 million



Policy changes; requires legislation



Collaborative effort; multiple agencies or organizations

Subgroup recommendations

Each subgroup submitted 1-3 recommendation to the work group addressing critical needs in their area. The work group voted unanimously to adopt all nine recommendations noting the significant work of the subgroups to present only their highest priorities to the full work group, and all are needed to meet the current and growing demand for services.

While the workgroup recognized all the recommendations unanimously as the top actions the state needs to take, Appendix A records the voting count of the nine subgroup recommendations for reference

Workforce and Rates	
\$	Provide funding to explore implementation of Certified Community Behavioral Health Clinics (CCBHC) Develop a sustainable, alternative payment model for comprehensive community behavioral health services by studying the Certified Community Behavioral Health Clinic (CCBHC) model, conducting related actuarial analysis, and proposing a pathway for statewide implementation. <i>Also: Health Care Authority budget request (decision package)</i>
\$ 	Create a clinical supervision work group to reduce barriers to certification This workgroup shall be made up of individuals with clinical supervision experience to make recommendations for all three masters level licenses on the number of supervision hours, and any specific specialty supervision hours needed. Some funding will be needed to support the workgroup.
Behavioral Health Integration	
\$\$\$	Provide funding for startup activities for behavioral health integration in primary care clinics Provide start-up funds to clinics which demonstrate objective and specific readiness to build collaborative care behavioral health integration programs in primary care settings to expand access to early identification and treatment of mental health issues in children and youth.
\$ TBD 	Reimbursement for non-licensed staff in primary care settings to support and coordinate care Allow reimbursement for non-licensed staff like Community Health Workers, navigators, and care coordinators to support kids' behavioral health in primary care settings.
Prenatal through Five Relational Health	
\$-\$\$	Expand the Parent Support Warm Line to better support expectant and new parents Invest in Perinatal Support Washington's Parent Support Warm Line (the Warm Line) so un- and underserved expectant and new parents have greater and more equitable access to mental health services through peer-to-peer engagement and increased public awareness.
School-based Behavioral Health and Suicide Prevention	
\$\$	Provide grants to put more behavioral health clinicians in schools to meet urgent needs of students Provide base-level funding grants for 100 school-based licensed behavioral health clinicians in 2022 at \$65,000/FTE. To be eligible, school districts would need to designate matching funds from another source to fund full-time positions, including other district funds, grants, Medicaid billing, etc.
Youth and Young Adult Continuum of Care	
\$-\$\$\$ 	Ensure stable housing and care coordination for youth exiting inpatient settings Potential solutions include (1) implementing peer bridgers for transition age youth (TAY), (2) expanding behavioral health housing vouchers and earmark for TAY, (3) grant funding to develop TAY-specific SUD and mental health recovery housing, (4) flexible funds to prevent TAY homelessness upon discharge, (5) amending managed care contracts to require housing-related care coordination along with funding a position at HCA to provide oversight, (6) creating performance measures related to TAY housing stability, and (7) expanding behavioral health supports in youth shelters.
\$	Provide a parent portal and tool kit to make it easier for families in crisis to get information Convene stakeholders including parents/caregivers and youth and young adults to develop a work plan to design the Parent Portal, look for funding partners, and send out an RFP for ongoing care and management of the portal.
\$	Invest in a communications/outreach position at HCA to share information with providers and families Fund a full-time staff person at HCA to connect families, providers, educators, and others with current information about behavioral health care legislation.

Detailed information about each of these recommendations is available in *Appendix C: Detailed recommendation proposals.*

Statements of support

At the CYBHWG meeting on December 10, 2021, members approved the following statements of support.

Submitted by subgroups

Workforce & Rates	
\$\$\$	<p>Strengthen and fund loan repayment programs, including the established Washington Health Corps model, that incentivize direct (clinical) behavioral health service provision.</p> <p>Increase funds allocated to expand the number of behavioral health workers in Washington who receive loan support through the Behavioral Health Program. Additional funding sources should be explored, including private philanthropy and the private sector, and a dedicated funding source should be established.</p> <p><i>Recommendation of the Workforce Board</i></p>
\$\$\$	<p>Increase rates by 7% for services that are not funded by Medicaid, primarily those related to crisis response and crisis-related services.</p> <p>\$3,327,310 for FY 2022 and \$6.655,000 for FY 2023. Non-Medicaid funding for these services has tended to remain stagnant, thus increasing the imbalance over time and diluting the value of Medicaid rate increases.</p> <p><i>Recommendation of the Washington Council for Behavioral Health</i></p>
\$\$\$	<p>Provide bridge funding for the current Certified Community Behavioral Health Clinics (CCBHCs) in our state to accompany the CCBHC study for a statewide initiative.</p> <p>There are 12 CCBHCs in Washington, funded through SAMHSA expansion grants; these programs currently receive \$2 million/year. Estimates for providing bridge funding for these programs over the next two years while Washington state pursues a statewide planning process for CCBHCs are 6 to 12 million dollars.</p> <p><i>Recommendation of the Washington Council for Behavioral Health</i></p>
School-based Behavioral Health & Suicide Prevention	
\$\$\$	<p>Support the expansion of the School-Based Health Center (SBHC) program to increase access to behavioral health care in academic settings</p> <p>The SBHC program was established in 2021 through passage of HB 1225.</p> <p><i>Included in Department of Health decision package in support of Young Adult Behavioral Health.</i></p>
\$\$\$\$	<p>Support the increase to staffing ratios for school nurses detailed in Initiative 1351 and endorsed by Washington state voters in 2014.</p> <p><i>This strategy is included in the Office of Superintendent of Public Instruction (OSPI) 2022 decision package in support of resourcing schools so that every student has access to a school nurse.</i></p>

Proposed by members at the December 10 work group meeting

\$ TBD	<p>Convert youth partial hospitalization/intensive outpatient pilots into a covered service by requiring their including in the state Medicaid plan</p> <p><i>Potential legislation</i></p>
\$ TBD	<p>Grants for pandemic-specific retention incentive bonuses for behavioral health workers</p> <p><i>Recommendation of the Washington Council for Behavioral Health</i></p>
\$ TBD	<p>Certification of peer counselors to expand their use to more settings</p> <p><i>Potential legislation</i></p>
\$\$	<p>Stabilize three infant and early childhood mental health consultation FTEs</p> <p>The grant funding for these three FTE consultants expires in December 2022.</p> <p><i>Recommendation from the October 2021 Project Education Impact report</i></p>

Appendix A: Results – Prioritization vote by work group members (22 voting members)



Appendix B: About the Children and Youth Behavioral Health Work Group

Since 2016, this work group has brought together legislators, providers, agencies, managed care organizations, tribes, advocates, and family members and youth who have received mental health and substance use services to identify and address barriers to access to these services for children, youth, and families, and make recommendations to the Legislature. Recommendations for the 2022 legislative session were developed by five subgroups, described below.

Workforce and Rates

Co-leads: *Representative Mari Leavitt (28th district), Hugh Ewart (Seattle Children's Hospital), and Laurie Lippold (Partners for Our Children)*

The Workforce and Rates subgroup is open to anyone who wants to participate. With a mailing list of over 100 people and 30 or more people attending each meeting, the work group benefited from the participation of many individuals with considerable expertise who drew on their professional and personal experience. Throughout the process, the group coordinated with others, including the Workforce Training and Education Board, the Behavioral Health Institute, University of Washington, and the philanthropic community. Their recommendations, leading with the critical need for rate increases, reflect their findings that: (1) there is a significant shortage of behavioral health providers for children and youth, at a time when behavioral health needs are expected to grow; and (2) the greatest shortages are among providers who are reflective of the communities and people they serve. The Workforce and Rates subgroup is in the process of developing and disseminating a survey related to access that is expected to go out in mid-November.

Prenatal through Five Relational Health

Co-leads: *Representative Debra Entenman (47th district) and Bridget Lecheile (Washington Association for Infant Mental Health), with support from Kristin Wiggins (Kristin Wiggins Consulting LLC)*

In 2021, the Prenatal through Five Relational Health Subgroup did robust and intentional outreach to engage stakeholders of different racial, ethnic, and cultural backgrounds, incomes, and family structures as well as professionals who work directly with children and families to have a community-informed policy development approach. Numerous parents of children with behavioral health needs participated in subgroup meetings and one-on-one conversations to share about the barriers that prevent families from accessing support and potential solutions. Stipends were available to some parents to participate in subgroup meetings to compensate them for their time and respect and appreciate their expertise. Additionally, the group reached out to dozens of parents, practitioners, and community leaders to listen and learn. There was a particular focus on outreach to parents who have experienced perinatal mood and anxiety disorders themselves as well as parent leaders who are knowledgeable about the experiences of others in their communities. In addition to parents, the group of nearly 100 diverse stakeholders included behavioral and mental health professionals and clinicians, policymakers, advocates, physicians, and those familiar with Medicaid and private insurance.

Top criteria for adopting any recommendations in 2021 and putting them before the Children and Youth Behavioral Work Group for consideration were (1) being community-informed by prioritizing approaches and ideas shared by impacted communities; (2) centering and advancing equity, meaning recommendation concepts held the promise of measurably closing gaps; (3) being achievable; (4) having capacity to implement well and quickly; (5) strengthening and transforming foundational systems; and (6) it fit the scope of the subgroup and work group at large and did not duplicate the work of others.

School-based Behavioral Health and Suicide Prevention

Co-leads: *Representative My-Linh Thai (41st district) and Lee Collyer (Office of Superintendent of Public Instruction)*

The 25 appointed members on this subgroup represent 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, philanthropy, and advocacy groups. Non-members are encouraged to join the mailing list and attend the group's meetings and share their perspectives during the public comment period. From December 2020 through October 2021, six public meetings included comment from family members, as well as presentations from stakeholders.

Building upon the work done in 2020, the subcommittee examined funding systems and streams which support, or often fail to support, school-based behavioral health services. The subcommittee heard a presentation on the 2021 performance audit and subsequently invited a presentation from South Carolina's Department of Community Mental Health, which has successfully placed behavioral health clinicians in 63% of the state's public schools. The subcommittee continues to recommend support for the implementation of a Multi-Tiered System of Supports in Washington schools, which will help to

provide prevention universal supports for students' social, emotional, and behavioral needs, and will help to ensure that any behavioral health services delivered through school settings are integrated through the Interconnected Systems Framework. The subcommittee also proposed a grant program loosely based upon the South Carolina model to help fund 100 behavioral health clinicians in schools as an interim step until a more comprehensive gap analysis and strategic planning process can be completed to identify more sustainable approaches to funding school-based behavioral health services in schools.

Youth and Young Adult Continuum of Care (YYACC)

Quad leads: *Representative Lauren Davis (32nd district), Representative Carolyn Eslick (39th district), Michelle Karnath (parent), and Lillian Williamson (young adult)*

The YYACC addresses the unique behavioral health needs of youth and young adults, ages 13-25, across the continuum of care, including prevention, early intervention, outpatient services, intensive services and inpatient treatment, and recovery supports. As part of this work, the group studies problems and proposed solutions raised by the regional network of Family, Youth and System Partner Round Tables (FYSPRTs) which identify access problems in local communities. The subgroup includes mental health providers, advocates, health plans, agency representatives, youth who have received mental health and substance use services, and their parents or other family members.

This year, the group's recommendations focus on two immediate and critical problems – parents whose children and youth are experiencing behavioral health crises who are having trouble finding help, and the many young people who leave inpatient treatment and end up homeless within days, weeks, or months.

Behavioral Health Integration

Co-leads: *Kristin Houser (Parent Advocate) and Sarah Rafton (Washington Chapter of the American Academy of Pediatrics)*

The Behavioral Health Integration subgroup was newly formed this year to respond to the large unmet need for behavioral health services early on when children and teens first present with needs. Primary care clinics can identify behavioral health issues early in a child's life and provide effective treatment before problems become more severe.

There is a growing consensus that behavioral health integration, which embeds behavioral health counselors in primary care clinics and provides a team-based approach to care actively involving the primary care provider, is an effective means of leveraging scarce behavioral health resources to provide such early identification and treatment. A variety of integrated pediatric services exist in Washington State, but they cover only a small portion of youth, whose needs are reaching crisis levels, in part due to the stresses of COVID-19.

This subgroup's purpose is to determine what the gaps and barriers are to implementing behavioral health integration in primary care, determine what the successful models are, and make recommendations for expansion of such services to children and youth throughout the State. The subgroup includes statewide representation from behavioral health centers, primary care clinics, Seattle Children's, UW Medicine, Medicaid MCOs and commercial carriers, and state agencies. It is open to anyone who wants to participate.

Representatives from the following organizations contributed to the 2022 recommendations

Advocates and Community Organizations

A Way Home Washington
Association of Washington School Principals
Behavioral Health Institute
Building Changes
Childhaven
CHOICE Regional Health Network
Communities in Schools of Washington
Forefront in the Schools
National Council for Mental Well-being
NorthStar Advocates
Northwest Healthcare Response Network
Partners for Our Children
Washington Association for Community Health
Washington Association for Infant Mental Health
Washington Association of School Social Workers
Washington Chapter of the American Academy of Pediatrics
Washington Council for Behavioral Health
Washington Education Association
Washington Mental Health Counselors Association
Washington National Alliance on Mental Illness
Washington PAVE
Washington School-Based Health Alliance
Washington State Council of Child and Adolescent Psychiatry
Washington State Hospital Association
Washington State Medical Association
Washington State Parent Teachers Association
Washington State Psychological Association
Washington STEM

Education

Chief Leschi School District
Educational Service District 101
Educational Service District 105
Educational Service District 113
Educational Service District 114
Medical Lake School District
Monroe School District
Mount Vernon School District
Puget Sound Educational Service District
Snoqualmie Valley School District
Spokane Public Schools
Sumner-Bonney Lake School District
UW Dept. of Psychiatry
UW Evidence-based Practice Institute
UW SMART Center
Washington Association of Educational Service Districts

Managed Care Organizations

Amerigroup Washington

Community Health Plan of Washington
Coordinated Care
Kaiser Permanente
Molina Healthcare
Premera Blue Cross

Philanthropic organizations

Ballmer Group
Perigee

Providers

Advanced integrative Medical Science Institute
Amazon Care
Catholic Charities of Central Washington
Catholic Community Services of Western Washington
Children’s Village
Community Youth Services
Compass Health
Comprehensive Healthcare
Excelsior Wellness Center
Hope Sparks
Kitsap Children’s Clinic
Mary Bridge Children’s Hospital
Mercer Island Youth and Family Services
Northwest Neighborhood Clinics
Northwest Pediatric Center
Peace Health
Pediatrics Associates of Whidbey Island
Seattle Children’s Hospital
Seattle Counseling Service
SMP Services from Washington
UW Neighborhood Clinic
Yakima Valley Farmworkers Clinic

State and County Agencies

Clark County Juvenile Justice
Department of Children, Youth and Families
Department of Health
Department of Social and Health Services
Family, Youth and System Partner Roundtable
Governor’s Office
Health Care Authority
King County Behavioral Health and Recovery
Legislators and Legislative Staff
Office of Homeless Youth
Office of the Insurance Commissioner
Office of the State Auditor
Office of Superintendent of Public Instruction
Ombuds Services
Tacoma-Pierce County Health Department
Workforce Training and Education Coordinating Board

And youth and young adults who have received behavioral health services, and their parents

Children and Youth Behavioral Health Work Group Members

Co-Chairs: Representative Lisa Callan, 5th legislative district
Dr. Keri Waterland, Health Care Authority

Hannah Adira, *Youth/Young adult (alternate)*

Javiera Barria-Opitz, *Youth/Young adult*

Dr. Avanti Bergquist, *Child and Adolescent Psychiatry*

Jane Beyer, *Office of Insurance Commissioner*

Tony Bowie, *Child Study and Treatment Center, DSHS*

Representative Michelle Caldier, 26th legislative district
Diana Cockrell, *Health Care Authority*

Lee Collyer, *Office of the Superintendent of Public Instruction*

Representative Carolyn Eslick, 39th legislative district
(alternate) Dr. Thatcher Felt, *Yakima Valley Farm Workers Clinic*

Tory Gildred, *Coordinated Care (resigned Oct. 2021)*

Dorothy Gorder, *Parent*

Summer Hammons, *Tulalip Tribes*

Dr. Bob Hilt, *Seattle Children's*

Kristin Houser, *Parent*

Avreayl Jacobson, *King County Behavioral Health and Recovery*

Nichole Jensen, *Developmental Disabilities Administration, DSHS (non-voting)*

Andrew Joseph, Jr., *Confederated Tribes of the Colville Reservation*

Kim Justice, *Office of Homeless Youth, Department of Commerce*

Michelle Karnath, *Statewide FYSPRT parent tri-lead*

Judy King, *Department of Children, Youth and Families*

Amber Leaders, *Office of the Governor*

Bridget Lecheile, *Washington Association for Infant Mental Health*

Laurie Lippold, *Partners for Our Children*

Cindy Myers, *Children's Village*

Michelle Roberts, *Department of Health*

Joel Ryan, *Washington State Association of Head Start and ECEAP*

Noah Seidel, *Developmental Disabilities Ombuds*

Mary Stone-Smith, *Catholic Charities of Western Washington*

Representative My-Linh Thai, 41st legislative district
(alternate) Jim Theofelis, *Northstar Advocates*

Dr. Eric Trupin, *UW Evidence-based Practice Institute*

Senator Judy Warnick, 13th legislative district
Senator Claire Wilson, 30th legislative district

Lillian Williamson, *Youth/Young adult*

Dr. Larry Wissow, *University of Washington/Seattle Children's*

Jackie Yee, *Educational Service District 11*

Appendix C: Detailed recommendation proposals

Recommendations for 2022 legislative session

Children and Youth Behavioral Health Work Group

Companion document – Detailed recommendation proposals

October 29, 2021

Originally created for 10/15/21 CYBHWG meeting

Updated - technical fixes: 11/3/2021

CYBHWG: 2022 recommendation proposals

Budget proposals: **\$** < \$500,000 **\$\$** = \$500,000 - \$999,000 **\$\$\$** = \$1 million - \$10 million **\$\$\$\$** > \$10 million






Policy proposal/Legislation



Collaborative effort; multiple agencies or organizations

Overarching recommendations

\$\$\$\$	<p>Medicaid rate increase – <i>See page 4.</i></p> <p>To stabilize the community behavioral health safety net and improve access to care, implement a 7% Medicaid rate increase directed to community behavioral health agencies retroactive to January 1, 2022.</p> <p><i>Originated in: Workforce & Rates subgroup</i></p>
\$  	<p>Compensation for people with lived experience – <i>See page 8.</i></p> <p>Change RCW 43.330.220 to allow people with lived experience with system services who participate in work groups to be compensated; provide funding to compensate youth and family members who participate in the CYBHWG and its subgroups.</p> <p><i>Also: Department of Commerce/Office of Homeless Youth agency request legislation</i></p>
\$ 	<p>Prenatal to Age 25 Behavioral Health Strategic Plan – <i>See page 10.</i></p> <p>Develop a strategic plan to ensure that all Washington children and young people ages 0-25 years and families have timely access to high-quality, equitable, well-resourced behavioral health education, care and supports across the continuum when and where they need it, including prenatal care.</p> <p><i>Originated in: School-based Behavioral Health & Suicide Prevention subgroup and expanded to include all subgroups</i></p>

Prenatal Through Five Relational Health

\$-\$\$	<p>Expand the Parent Support Warm Line – <i>See page 15.</i></p> <p>Invest in Perinatal Support Washington’s Parent Support Warm Line (the Warm Line) so un- and underserved expectant and new parents have greater and more equitable access to mental health services through peer-to-peer engagement and increased public awareness.</p>
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School-based Behavioral Health & Suicide Prevention – *See page 26 for overview.*

\$\$	<p>1. Behavioral health grants (for clinicians in schools) in response to urgent needs of students – <i>See page 28.</i></p> <p>Provide base-level funding grants for 100 school-based licensed behavioral health clinicians in 2022 at \$65,000/FTE. To be eligible, school districts would need to designate matching funds from another source to fund full-time positions, including other district funds, grants, Medicaid billing, etc.</p>
\$	<p>Gap analysis of behavioral health services and needs – <i>See page 30.</i></p> <p><i>Incorporated into Prenatal to Age 25 behavioral health strategic plan.</i></p> <p><i>Not included in prioritization.</i></p>
\$\$\$	<p>Recommendation for 2023: Build the capacity for school districts to implement MTSS – <i>See page 32.</i></p> <p>Build the capacity for school districts to implement a Multi-Tiered System of Supports (MTSS), including effective collaboration with behavioral health systems through an Integrated Systems Framework (ISF) by continuing existing Regional Implementation Coordinator (RIC) positions and increasing the number of RIC positions over a period of years.</p> <p><i>Not included in prioritization.</i></p>

Youth & Young Adult Continuum of Care (YYACC)	
\$	<p>Children, youth and families communications and outreach position at HCA – <i>See page 34.</i></p> <p>Fund a full-time staff person at HCA to connect families, providers, educators, and others with current information about behavioral health care legislation.</p>
\$	<p>Parent portal and tool kit – <i>See page 37.</i></p> <p>Convene stakeholders including parents/caregivers and youth and young adults to develop a work plan to design the Parent Portal, look for funding partners, and send out an RFP for ongoing care and management of the portal.</p>
\$-\$\$\$ 	<p>Ensure stable housing and care coordination for youth exiting inpatient settings – <i>See page 40.</i></p> <p>Use a combination of strategies to meet this goal. Potential solutions include (1) implementing peer bridgers for transition age youth (TAY), (2) expand behavioral health housing vouchers and earmark for TAY, (3) grant funding to develop TAY-specific SUD and mental health recovery housing, (4) flexible funds to prevent TAY homelessness upon discharge, (5) amending managed care contracts to require housing-related care coordination along with funding a position at HCA to provide oversight, (6) create performance measures related to TAY housing stability, and (7) expanding behavioral health supports in youth shelters.</p>
Behavioral Health Integration – <i>See page 43 for overview.</i>	
\$\$\$	<p>1. Provide funding for startup activities for behavioral health integration in primary care clinics – <i>See page 47.</i></p> <p>Provide start-up funds to clinics which demonstrate objective and specific readiness to build collaborative care behavioral health integration programs in primary care settings.</p> <p><i>Also supported by Workforce & Rates subgroup.</i></p>
\$ TBD 	<p>2. Reimbursement for non-licensed staff in primary care settings – <i>See page 50.</i></p> <p>Allow reimbursement for non-licensed staff like Community Health Workers, navigators and care coordinators to support kids’ behavioral health in primary care settings.</p> <p><i>Also supported by Workforce & Rates subgroup.</i></p>
Workforce & Rates	
\$	<p>1. Provide funding to explore implementation of Certified Community Behavioral Health Clinics (CCBHC) – <i>See page 53.</i></p> <p>Develop a sustainable, alternative payment model for comprehensive community behavioral health services by studying the Certified Community Behavioral Health Clinic (CCBHC) model, conducting related actuarial analysis, and proposing a pathway for statewide implementation.</p> <p><i>Also: Health Care Authority budget request (decision package)</i></p>
\$ 	<p>2. Create a clinical supervision work group – <i>See page 57.</i></p> <p>This workgroup shall be made up of individuals with clinical supervision experience to make recommendations for all three masters level licenses on the number of supervision hours, and any specific specialty supervision hours needed. Some funding will be needed to support the workgroup.</p>

Children & Youth Behavioral Health Work Group: *Overarching candidate***Recommendation: Medicaid rate increase for community behavioral health**

Recommendations proposed from subgroups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Children & Youth Behavioral Health Work Group – *Workforce/Rates Subgroup* **Recommendations Brief – Community Behavioral Health Medicaid Rate Increase**

Recommendation:

In order to stabilize the community behavioral health safety-net and improve access to care, implement a 7% Medicaid rate increase directed to community behavioral health agencies retroactive to January 1, 2022. The rate increase shall be implemented to all behavioral health non-hospital inpatient, residential, and outpatient providers receiving payment for services through Medicaid managed care organizations under the Community Behavioral Health section of the operating budget.

1. What is the issue?

Chronically low Medicaid rates leave community behavioral health agencies (BHAs) unable to offer competitive salaries and compensation to their employees. This historical baseline reality has been exacerbated by a growing national behavioral health workforce shortage and the simultaneous loss of workers due to pandemic-related concerns (e.g., no childcare, family illness, vaccine mandates). Competition for behavioral health workers is extreme and accelerating and the compensation gap is growing.

A recent survey conducted by the Washington Council for Behavioral Health¹ documented these alarming trends:

- Over half of surveyed provider agencies have closed or limited access to outpatient services
- Vacancies for master level clinical staff average 30% and are as high as 60% in rural communities
- All-staff vacancy rates have increased by 38% in the past five months
- Annual turnover rates have climbed to 30%
- More treatment beds have been taken offline and branch office sites have closed

BHAs primarily serve Medicaid enrollees and other very low-income individuals and families. These communities represent an underserved health disparities population, including children, youth, and adults with serious emotional disturbances, serious mental illness, and/or addition disorders. These communities experience premature mortality with life expectancy reductions of 10–25 years. In addition, people of color are disproportionately represented in the public behavioral health system due to the impacts of poverty, racism, and other social determinants of health. By providing upstream identification and intervention to children, youth, and families, BHAs can get help to patients sooner. However, the current workforce crisis is reducing capacity and limiting access.

2. What is the impact on the state budget and society?

Access is severely limited across the state. It is unprecedented that BHAs are limiting or closing admissions for basic outpatient services to new patients. In addition, clinic branch offices are closing; treatment bed capacity has been reduced (CLIP, E&T, SUD residential); and waitlists are growing. People cannot receive routine, ongoing treatment. Therefore, crisis calls are surging, as are referrals for WISE services. System partners are frustrated and overburdened.

Quality is impacted: Other impacts include staff turnover and multiple changes in assigned clinician, longer waits between appointments, and loss of same-day appointments.

¹Washington Council for Behavioral Health, workforce survey of licensed behavioral health agencies completed in August 2021.

Use of more costly acute care resources including emergency room visits, hospitalization, and encounters with law enforcement.

Most disturbing is the inability to respond promptly to individuals and families seeking and needing behavioral healthcare.

3. What options do we have to change this?

Over \$0.80 of every BHA revenue dollar is spent on staff compensation. Because BHAs are significantly (85–95%) dependent on Medicaid funding, **Medicaid provider rates must be increased so that BHAs can begin to offer competitive salaries.** Doing so will help stem the tide of departing clinical staff and improve BHA ability to recruit needed staff, expand capacity, and respond to growing community needs.

We recommend a 7% percent increase in Medicaid reimbursement rates directed for community behavioral health agencies effective January 2022. This ask will build on the 2% rate increase appropriated in the 2021–23 biennial operating budget, Sec. 215. (56), which was an important initial step, but inadequate in light of increased costs, general inflation, and growing competition for workers. HCA should continue mechanisms such as directed payment to assure the funding is used by the managed care organizations for a 7% provider rate increase as intended.

The projected cost of a 7% increase as described above is approximately \$144,480,000.

4. Given current circumstances, why is taking the recommended a smart move now?

Workforce shortages are forcing community BHAs to limit services exactly when they should be building capacity to treat more people. While workforce shortages exist in many sectors of society, the community behavioral health system has been hit disproportionately due to decades of low rates (and corresponding staff compensation). The system is now experiencing a workforce shortage crisis. While the supply of behavioral health workers cannot be addressed overnight, ***we have the ability to slow or stop the loss of qualified workers from this essential safety-net system by improving Medicaid rates and offering competitive compensation.***

Washington cannot afford to lose system capacity and infrastructure of the behavioral health safety-net. Once these workers leave, they do not return; once a branch office is closed, it does not reopen; once a treatment facility shuts down, those beds do not come back online. Valuable time, human resources, and facility infrastructure are lost to the community.

At the same time, we are experiencing the following critical needs in communities across the state:

- Pandemic -related increases in behavioral health needs, particularly among children and youth.
- Coming implementation of Washington’s 988 line, and planned expansion of the behavioral health crisis response system, which is primarily located in the behavioral health safety-net system.
- Governor Inslee’s state psychiatric hospital transformation, transitioning civil commitments out of the current large state hospitals with a goal of building out capacity for long-term inpatient detention in smaller community settings.
- Achieving the promise of integrated whole person care to improve the overall health status of children, youth, and families.

5. Describe any outreach that helped to develop this recommendation.

Multiple behavioral health workforce initiatives and committees are currently underway. All point to the need for long-term investments in workforce development to encourage and expand the pool of workers entering behavioral health careers. These efforts are essential, but more immediate solutions and investments are critically needed.

The people and communities seeking and receiving care at community BHAs represent the broadest range of racial and ethnic diversity; most are extremely low-income and live with multiple health and social challenges; many have no other option for receiving care. Other health system providers, child/youth-serving systems, schools, and community partners (including law enforcement) rely on the community behavioral health safety-net to respond to needs that cannot be effectively addressed elsewhere. These include mobile crisis response services and designated crisis responders, WISe and other intensive community-based treatment and support, specialty behavioral health treatment to address severe and complex needs, evidence-based early intervention programs, and youth residential treatment programs.

A Medicaid rate increase to providers will help the behavioral health safety-net to close gaps in access and health outcomes for these children, youth, and families as we build toward a longer term and more transformational solution.

Children & Youth Behavioral Health Work Group: *Overarching***Recommendation: Compensation for people with lived experience**

Recommendations proposed from subgroups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation (Both policy and potentially budget)

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Children & Youth Behavioral Health Work Group – Compensation for people with lived experience**Recommendation:**

Support legislation that allows stipends/reimbursement/compensation (to be determined) for people with lived experience to participate on boards, commissions, councils, committees, or other similar groups established by the executive, legislative, or judicial branch

1. What is the issue?

Workgroup, advisory committees, task forces and the like that are created by the executive and/or legislative branches are frequently directed to include people with lived experience as members. The richness that lived experience brings to such groups cannot be overstated and as a result of their involvement, recommendations are more relevant and meaningful than they would otherwise be.

Unfortunately, current statute prohibits those with lived experience from receiving a stipend or being reimbursed/compensated in any way for their involvement on these committees. This is an issue of equity and needs to be addressed.

2. What is the impact on the state budget and society?

It is unclear what the fiscal impact will be. The specifics of the proposal are still being worked out. The impact of not having the voices of those with lived experience on the committees is clear --- policies and practices will lack the depth, significance, and relevance that they have when shaped by those for whom the issue most impacts.

3. What options do we have to change this?

There are proposals in the works related to the RCW language that would need to be included to address the prohibition and potentially lay out the mechanism for compensating/reimbursing those with lived experience. No decisions have been made at this point in terms of the exact language. Decisions also have to be made with respect to funding – how much, where the \$ will be housed, what form it will come in (e.g. stipend? reimbursement for certain expenses? Lump sum? other?)

4. Given current circumstances, why is taking the recommended a smart move now?

We cannot continue to ask people to participate on advisory committees, etc. and not reimburse them in some way for their time and expertise. Those who serve on these committees in their professional capacity and getting paid for their time to be there. This is not the case for those whose opinions are of equal and often greater value. The legislature can rectify this inequity by changing the statute and providing the funds necessary to adequately reimburse/compensate/give a stipend to people giving their time and expertise that is a result of their lived experience.

5. Describe any outreach that helped to develop this recommendation.

This is a priority of the Poverty Reduction Workgroup, a number of coalitions, multiple legislators, state agencies, and others. Discussions have taken place with individuals from these areas and all have had conversations with individuals and organizations about the importance of doing this. That said, the specifics of the proposal will need to be vetted by these individuals and groups prior to finalizing it.

Children & Youth Behavioral Health Work Group: *Overarching***Recommendation: *Statewide Children, Youth and Families Behavioral Health Strategic Plan***

Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Children & Youth Behavioral Health Work Group (CYBHWG) – Recommendations Brief
Statewide Children, Youth, and Families Behavioral Health Strategic Plan (10-12-21)

Recommendation:

The Children and Youth Behavioral Health Work Group (CYBHWG) subgroup leads recommend that the Legislature provide funds for a facilitated process to develop a Children, Youth, Young Adult, and Families Behavioral Health Strategic Plan to ensure that all Washington children and youth ages 0-25 years and families have timely access to high-quality, equitable, well-resourced behavioral health education, care and supports across the continuum when and where they need it.

We recommend that the strategic planning process include the following in this sequence:

1. A definition of vision for the ideal behavioral health system needed to ensure Washington children and youth ages 0-25 years and families have timely access to high-quality, equitable, well-resourced behavioral health education, care and supports across the continuum when and where they need it, beginning with prenatal care. This should include expert input from key stakeholders including (but not limited to):
 - a. Community members, those with lived experience, and programs that work directly with impacted people
 - b. Behavioral health workforce and providers from the entire continuum of care: preventive services, school-based behavioral health, outpatient providers, wraparound service providers, inpatient psychiatric unit workforce, and residential facility workforce
 - c. Primary care providers and hospital-based care providers
 - d. State agency representatives
 - e. State legislators
 - f. Governor’s office
2. An articulation of the current landscape, outlining:
 - a. The current service continuum, cost of care, delivery service models, and state oversight
 - b. Current gaps in the service continuum, service deserts, workforce demand, and capacity shortages
 - c. The barriers to accessing care experienced by children, youth, and families, including:
 - i. Inequities in service access
 - ii. Affordability
 - iii. Cultural, linguistic, and gender responsiveness
 - iv. Developmentally appropriate
3. A gap analysis – as recommended by the school-based subcommittee – to develop an estimate of the prevalence of needs for all children and youth, including:
 - a. The estimated number of children/youth, ages 0-25 years, who would need clinical behavioral health services on an annual basis.
 - b. The estimated number of expectant parents and caregivers in need of prenatal behavioral health services (this concept is added at the suggestion of the Prenatal through 5 Relational Health Subgroup and was not part of the initial school-based committee conversation).
 - c. Where possible, collect and provide analysis on disaggregated data to better understand regional, economic, linguistic, gender, and racial gaps in access to behavioral health services.
 - d. The estimated costs of providing services that include a range of behavioral health supports (benefit package) commensurate with the projected needs of the population.
 - e. Recommendations on the distribution of resources to deliver needed services to children/youth and their families across multiple settings, including:
 - i. Schools and early learning environments
 - ii. Behavioral health outpatient clinics
 - iii. Primary care settings

- vii. Home and community settings
 - viii. Telehealth
 - ix. Intensive outpatient, partial hospitalization, and residential treatment programs
 - x. Inpatient and other intensive settings
 - xi. Young Adult service settings
4. A review of best practice models including:
 - a. Best practices from other states
 - b. Evidence-based models that are outcomes-driven
 - c. Strategies to maximize federal investment and resources from any alternative funding sources
 - d. Workforce pipeline development strategies that ensure sustained representative and diverse workforce, increasing retention
 5. An action plan informed by the above elements to ensure that Washington State achieves the strategic vision and ensures equitably accessible care for all children, youth, young adults, and families. The action plan may also include further research questions and investigation topics that arose during the Strategic Plan process and a proposed budget to continue the Strategic Plan work and/or implementation process.

It would be important for this study to occur quickly, with findings due at the end of 2022, in time to inform 2023 advocacy priorities. The CYBHWG and its subcommittees should use the findings and recommendations to engage in strategic planning and develop future recommendations for funding and delivery systems and structures.

What is the issue?

There are significant capacity issues at every level of the behavioral health system for children and youth. Demand far outpaces capacity, and children and families are facing multiple barriers to accessing care. The issues in Washington’s behavioral health system serving prenatal through young adulthood are outlined in every other policy recommendation before the workgroup this session. The overarching issue is just that: we do not have an overarching, comprehensive, collaborative approach to identifying problems and implementing solutions.

The school-based subcommittee of CYBHWG identified a need for a gap analysis, noting that a performance audit highlighted the lack of a lead agency and systemic approach to providing behavioral health in schools. There is a lack of coordination of school-based behavioral health services across the state, a lack of a continuum of care which would provide more intensive services to students in schools when they need them, and there is no single state agency responsible to fund services across the continuum or provide oversight.

The lack of coordination and systemic approach is evident system-wide and is not limited to the school-based behavioral health system. There are minimal shared data sets and a varied understanding of the landscape of behavioral health services. Improvements to the mental health system currently are done at individual levels of care, without an agreed-upon vision. The solutions are reactive rather than proactive – mirroring an equally reactive behavioral health system.

Before the pandemic, over 25% of pediatric primary care visits were for behavioral health concerns -- today more than half of primary care appointments are for behavioral health needs. Primary care is not currently resourced to rapidly provide behavioral health care or to coordinate the services children and youth need. Coordination of care among primary care clinics, schools, and specialty providers is also crucial, but there is not currently a system-wide commitment to fund these activities.

In addition to schools and early learning settings, pediatricians, family physicians and other primary care professionals play a critical role in screening, early identification, and timely support for kids’ behavioral

health needs. However, many primary care clinics are overburdened and cannot adequately meet children and teen's rapidly rising behavioral health needs. It is a critically important time to invest in transformative efforts to maximize our behavioral health workforce, care coordination, and primary care integration.

A strategic plan for Washington's child and youth behavioral health system is critically necessary. This process could enable the state, providers, and community to be proactively and equitably designing a system that would truly support children, youth, and families. A strategic plan with outside facilitation would enable key stakeholders and community to define a goal and vision for Washington in terms of ensuring children, youth, and families have access to behavioral health care. This process could include an assessment of current state, a gap analysis, and a strategic action plan to achieve the vision. Washington State's system could be outcomes-driven, learning from the best practice models in other states, and making thoughtful decisions about where to invest resources maximizing federal investment as well as revenue from any other alternative sources.

A strategic plan lays the foundation for all other behavioral health improvements. Ranked 46th of 50, Washington is one of the worst states in the nation for mental health care and has even fewer resources for specialized mental health care during pregnancy and postpartum.ⁱ Yet we can have a system where care is equitably accessible, where services are culturally and linguistically responsive, where the workforce is diverse and representative – but we must design that system. Now is the time to make this plan for our children, youth, and families. The impacts of the COVID-19 pandemic on mental health will likely be felt for at least a decade; we need a behavioral health system that is ready to support this generation of youth and the next.

What is the impact on the state budget and society?

To be determined – the CYBHWG recommends that the Legislature fund a strategic planning process, as outlined above, to develop future recommendations for funding and delivery systems and structures. The strategic plan, as the outcome of this recommendation, would lead to significant investments in behavioral health that are both strategic and efficient.

What options do we have to change this?

The goal is to create a state-wide strategic plan for children, youth, and young adult behavioral health inclusive of prenatal services. The alternative – not having one – perpetuates the current silos and inefficiencies. Without this plan, the system continues in current state. In current state, children and families spend weeks or months waiting for critically necessary behavioral health care. In current state, children fall through the gaps in the continuum of services – sometimes with devastating life-altering consequences, and most certainly with longer, more complex, and more expensive behavioral health needs to resolve

Given current circumstances, why is taking the recommended approach a smart move now?

The COVID-19 pandemic has exacerbated pre-existing issues in children's behavioral health – putting the whole system into crisis. Currently, Washington faces workforce shortages, prohibitively long wait times to access care, and full and over-burdened emergency departments and inpatient psychiatric units.

These issues existed long before the COVID-19 pandemic; however, the rise in mental illness in youth during this pandemic has strapped our already inadequate mental health system. Youth suicide is a particular area of concern: Washington State is among the 15 states with the highest teen suicide rates the country according to America's Health Rankings. Even while our relative ranking among other states improved, the teen suicide rate increased from 2019-2020 (15 per 100,000 in 2019 to 15.7 per 100,000

in 2020) and is above the national average (11 per 100,000). This is consistent with an upward trend over the past decade in which our teen suicide rate continues to increase.

Additionally, the COVID-19 pandemic has exacerbated behavioral health disorders for new and expectant parents. Across the world, including here in Washington State, birthing parents have reported more clinically significant symptoms of depression and anxiety than before the pandemic.ⁱⁱ As stated above, one study found 43%, 31%, and 54% of pregnant and postpartum women exceeding elevated thresholds for PTSD symptoms in relation to COVID-19, depression/anxiety, and loneliness respectively.ⁱⁱⁱ Left untreated, COVID-19 pandemic–associated stress can result in adverse birth outcomes, even among the uninfected.^{iv}

The evidence suggests that Washington has higher than average rates of mental illness that we are not adequately treating – with Mental Health America ranking Washington 43rd for youth mental health using a combination of data points including access to care, insurance coverage, and rates of mental illness. Without a targeted effort to provide mental health services to youth across the continuum of care, it is likely that our suicide rate will continue to increase.

Describe any outreach that helped to develop this recommendation.

There have been multiple discussions among members and subgroup leads of the Children and Youth Behavioral Health Workgroup. These discussions are informed by first-hand knowledge and encounters/experience of other providers, school administrators, and people with lived experience.

Our community of workforce and of children and families consistently articulate the need for a more functional behavioral health system. A vision for a functioning system with equitable access to a range of high-quality mental and behavioral health services for children and youth is far from being realized.

ⁱ Adult Ranking 2020. Mental Health America. DOI: <https://www.mhanational.org/issues/ranking-states#one>

ⁱⁱ Berthelot N., Lemieux R., Garon-Bissonnette J., Drouin-Maziade C., Martel É., Maziade M. (2020) Uptrend in distress and psychiatric symptomatology in pregnant women during the coronavirus disease 2019 pandemic. *Acta Obstetrica et Gynecologica Scandinavica*. 99(7): 848–855. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8256336/#bib11>.

ⁱⁱⁱ Basu A, Kim HH, Basaldua R, Choi KW, Charron L, Kelsall N, et al. (2021) A cross-national study of factors associated with women’s perinatal mental health and wellbeing during the COVID-19 pandemic. *Plos One*. <https://doi.org/10.1371/journal.pone.0249780>.

^{iv} Zanardo V., Manghina V., Giliberti L., Vettore M., Severino L., Straface G. (2020). Psychological impact of COVID-19 quarantine measures in northeastern Italy on mothers in the immediate postpartum period. *International Journal of Gynaecology and Obstetrics*. 150(2):184–188. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8256336/#bib124>.

**Children & Youth Behavioral Health Work Group: Prenatal through 5 Relational Health Subgroup
Recommendation: Expand the Parent Warm Line**

Recommendations proposed from subgroups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports
- Maintenance, sustained stability, and recovery services and supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

**Children & Youth Behavioral Health Work Group
Prenatal through 5 Relational Health Subgroup Recommendation Brief**

Budget Recommendation: Expand the Parent Support Warm Line

Invest in [Perinatal Support Washington's Parent Support Warm Line](#) (the Warm Line) so un- and underserved expectant and new parents have greater and more equitable access to mental health services through peer-to-peer engagement and increased public awareness.

1. Overview of the recommendation to expand the Warm Line

The Warm Line is a help line for new parents and caregivers experiencing mental health challenges. Staffed by peers with relevant lived experience and training, including English and Spanish speakers, the Warm Line provides timely support, tailored referrals, and reduces the harmful stigma that sometimes prevents people from seeking help.

Before the onset of COVID-19, postpartum depression was experienced by 1 in 7 new moms.ⁱ In the lasting wake of COVID-19, new parents and caregivers are experiencing significantly higher rates of distress. One study found 43%, 31%, and 54% of pregnant and postpartum women exceeding elevated thresholds for posttraumatic stress disorder (PTSD) symptoms in relation to COVID-19, depression/anxiety, and loneliness respectively.ⁱⁱ

Ranked 46th of 50, Washington State is one of the worst states in the nation for mental health care and has even fewer resources for specialized mental health care during pregnancy and postpartum.ⁱⁱⁱ As a result of institutional racism, there are also significant and persistent racial disparities in perinatal health and mental health treatment experiences.

The risks of untreated perinatal mood and anxiety disorders (PMADs) are significant for caregivers, children, and families – but we have the knowledge and tools to treat, and sometimes prevent, undue hardship. We can provide better access to perinatal mental health support for the 85,000 people each year who have babies in Washington state by expanding the Warm Line.^{iv}

2. What are perinatal mood and anxiety disorders (PMADs) and how are they treated?

A. Perinatal mental health issues are very common, yet often un- and undertreated



Mathematica: New Study Uncovers the Heavy Financial Toll of Untreated Maternal Mental Health Conditions. Apr 29, 2019. <https://www.mathematica.org/news/new-study-uncovers-the-heavy-financial-toll-of-untreated-maternal-mental-health-conditions>

Drs. Pilyoung Kim and Sarah Watamura at the University of Denver call the transition to parenting a time of “two open windows,” an exceptionally sensitive period when both infant and parent are highly receptive to being shaped by their environments and mutual human interactions. This transition, from pregnancy through the first year postpartum, is often referred to as the “perinatal” period. It can be a time of tremendous joy and connection, and simultaneously a time when parents are overloaded as they respond to their child’s needs and hold everything else together.

Because the transition to becoming a parent can be so stressful, post-partum depression is experienced by 1 in 7 new moms, 1 in 10 dads, and 1 in 8 adoptive mothers, and many other types of caregivers experience anxiety and other behavioral health disorders.^v Depression correlates with substance use, and new mothers with postpartum depression may be at high risk for substance use.^{vi} The impacts of behavioral health conditions disproportionately impact families that are already experiencing hardship.

Addressing perinatal mental health has a two generational impact and those with the biggest risk and prevalence are the least seen and served by the behavioral health system. Some studies show approximately 50% of low-income women reporting elevated, clinically significant, depressive symptoms.^{vii} However, relatively few can access support. Only 38.1% of referred women had at least one mental health appointment, and only 6% of those needing help received sustained treatment according to a recent study of pregnant and postpartum women screened for psychiatric distress in a publicly funded clinic and referred for mental health treatment.^{viii}

The COVID-19 pandemic has exacerbated behavioral health disorders for new and expectant parents. Across the world, including here in Washington State, birthing parents have reported more clinically significant symptoms of depression and anxiety than before the pandemic.^{ix} As stated above, one study found 43%, 31%, and 54% of pregnant and postpartum women exceeding elevated thresholds for PTSD symptoms in relation to COVID-19, depression/anxiety, and loneliness respectively.^x Left untreated, COVID-19 pandemic–associated stress can result in adverse birth outcomes, even among the uninfected.^{xi}

Behavioral health disorders, such as depression, also have a significant impact on mothers experiencing homelessness and their families. Research shows that lifetime rates of depression among mothers experiencing homelessness range from 45% to 85%.^{xii} Research also shows that maternal depression during the postpartum year is a significant risk factor for homelessness.^{xiii} Supports and screening for parental depression are often unavailable and oftentimes behavioral health issues can prevent families from getting housing.^{xiv} Moreover, many women experiencing homeless are fearful of a behavioral health diagnosis due to stigmatization, child welfare involvement, and loss of their children.^{xv}

The risks of untreated perinatal mood and anxiety disorders (PMADs) are significant for caregivers, children, and families – **but we have the knowledge and tools to treat, and sometimes prevent, undue hardship. In fact, treatment for PMADs is effective and is provided across a continuum. For some parents and caregivers, an intervention like the Warm Line can prevent significant fallout.**

B. Untreated perinatal mental health issues are the leading cause of pregnancy-related death in Washington

When left untreated, perinatal mental health disorders can deteriorate and become more serious, negatively impacting the individual, the infant, and the family. Un- and under-treated mental health conditions in new parents are a known disruptor to the critical relationship between parent and infant and can lead to long-term effects in the child across developmental domains and outcomes.^{xvi} For those with the most significant symptoms, mental health conditions can be catastrophic. In Washington, according to our state's Maternal Mortality Review Panel, mental and behavioral health conditions are the leading cause of pregnancy-related deaths within one year of the end of pregnancy. The Review Panel determined that 60% of these deaths were preventable.^{xvii} Expanding access to the Warm Line would be aligned with the Maternal Mortality Review Panel's 2019 recommendations to the Legislature.

Every maternal death is a tragedy and has a two-generation impact by affecting the well-being of young children as well as their trajectory into adulthood. Infant mortality is higher among children whose mothers die due to maternal causes versus children of surviving mothers.^{xviii} One study found that children who lost one or more parents are 2.5 to 4 times more likely than control groups to die of suicide or to attempt suicide.^{xix}

C. Mental health supports are not readily available to Washington parents – especially parents of color

Ranked 46th of 50, Washington State is one of the worst states in the nation for mental health care and has even fewer resources for specialized mental health care during pregnancy and postpartum.^{xx} A contributing factor is that there are not enough providers. In a recent survey by the University of Washington Maternal Child Mental Health Program, only 350 health providers in Washington State reported treating perinatal patients who have mental health problems. This included mental health providers of any kind, as well as obstetricians and nurses who can provide psychiatric medication.^{xxi} In stark contrast, there were 85,000 live births in Washington State in 2019^{xxii} and, according to Postpartum Support International, 15 to 20% of women experience significant mental health symptoms postpartum.^{xxiii} Layered onto the overall access issue is wide geographic variation. **In 30 of our 39 counties, fewer than 10 perinatal mental health providers of any kind exist.**

Also of notable concern is that the racial diversity of the provider workforce does not reflect the racial diversity of patients who need services. A 2019 Behavioral Health Provider Survey of publicly funded, state-certified, community-based behavioral health treatment agencies in Washington State found that 65.4% of providers who responded identified as white, 17.1% identified as Hispanic, 6.9% identified as Black or African American, 3.6% identified as Asian/Pacific Islander, and 1.7% as Native American or Alaska Native.^{xxiv}

As Dr. Ryan Huerto with the University of Michigan's Institute for Healthcare Policy and Innovation has noted,^{xxv} patient and provider racial and/or ethnic congruence leads to more patient positive effects,^{xxvi} improved patient perceptions of treatment decisions,^{xxvii} and decreased implicit bias.^{xxviii} The option for provider and patient congruence is especially important for behavioral healthcare where addressing stigma, culture, and community are critical for effective treatment and recovery.

Even when parents in need can find a provider, treatment is frequently beyond their means. More than 80% of those seeking mental health support are covered by Medicaid only,^{xxix} however, less than 20% of self-identified perinatal mental health providers in the UW survey said they accept public insurance leaving the vast majority of parents without access to perinatal mental health services.

D. Disparate care during pregnancy is a contributing factor for mental health conditions

People who are Black, Indigenous, and other People of Color (BIPOC) are less likely to have access to mental health services, less likely to receive needed care, more likely to receive poor quality of care, and more likely to end services prematurely than their white peers.^{xxx} There are significant and persistent racial disparities in perinatal health and mental health treatment experiences. Women of color, especially Indigenous, Hispanic, and Black women, experience much higher rates of mistreatment during birth than white women, including violation of privacy, threats to withhold treatment, ignoring or refusing requests for help, and shouting/scolding.^{xxxi} The long-term psychological toll of racism puts Black, Indigenous, and other women of color at higher risk for a range of medical conditions that threaten their lives and their infants' lives, including mental health conditions. In fact, mothers of color experience higher rates of Postpartum Depression, even when controlling for contextual factors.

The Warm Line matches parents with other parents who have also experienced perinatal mood disorders. Peer support reduces stigma and increases equitable access to essential supports. In fact, forty-two percent of Warm Line callers who shared demographic information self-identified as parents of color.^{xxxiv}

Quick Facts on the Warm Line

- As a result of the COVID-19 crisis, calls to the Warm Line have increased significantly – there was a 52% increase from 2019 to 2020 and a 63% increase from 2020 to 2021.
- Of Warm Line callers who disclosed demographic information, 40% identified as Black, Indigenous, and People of Color and 30% rely on Medicaid.
- From May 2020-June 2021, parents and caregivers who reached out to the Warm Line received the following targeted referrals: 62% referred to therapists, 41% to support groups, 8% to medication prescribers. Note that some callers were referred to more than one type of support.
- The Warm Line serves families all across Washington State in English and Spanish.

3. The Warm Line helps bridge the gap between need and support for new parents and caregivers

The Warm Line is a help line for new parents and caregivers experiencing mental health challenges. Staffed by peers with relevant lived experience and training, including English and Spanish speakers, the Warm Line provides timely support, tailored referrals, and reduces the harmful stigma that sometimes prevents people from seeking help.

The Warm Line peer support staff provides parents with information and education about the types of support that are available and works with parents until they find the support they need. That might mean one or two follow-up calls to ensure that parents received the appropriate referrals. Or, helping parents through an extended peer support program where the Warm Line team is regularly connecting

with parents over the course of weeks or months via phone, text, and video calls to navigate crisis support, talk through fears around accessing care, connect with a therapist or support group, or make a mental wellness plan. The Warm Line helps take the load off stressed and overwhelmed parents and makes care more readily available. **For some parents and caregivers, a minor intervention can prevent significant fallout.**

Especially in response to the multiplying impacts of COVID-19, we can provide better access to perinatal mental health support for families in Washington State by expanding the [Perinatal Support Washington Warm Line](#).

As one parent who received support through the Warm Line shared, *“I have not felt very supported by the health care and childcare systems as a postpartum woman, and the Warm Line helped me feel more seen and supported.”*

Investments in the Warm Line would increase access to mental health services for expectant and new parents in un- and under-served racial, ethnic, linguistic, and geographic communities by:

- Adding staff coordinators for the Warm Line from priority communities
- Increasing public awareness through outreach and education to be sure priority communities know about the warm line and related services

4. What is the impact of perinatal mood and anxiety disorders (PMADs) on the state budget and on society?

The financial cost is immense, in addition to the potential for harm on parents, children, and families that cannot be monetized.

Un- and under-treated parent mental health challenges during pregnancy and postpartum have an enormous toll on families and society, from preterm birth and maternal health conditions to productivity loss and unemployment. The cost of perinatal mood and anxiety disorders (PMADs) is estimated at more than \$10,200 per mother over six years. This is more than five times the medical costs of other perinatal conditions. For instance, postpartum hemorrhage (bleeding) and gestational diabetes (diabetes during pregnancy) each cost up to \$3,300 per mother and take place only during pregnancy and childbirth.^{xxxv}

Writ large, PMADs had a total estimated six year (prenatal to age 5) societal cost of *\$304 million for mothers and children* born in Washington in 2017^{xxxvi} even after accounting for children’s resilience. This cost is repeated for every year’s births so every year Washington State is faced with an additional \$300+ million in costs for that year’s births and the sequelae of untreated parental mental health conditions.

There is also a tremendous human cost for undiagnosed and/or untreated conditions, resulting in greater family mental health challenges and increased health disparities. One of the most significant and damaging impacts of parent mental health disorders is on children. The science is clear – parents and infants develop together. Research shows that parent mental health issues affect the likelihood of secure infant-mother attachment.^{xxxvii} Research also shows that parent mental health issues are associated with pre-term delivery,^{xxxviii} low birthweight,^{xxxix} and increased likelihood of difficult infant temperament and sub-optimal breastfeeding practices.^{xl} On the other hand, babies who engage with responsive, nurturing caregivers and who live in safe and economically secure environments are more

likely to have strong emotional health. As they mature, their foundational emotional health fosters vigorous physical development and health, cognitive skills, language and literacy, social skills, and even positively impacts approach to learning and school readiness.^{xli}

5. What options do we have to address perinatal mood and anxiety disorders (PMADs)? Where should we invest our dollars to address this urgent problem?

We should expand the existing [Parental Support Warm Line](#) (the Warm Line) which currently serves pregnant and parenting people and their loved ones. We have the opportunity to invest in and grow this existing infrastructure. This expansion would help reduce maternal morbidity and mortality, reduce the cost of untreated mental health to the state and society, and in the long term, promote healthy child development and family strength and stability. It would extend needed support to more parents, regardless of their preferred language, race, income, and insurance status, by ensuring they are connected with relevant and appropriate mental health supports. With funding, additional staff can be hired and public awareness can be increased through outreach and education.

6. Why is expanding the Warm Line a smart move now?

Adopting this policy now will:

- A. Offer immediate and sustained relief to parents, with cascading positive impacts to children and families.** Peer support is effective at engaging and supporting pregnant and new parents with mental health needs.^{xliii} The Warm Line is available when parents need it, while the mental health system might take weeks to schedule an appointment.
- B. Decrease racial mental health disparities by offering support in multiple languages without requiring insurance coverage.** The Warm Line currently provides services in English and Spanish with simultaneous interpretation available in many more languages. State funding would increase the Warm Line's capacity to serve Spanish-speaking parents during additional times of day and days of the week.
- C. Save substantial costs down the road (an estimated total cost of \$304 million for every year's births).**^{xliiii} According to Washington State's Maternal Mortality Review Panel, mental and behavioral health conditions are the leading cause of pregnancy-related deaths and are largely preventable if parents can find and engage with the help they need.
- D. Invest in proven practices.** Started by parents with lived experience who did not want other parents to suffer alone, the Warm Line is still staffed by peer parents with experience in the range of mental health conditions that can arise in the perinatal period, including perinatal loss, trauma, anxiety, depression, psychosis, and suicidal ideation. Parents or their loved ones can call the Warm Line at any time, day or night, and the team provides supports to the whole family. The Warm Line currently offers live answering during the day 5 days a week and calls back as soon as possible during evenings and weekends.

As a result of the COVID-19 crisis, calls to the Warm Line have increased significantly – there was a 52% increase from 2019 to 2020 and a 63% increase from 2020 to 2021. The acuity and severity of reasons parents are calling during the pandemic has also increased, and include

issues like postpartum psychosis, suicidal ideation, as well as overall increased symptomatology in depression, anxiety, and acute stress. Of Warm Line callers who reported demographic information 42% were parents of color and one out of three callers relied on Medicaid as their primary form of insurance.

Above all, Warm Line staff and volunteers meet parents where they are at, normalize the experience, and offer ongoing contact and support until parents have the services they need. As one parent explained: *“Prior to connecting with the warm line, I felt very alone in my experience. I wasn't getting anywhere in regard to connecting with a therapist or treatment program and felt less and less hopeful with each passing day. After speaking with a warm line volunteer, I felt hopeful. I knew someone understood my experience and was going to help create the connections with providers I was having difficulty facilitating.”*

- E. Address increased demand for perinatal mental health support resulting from a new [National Maternal Mental Health Hotline](#):** The national Maternal Mental Health Hotline is expected to launch in early 2022. While this is fantastic news, the result will be a significant increase in the number of calls directed to Warm Line staff and volunteers. Funding for the federal hotline is limited and state and local organizations are expected to help staff the response.

7. The recommendation to expand the Warm Line was shaped by community outreach to parents and providers.

The Prenatal through 5 Relational Health Subgroup's membership is nearly 100 diverse stakeholders of different racial, ethnic, and cultural backgrounds, incomes, and family situations with rich and multi-faceted lived experiences related to mental health. Robust conversations involving parents, behavioral and mental health professionals and clinicians, policymakers, advocates, physicians, and those familiar with Medicaid and private insurance led to the creation of this recommendation. The Prenatal through 5 Relational Health Subgroup provides stipends to parents who participate in meetings so that their time is compensated and insights are valued.

A number of Prenatal through 5 Relational Health Subgroup members shared this recommendation concept with their staff who work directly with parents across the state and provided input for us to both strengthen this recommendation and help inform any implementation. Additionally, other outreach was done to non-subgroup members who serve parents across the state.

Outreach beyond the Prenatal through 5 Relational Health Subgroup's membership had an intentional focus on conversation and consultation with (1) parents who have experienced perinatal mood and anxiety disorders themselves along with (2) parent leaders who are knowledgeable about the experiences of others in their communities. Within those two groups of parents, we ensured there was intentional outreach to individuals and communities who identify as Black, Indigenous, and People of Color to be sure our recommendation centers and advances equity per our subgroup criteria below.

The Prenatal through 5 Relational Health Subgroup (P5RHS) has prioritized policy recommendations based on these criteria:

1. **COMMUNITY-INFORMED** - Prioritizes approaches and ideas that strengthen child and family well-being, as shared by members of impacted communities and those that serve them
2. **CENTERS & ADVANCES EQUITY** – Holds the promise to measurably closes the gaps in health access and outcomes
3. **ACHIEVABLE** – Size and scope are appropriate for Washington’s budget context policy landscape
4. **CAPACITY** – Implementation could be described and executed well and quickly
5. **STRENGTHENS/TRANSFORMS** – Helps to build, sustain, or transform foundational systems
6. **FIT** – Fits within the P5RHS and CYBHWG scope, and avoids duplicating the work of other groups

ⁱ Mott, S.L., Schiller, C.E., Richards, J.G., O’Hara, M.W., Stuart, S. (August 2011). Depression and anxiety among postpartum and adoptive mothers. *Archives of Women’s Mental Health*. 14(4): 335–343.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433270>.

ⁱⁱ Basu A, Kim HH, Basaldua R, Choi KW, Charron L, Kelsall N, et al. (2021). A cross-national study of factors associated with women’s perinatal mental health and wellbeing during the COVID-19 pandemic. *Plos One*.
<https://doi.org/10.1371/journal.pone.0249780>.

ⁱⁱⁱ Adult Ranking 2020. Mental Health America. DOI: <https://www.mhanational.org/issues/ranking-states#one>

^{iv} COVID-19 Pandemic Resources and Support (2019). *March of Dimes*.
<https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=53&top=2&stop=1&lev=1&slev=4&obj=1>.

^v Mott, S.L., Schiller, C.E., Richards, J.G., O’Hara, M.W., Stuart, S. (August 2011). Depression and anxiety among postpartum and adoptive mothers. *Archives of Women’s Mental Health*. 14(4): 335–343.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433270>.

^{vi} Shawna L. Carroll Chapman PhD & Li-Tzy Wu ScD (2013) Postpartum Substance Use and Depressive Symptoms: A Review, *Women & Health*, 53, 479-503, 10.1080/03630242.2013.804025.

^{vii} Chaudron, LH, Szilagyi, PG, Tang, W, Anson, E, Talbot, NL, Wadkins, HIM, Tu, X and Wisner, KL. (2010). Accuracy of depression screening tools for identifying postpartum depression among urban mothers. *Pediatrics*. 125(3): e609-e617.
<https://doi.org/10.1542/peds.2008-3261>. and Chung EK, McCollum KF, Elo IT, Lee HJ, & Culhane JF. (2004). Maternal depressive symptoms and infant health practices among low-income women. *Pediatrics*, 113(6): 523-9.
<https://pediatrics.aappublications.org/content/113/6/e523>.

^{viii} Smith, M. V., Shao, L., Howell, H., Wang, H., Poschman, K., & Yonkers, K. A. (2009). Success of mental health referral among pregnant and postpartum women with psychiatric distress. *General Hospital Psychiatry*, 31(2): 155-162.
<https://doi.org/10.1016/j.genhosppsych.2008.10.002>.

^{ix} Berthelot N., Lemieux R., Garon-Bissonnette J., Drouin-Maziade C., Martel É., Maziade M. (2020) Uptrend in distress and psychiatric symptomatology in pregnant women during the coronavirus disease 2019 pandemic. *Acta Obstetrica et Gynecologica Scandinavica*. 99(7): 848–855. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8256336/#bib11>.

^x Basu A, Kim HH, Basaldua R, Choi KW, Charron L, Kelsall N, et al. (2021) A cross-national study of factors associated with women’s perinatal mental health and wellbeing during the COVID-19 pandemic. *Plos One*.
<https://doi.org/10.1371/journal.pone.0249780>.

^{xi} Zanardo V., Manghina V., Giliberti L., Vettore M., Severino L., Straface G. (2020). Psychological impact of COVID-19 quarantine measures in northeastern Italy on mothers in the immediate postpartum period. *International Journal of Gynaecology and Obstetrics*. 150(2):184–188. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8256336/#bib124>.

^{xii} Bassuk, E. L., & Beardslee, W. R. (2014). Depression in Homeless Mothers: Addressing an Unrecognized Public Health Issue. *American Journal of Orthopsychiatry*, 73-81.

^{xiii} Curtis, M. A., Corman, H., Noonan, K., & Reichman, N. E. (2014). Maternal Depression as a Risk Factor for Family Homelessness. *American Journal of Public Health*, 1664-1670.

- ^{xiv} Bassuk, E. L., & Beardslee, W. R. (2014). Depression in Homeless Mothers: Addressing an Unrecognized Public Health Issue. *American Journal of Orthopsychiatry*, 73-81.
- ^{xv} Bassuk, E. L., & Beardslee, W. R.. Depression in Homeless Mothers: Addressing an Unrecognized Public Health Issue (2014). *American Journal of Orthopsychiatry*, 73-81.
- ^{xvi} Arteche A, Joormann J, Harvey A, et al. The effects of postnatal maternal depression and anxiety on the processing of infant faces. *J Affect Disord* (2011). *Journal of Affective Disorders*. 133:197–203. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3161178/>
- ^{xvii} Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016 (2019). *Department of Health Report to the Legislature*. <https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-010-MMRPMaternalDeathReport2014-2016.pdf>.
- ^{xviii} Effect of Maternal Mortality on Survival of Under-five Children: Evidence from Matlab, Bangladesh. *Princeton*. <https://paa2012.princeton.edu/papers/120545#:~:text=In%20fact%2C%20maternal%20death%20can, costs%20associated%20with%20mother's%20death.>
- ^{xix} E Lange, C Garten (1989). Parent, mother or father loss in childhood and suicidal behavior in adulthood. *Psychiatr Neurol Med Psychol (Leipz)*. 41(4):218-23. <https://pubmed.ncbi.nlm.nih.gov/2740462/>.
- ^{xx} Ranking the States 2020. *Mental Health America*. <https://www.mhanational.org/issues/ranking-states#one>.
- ^{xxi} Bhat, A., Cowley, D. (2019), Moms Access Project Report. *UW Medicine School of Psychiatry unpublished data*. 2018/2019 Behavioral Health Provider Survey conducted under a collaboration between the Washington State Health Care Authority (HCA) and the Washington State University Social and Economic Sciences Research Center (SESRC). With 346 agencies participating in the survey (numerator), the response rate was 56.6%. Responding agencies reported a total of 6,428 BH clinical staff.
- ^{xxii} COVID-19 Pandemic Resources and Support (2019). *March of Dimes*. <https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=53&top=2&stop=1&lev=1&slev=4&obj=1>.
- ^{xxiii} Postpartum Support International. <https://www.postpartum.net/learn-more/>.
- ^{xxiv} Bhat, A., Cowley, D. (2019), Moms Access Project Report. *UW Medicine School of Psychiatry unpublished data*. 2018/2019 Behavioral Health Provider Survey conducted under a collaboration between the Washington State Health Care Authority (HCA) and the Washington State University Social and Economic Sciences Research Center (SESRC). With 346 agencies participating in the survey (numerator), the response rate was 56.6%. Responding agencies reported a total of 6,428 BH clinical staff.
- ^{xxv} Huerto, R. (2020). Opinion: Minority patients benefit from having minority doctors, but that's a hard match to make. *Institute for Healthcare Policy & Innovation*. <https://ihpi.umich.edu/news/opinion-minority-patients-benefit-having-minority-doctors-thats-hard-match-make>.
- ^{xxvi} Cooper L., Roter D., Johnson R., Ford D., Steinwachs D., Powe N. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Ann Intern Med*. 139(11):907-15. 14644893. <https://pubmed.ncbi.nlm.nih.gov/14644893/>.
- ^{xxvii} Saha, S., Beach, M.C. (2020). Impact of Physician Race on Patient Decision-Making and Ratings of Physicians: a Randomized Experiment Using Video Vignettes. *J GEN INTERN MED*. 35, 1084–1091. <https://doi.org/10.1007/s11606-020-05646-z>.
- ^{xxviii} Hagiwara N., Slatcher R.B., Eggly S., Penner L.A. (2016). Physician Racial Bias and Word Use during Racially Discordant Medical Interactions. *Health Commun*. 32(4):401-408. <https://pubmed.ncbi.nlm.nih.gov/27309596/>.
- ^{xxix} Washington 2018 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting Measures. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Washington-2018.pdf>
- ^{xxx} Perzichilli, T. (2020). The Historical Roots of Racial Disparities in the Mental Health System. *Counseling Today*. <https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/>
- ^{xxxi} Vedam, S., Stoll, K., Taiwo, T.K. et al. (2019). The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health*. 16, 77. <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2>
- ^{xxxii} Taylor, J., Novoa, C., Hamm, K., and Phadke, S. (2019). Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint. *Center for American Progress*. <https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/#fn-469186-12>
- ^{xxxiii} Gress-Smith, J. L., Luecken, L. J., Lemery-Chalfant, K., & Howe, R. (2012). Postpartum depression prevalence and impact on infant health, weight, and sleep in low-income and ethnic minority women and infants. *Maternal and Child Health Journal*. 16, 887–893. <https://pubmed.ncbi.nlm.nih.gov/21559774/>. and Ceballos, M., Wallace, G. & Goodwin, G. (2017). Postpartum depression among African-American and Latina mothers living in small cities, towns, and rural communities. *Journal of Racial and Ethnic Health Disparities*. 4, 916–927. <https://link.springer.com/article/10.1007/s40615-016-0295-z>
- ^{xxxiv} Perinatal Support Washington Internal Data
- ^{xxxv} Luca, D.L., Garlow, N., Staats, C., Margiotta, C., Zivin, K. (2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States. *Mathematica Policy Research*. <https://mathematica.org/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-the-united-states> (adjusted to reflect the estimated cost for mother alone, rather than mother and child).

- ^{xxxvi} Luca, D.L., Garlow, N., Staatz, C., Margiotta, C., Zivin, K. (2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States. *Mathematica Policy Research*. <https://mathematica.org/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-the-united-states> (adjusted to reflect the estimated cost for mother alone, rather than mother and child).
- ^{xxxvii} Atkinson, L., Paglia, A., Coolbear, J., Niccols, K., Parker, K.C., Guger, S. Clinical (2000). Attachment security: A meta-analysis of maternal mental health correlates. *Clinical Psychology Review*. 20(8), 1019-1040. <https://www.sciencedirect.com/science/article/pii/S0272735899000239>
- ^{xxxviii} Yaari, M., Treyvaud, K., Lee, K.J., Doyle, L.W., Anderson, P.J. (2019). Preterm Birth and Maternal Mental Health: Longitudinal Trajectories and Predictors. *Journal of Pediatric Psychology*. 44(6), 736–747. <https://doi.org/10.1093/jpepsy/jsz019>.
- ^{xxxix} Grote, N.K., Bridge, J.A., Gavin, A.R., Melville, J.L., Iyengar, S., Katon, W.J. (2010). A Meta-analysis of Depression During Pregnancy and the Risk of Preterm Birth, Low Birth Weight, and Intrauterine Growth Restriction. *Archives of General Psychiatry*. 67(10):1012-1024. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/210887>.
- ^{xl} Wouk, K., Stuebe, A. M., & Meltzer-Brody, S. (2017). Postpartum Mental Health and Breastfeeding Practices: An Analysis Using the 2010-2011 Pregnancy Risk Assessment Monitoring System. *Maternal and child health journal*. 21(3), 636–647. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5253344/>
- ^{xli} Adapted from ZERO TO THREE Infant Mental Health Task Force, 2001. <https://www.ecmhc.org/IMH/defining-imh.html>.
- ^{xlii} A significant Solution for Maternal Mental Health: Certified Peer Specialists. Issue brief from 2020 Mom. <https://www.2020mom.org/issue-brief-download>.
- ^{xliii} Luca, D.L., Garlow, N., Staatz, C., Margiotta, C., Zivin, K. (2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in Washington. *Mathematica Policy Research*. <https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-washington>

School-based Behavioral Health and Suicide Prevention Subcommittee of the Children and Youth Behavioral Health Work Group

Findings and Recommendations, October 2021

Findings:

The School-based Behavioral Health Subcommittee spent the last 12 months reviewing the availability of services and gaps in the service systems which include (or often do not include) school-based behavioral health care and related supports. The subcommittee heard presentations on Medicaid, private commercial insurance, local service examples, district and regional approaches, and comparisons to other states, including a presentation from the South Carolina Department of Mental Health, which provides funding for behavioral health clinicians in 64% of South Carolina Schools, and a presentation on the 2021 Performance Audit on school-based behavioral health.

The performance audit found:

- Most schools have not implemented a full continuum of supports
- Few schools screen students systematically (only 18% of schools surveyed screen all students)
- Current approaches receive only a fraction of the resources that would be needed to implement them statewide
- Washington's approach to K-12 student behavioral health is fragmented, including the lack of a single state agency to provide oversight or guidance.

The subcommittee identified some of the primary barriers to meeting the behavioral health needs of students:

1. There are not enough behavioral health professionals in schools or in their communities to serve the students who need services in a timely manner.
2. The system for providing behavioral health supports in schools is fragmented and not really a system.
3. Educators do not receive adequate training to support student behavioral health.
4. Educators and behavioral health providers need training in culturally responsive and trauma-informed behavioral health supports for students.
5. The COVID pandemic has exacerbated and highlighted the need for clinical behavioral health services in schools. Currently, there is no system of support to fund, distribute, or deliver behavioral health services to students in school settings. Instead, school-based behavioral health occurs on an ad-hoc basis, resulting from decisions by individual districts and the availability of resources through grants or other sources.

6. In addition to sufficient resources, it will be important to organize a continuum of social, emotional, and behavioral supports at all tiers, including prevention. Schools also need support to systematically implement a Multi-tiered System of Supports. Behavioral health services, once in place, should be integrated with the MTSS framework so that student needs are routinely screened, identified, and met when they need them and where they can best receive them. Many students who need behavioral health services would benefit from receiving them in school, where they spend much of their time, and in a way that is coordinated with school-based systems and staff.
7. Consistent with the Performance Audit conducted by the Office of the State Auditor (2021), the subcommittee agrees that the lack of a responsible agency for school-based behavioral health inhibits the development of a school-based behavioral health system. There is a lack of data on the level of need for behavioral health services in schools and other settings, what the costs for delivering those services would be, and what an equitable and efficient system for identification of need and service delivery would be.

**Children & Youth Behavioral Health Work Group: *School-based Behavioral Health and Suicide Prevention*
Subcommittee**

Recommendation 1: Behavioral health grants (clinicians in schools) in response to urgent needs of students

Recommendations proposed from subgroups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports
- Maintenance, sustained stability, and recovery services and supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Recommendation 1: Behavioral Health Grants (for clinicians in schools) in Response to Urgent Needs of StudentsRationale:

Subcommittee members want to see more culturally responsive behavioral health clinicians in schools to meet student needs. Complex and fragmented funding systems, provider panel limitations, and limits on billable services under both Medicaid and private insurance plans greatly limit the availability of behavioral health services in school settings.

The subcommittee recommends that funding be appropriated to provide “coverage-blind” services and supports to ensure more equitable access and to allow providers to coordinate their services with school staff through co-location, care coordination, and participation in MTSS teams, IEP teams and other meetings which are not typically billable as behavioral health services.

Recommendation:

The subcommittee proposes providing base-level funding grants for 100 school-based behavioral health positions in 2022 at \$65,000/FTE. To be eligible, school districts would need to designate matching funds from another source to fund full-time positions, including other district funds, grants, Medicaid billing, etc. Each clinician would serve one school. Each clinician should be a masters-level clinician and should be licensed behavioral health providers or be supervised by a licensed clinician and/or licensed agency.

Because the goal is to use state funds to serve students without coverage, students with coverage who cannot receive behavioral health services in timely manner, and to allow the clinician to coordinate services with school staff (e.g., through MTSS team meetings, IEP meetings, and other methods), the funded positions should not be assigned to more than one school, except in instances where the clinician serves two small schools (a combination of no more than 500 enrolled students. Qualified behavioral health provider positions created can be employees of:

- a. A school district
- b. A community behavioral health provider, including, for example, the sponsoring agency of a school-based health center (with the agreement of the school district)
- c. An Education Service District (with the agreement of the school district where the clinician is stationed), **OR**
- d. In instances where options a-c are not available, districts may apply for funding to provide behavioral health services to students via telehealth.

Proposed cost: \$6,500,000 in FY 2022-23.

**Children & Youth Behavioral Health Work Group: *School-based Behavioral Health and Suicide Prevention*
Subcommittee**

Recommendation 2: Gap analysis of behavioral health needs and services

Recommendations proposed from subgroups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports
- Maintenance, sustained stability, and recovery services and supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Recommendation 2: Gap Analysis on the Need for Behavioral Health Services and Recommendations for Funding and Delivery SystemsRationale:

The performance audit highlighted the lack of a lead agency and systemic approach to providing behavioral health in schools. There is a lack of coordination of school-based behavioral health services across the state, a lack of a continuum of care which would provide more intensive services to students in schools when they need them, and there is no single state agency responsible to fund services across the continuum or provide oversight.

Recommendation:

The subcommittee recommends that the Legislature provide funds for a health economist, behavioral health actuary, or similar entity to develop an estimate of the prevalence of needs for all children and youth, including:

- e. The estimated number of children/youth, ages 0-25, who would need clinical behavioral health services on an annual basis.
- f. The estimated costs of providing services that include a range of behavioral health supports (benefit package) commensurate with the projected needs of the population.
- g. Recommendations on the distribution of resources to deliver needed services to children/youth and their families across multiple settings, including:
 - i. Schools
 - ii. Behavioral health outpatient clinics
 - iii. Primary care settings
 - iv. Home and community settings
 - v. Telehealth
 - vi. Intensive outpatient, partial hospitalization, and residential treatment programs
 - vii. Inpatient and other intensive settings

It would be important for this study to occur quickly, with findings due in 2023. The CYBHWG and its subcommittees should use the findings and recommendations to engage in strategic planning and develop future recommendations for funding and delivery systems and structures.

Proposed cost: TBD (may be combined with other subcommittees' recommendations)

**Children & Youth Behavioral Health Work Group: *School-based Behavioral Health and Suicide Prevention*
Subcommittee**

Recommendation 3: Multi-Tiered Systems of Support (MTSS)

Recommendations proposed from subgroups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports
- Maintenance, sustained stability, and recovery services and supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only
- Budget ask
- Agency policy change
- Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation
- New recommendation

Recommendation 3: 2023 and Beyond: Build the Capacity for School Districts to Implement a Multi-Tiered System of Supports (MTSS), including Effective Collaboration with Behavioral Health Systems through an Integrated Systems Framework (ISF)

The subcommittee recommends that the work group support capacity building of Multi-tiered System of Supports (MTSS) in Washington school districts. This will be accomplished by funding regional coaching positions and supports from OSPI, including coordination, training development, evaluation, and administrative supports.

Encourage OSPI to develop a Decision Package for 2023-25 that ensures continuation of Regional Implementation Coordinator (RIC) positions in every region. This would include continuation of provisos supporting two RIC positions (ESDs 105 and 114) and replacing federal grant funding that expires in September 2023 (supporting RIC positions in ESDs 101 and 113).

In order to support more districts annually, add 3.0 FTE RIC positions in the next biennium to increase capacity in regions with the largest student populations, and provide increased support for coordination at the OSPI and ESD levels. Over time, capacity would increase to approximately 20 MTSS implementation coordinator positions to assist all districts to implement MTSS and sustain MTSS with fidelity.

Proposed costs to be determined (approximately \$3.5M-\$4M in 2023-25).

Children & Youth Behavioral Health Work Group: Youth & Young Adult Continuum of Care

Communications and outreach position

Recommendations proposed from subgroups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
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- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative - policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Communication and Outreach Position

Recommendation:

A full-time employee position at the Health Care Authority is needed to improve the communication of existing and new behavioral health laws to stakeholders.

The Issue

The Youth and Young Adult Continuum of Care (YYACC) subgroup has held several meetings over the past year discussing behavioral health service accessibility with as many as 30 youth, parents and families, and other stakeholders. A common theme throughout the meetings is that caregivers and youth are having trouble understanding the behavioral health legislation that affects them.

While the Washington legislature is excellent at crafting behavioral health legislation, the lack of communication with stakeholders about new and existing legislation is an issue with serious ramifications for the lives of youth and their families. Youth and their caregivers consistently report issues with their behavioral health care stemming from a lack of knowledge about behavioral health care legislation present in both themselves and their providers.

The Impact

The impact of this issue on the state budget and society as a whole is large. Because of unclear communication about behavioral health legislation, youth may be receiving inadequate care, which is inefficient and costly for the state, as well as potentially devastating for the youth.

Potential solutions

The YYACC recommends that, to address this issue, a full-time employee position at the Health Care Authority should be funded. This FTE would be responsible for connecting families, behavioral health providers, educators, and other stakeholders with current information about behavioral health care legislation. This job would entail creating shareable content appropriate for specific networks to spread Behavioral Health legislation and resources. The FTE would work alongside the Department of Health, the Department of Children, Youth, and Families and other state agencies, to craft a communications plan involving social media and other forms of direct outreach to providers, families, and youth. In addition, the FTE should be well-known as a readily available resource for those with questions about behavioral health legislation.

We recommend that the FTE have a strong background in communications, ideas for innovative ways to engage families, youth, and providers, and experience in social media marketing and optimization.

Why now?

Our meetings with young adults, families, and providers reveal a severe lack of knowledge about current behavioral health legislation. This has the potential to lead to significant gaps in services and low-quality care. It is imperative that an FTE position be funded to address these issues.

Outreach

The YYACC developed this recommendation because the subgroup was made aware of significant problems in the communication of behavioral health legislation by behavioral health services stakeholders. After hosting several meetings with a diverse and committed group of providers, young adults, and parents, the consensus was that an FTE whose sole job it is to communicate behavioral health legislation to those affected by it is the best way to address this important issue.

**Children & Youth Behavioral Health Work Group: YYACC
Recommendation: Parent portal & tool kit**

Recommendations proposed from subgroups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
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- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Recommendation: Parent Portal/Tool kit

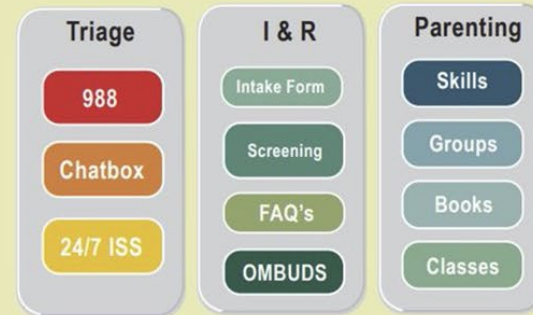
- 1. The Issue:** Parents/caregivers do not have an efficient, user friendly place to access comprehensive information about the behavioral system. The intent of the portal is not to duplicate or replace other websites and call centers, but to instead provide a means to help families navigate quickly to the correct community resource or information. The Parent Portal is intended to be comprehensive by including information about and access to all relevant child serving systems including the Health Care Authority (HCA), Department of Children Youth Families (DCYF), Juvenile Justice and Juvenile Rehabilitation, Department of Disabilities Administration (DDA), Child Protective Services (CPS), and Office of Superintendent of Public Instruction (OSPI). In addition, parents/caregivers will have easy access to book recommendations and educational resources to enhance their ability to support their child.
- 2. The Impact:** The impact on the state budget will be a low financial cost for building a web portal and providing search optimization. Also, there will be a cost for a full-time employee (FTE) to develop and maintain the portal and to market and promote it throughout the state.
- 3. Potential Solutions:** Convene stakeholders including parents/caregivers and youth and young adults to develop a work plan to design the Parent Portal, look for funding partners, and send out an RFP for ongoing care and management of the portal.
- 4. Why Now:** The Parent Portal provides an opportunity for parents/caregivers to connect to behavioral health and education infrastructure, learn additional parenting skills, access resources, connect to parent support and more. The Parent Portal will help reduce disparities by creating a one stop location for all families with children ages 0-25 to access relevant child serving systems. Parents/caregivers across the state have identified challenges to accessing care, services, and information. System parents have also shared the same challenges and would be able to connect the families they serve to the Parent Portal.
- 5. Outreach:** The idea for the Parent Portal was presented to the Youth, Young Adult Continuum of Care (YYACC) subgroup by a parent advocacy group, Healthy Minds/Healthy Futures. They are also collaborating with Washington State Community Connectors (WSCC) and have started to develop and identify evidence-based programs, materials for parents, and additional tool kit components.

Parent Portal & Tool Kit

Parenting children, youth, and young adults with emotional regulation problems is not intuitive. The Parent Portal & Tool Kit will seamlessly connect families to their community's behavioral health and education infrastructure.



Our Proposed Solution:



Children & Youth Behavioral Health Work Group: YYACC

Recommendation: Ensuring stable housing and care coordination for youth exiting inpatient settings

Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
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Type of Recommendation

- Legislative - policy only** **Budget ask** **Agency policy change** **Rule change**

Is this a previous priority of the work group or is it new?

- Previous recommendation** **New recommendation**

The Issue

Safe, quality, supportive housing is essential to helping transition age youth (TAY) remain in recovery from mental health and substance use challenges post-release from inpatient behavioral health settings. Of TAY who experienced homelessness within a year of exiting a system of care (foster care, JR, behavioral health inpatient), two-thirds experienced homelessness post-discharge from the behavioral health system. Our system should bring down the moon for youth who have the courage to seek help, not kick them to the curb.

The Impact

It is wildly unrealistic to expect TAY to maintain symptom remission, follow through on outpatient treatment and pursue recovery goals while experiencing the daily traumatic experience that is homelessness and housing instability. TAY living with behavioral health challenges who are experiencing homelessness are much more likely to be re-hospitalized, to visit the emergency department and to encounter the criminal legal system—all at great expense to state and local governments.

Potential Solutions

- **Implement youth and family peer bridgers for TAY discharging from behavioral health inpatient settings:** Identify and address barriers to implementation of youth and family peer bridgers who support TAY while transitioning from inpatient/residential treatment back to the community
 - *Estimated costs:* TBD based on determining existing barriers to uptake of peer bridgers
- **Expand short and long-term behavioral health housing vouchers and earmark for TAY:** Create TAY-specific funding under the HARPS (short-term) and CBRA (long-term) behavioral health rental voucher programs
 - *Estimated cost:* Scalable, \$2,000,000 general fund state and up
- **Grant funding for the development of TAY-specific SUD recovery housing and mental health recovery housing:** Funding to the Department of Commerce to provide grants to SUD and mental health recovery housing providers for start-up and ongoing operating expenses related to the establishment of TAY-specific recovery housing
 - *Estimated cost:* Scalable, \$500,000 general fund state and up
- **Flexible funds to prevent TAY homelessness upon discharge:** Create a pot of flexible funds to prevent youth from experiencing homelessness post-discharge from behavioral health settings. This could include funding for plane or bus tickets, short-term hotel stays etc.
 - *Estimated cost:* Scalable, \$250,000 and up. This may be an allowable use for mental health and substance use disorder block grant funds. If not, it would have to be general fund state dollars.
- **Amend managed care contracts to require housing-related care coordination and fund an FTE at HCA to provide oversight over MCO contracts related to transitions from inpatient behavioral health care:** Amend HCA contracts with MCOs to add a requirement that MCOs provide housing-related care coordination for individuals discharging from inpatient behavioral health settings (MCOs currently have this requirement for plan enrollees releasing from correctional settings). Fund an occupational nurse consultant to provide oversight and potential corrective action related to MCO obligations for care coordination upon discharge from behavioral health settings. These obligations include systemic protocols to ensure follow-up care was accessed, the identification

and re-engagement of enrollees who do not access follow-up care, telephonic reinforcement of the discharge plan and problem solving within 48 to 72 hours of discharge, and an assessment by the enrollee's primary care provider or care coordinator within a week of discharge. These obligations exist in contract but are largely not being met in reality.

- *Estimated cost:* \$83,000 general fund state; \$248,000 general fund federal for one occupational nurse consultant
- **Create performance measures related to TAY housing stability and a plan for performance improvement targets and value-based purchasing according to those metrics:** Direct the Performance Measures Coordinating Committee to develop performance measures which track TAY Medicaid enrollees who have a behavioral health diagnosis and experience homelessness. Direct the HCA to establish performance improvement targets and a plan for integrating value-based purchasing terms and a performance improvement project into managed care contracts related to those measures.
 - *Estimated cost:* \$44,000 general fund state, \$136,000 general fund federal

Why now?

In 2018, the legislature passed Senate Bill 6560 directing that a plan be developed to ensure no unaccompanied youth is discharged from a public system of care into homelessness and a declaration that beginning January 1, 2021, any youth leaving a public system of care would be discharged into safe, stable housing. Tragically, the funding and policy necessary to achieve this declaration has not been realized.

Outreach

There has been extensive study of this issue, including the original A Way Home Washington report, the SB 6560 report, and the recent report "Safe and supportive transition to stable housing for youth ages 16-25." Addressing the issue of youth exiting behavioral health systems into homelessness has been a top priority of the YYACC this interim as demonstrated through both YYACC committee meetings and a survey sent to YYACC members.

Oral amendment - proposed and approved at 10/15/2021 work group meeting:

Added expanding behavioral health supports in youth shelters as a 7th potential solution.

**Children & Youth Behavioral Health Work Group – Behavioral Health Integration Subgroup
2022 Recommendations to CYBHWG Brief – October 2021**

Recommendations:

1.) Provide funding for start-up activities for primary care clinics (pediatrics or family practice) that are committed to establishing collaborative care for children and adolescents.

\$2M to support start-up costs at 10 clinics, including support of expert agencies like Hope Sparks, UW AIMS Center, FAST training (time-limited evidence-based interventions) from Seattle Children’s psychologists, and / or Seattle Children’s Care Network.

2.) Finance non-licensed professionals, such as health navigators or community health workers, in primary care settings to support coordination of care for behavioral health needs and helping families to address Social Determinants of Health.

- a. Direct HCA to submit a state Medicaid Plan amendment to allow funding of non-licensed professionals to serve children and adolescents on Apple Health through Value Based Contracts with PMPM payments adequate to support this role.
- b. Direct HCA to determine appropriate PMPM to fund these roles for implementation in the January 1, 2023 contract year. Fund provision of this PMPM in the 2022 supplemental session for financing January 1, 2023-June 30, 2023.

What is the issue?

Before the COVID-19 pandemic, behavioral health disorders affected about one in five children. Pre-pandemic the National Health Interview Survey found unmet mental health needs for 80% of Black, 82% of Hispanic, and 72% of white children. Today needs have grown substantially. During the pandemic, 11-17-year-olds have been more likely than any other age group to have moderate to severe anxiety and depression. In September 2020, over half of teens reported frequent or even daily thoughts of suicide or self-harm and children’s significant Emergency Department (ED) use and steeply rising hospitalizations for BH reasons are now well-documented in WA State.

At Mary Bridge Children’s Hospital, the current length of stay in the ED for patients with BH issues is 30 hours (the range of stays runs 6 hours to 6 weeks). This often means that a room in the ED is taken offline for children’s medical needs while BH patients are boarding to provide a safe space for those patients. 80% of patients with BH issues are discharged from Mary Bridge’s ED to the community, indicating that outpatient care can be a more appropriate way to help this population. Primary care clinics with integrated behavioral health services, including care coordination, can be an important resource to help children and adolescents sooner, in more appropriate and less costly settings.

The 2018-2019 Consumer Voice Listening Project conducted by HealthierHere and the Center for Multicultural Health included 2,860 surveys with individuals, specifically seeking input from community-based organizations dedicated to BIPOC. Even before the crisis we face today, behavioral/mental health was the number one health condition for the majority of the communities surveyed, and in the top 3 health conditions for all respondents.

A November 2020 WCAAP study found typical waits of 1-2 months for children and youth to receive an intake with a behavioral health provider, and 78% of primary care doctors receive no further information or coordination after they refer kids for behavioral health care outside their office. Before the pandemic, over 25% of pediatric primary care visits were for behavioral health concerns -- today more than half of primary care appointments are for behavioral health needs. Primary care is not currently resourced to rapidly provide behavioral health care or to coordinate the services children and youth need.

How does this recommendation advance timely identification, access and equity?

Primary care is the first place many families turn for help with children and teens' symptoms, worries, anxiety, or depression and nearly 100% of children under age three regularly visit primary care, affording a unique and important opportunity to support parents of the youngest children. Primary care settings are a critical link to aid in identifying and addressing mental health problems for BIPOC. [Toward Culturally Centered Integrative Care for Addressing Mental Health Disparities among Ethnic Minorities \(nih.gov\)](#) Yet behavioral health integration in primary care for children and youth is the exception not the norm, and significant unmet needs exist for timely, effective treatment and coordination of care with schools, specialty behavioral health clinics, and other places where kids are seen.

Pediatricians, family physicians and other primary care professionals play a critical role in screening, early identification and timely support for kids' behavioral health needs. However, many primary care clinics are overburdened and cannot adequately meet children and teen's rapidly rising behavioral health needs. It is a critically important time to invest in transformative efforts to maximize our primary care and behavioral health workforce.

Increasing primary care capacity for evidenced-based mental health care is an essential approach to supporting kids' mental health needs and preventing children's symptoms from worsening to crises. We know behavioral health integration in primary care can be well-executed and achieve results. In 2021, the BHI Subgroup learned Washington State clinics implementing collaborative care for children and youth are achieving measurable improvements for patients and that programs are financially viable if carefully established and when billing for collaborative care. Without funding for start-up costs, including initial staffing and training, primary care clinics serving children who want to adopt this proven and cost-effective modality for providing BH care are unable to do so.

A second solution to timely and effective support for kids in primary care is increasing non-licensed staff supports for children and families. We advocate for this “rational redistribution of tasks among health workforce teams” whereby specific tasks are delegated to a non-licensed health workers to make more efficient use of our very stressed health professional and behavioral health workforce. “This study confirms partially the existing evidence on the effectiveness of CHW interventions as a strategy to address mental health in primary healthcare” [Int J Environ Res Public Health](#).

There is a growing body of knowledge of the qualities and functions that make community health workers or family navigators effective supporting families’ and children’s SDoH and mental health needs. In addition, these roles can be critical in advancing health equity and supporting clinics to be culturally and linguistically responsive and anti-racist.

What is the impact on the state budget and society?

\$2M in start-up funding to build collaborative care in primary care clinics for children could result in 10 more primary care sites providing timely identification and evidence-based treatment for children and youth.

We will work collaboratively with HCA and key stakeholders knowledgeable in value based payment and population-based financing strategies to determine the funding needed for a per member per month payment for Apple Health for Kids to be in place effective January 1, 2023 – June 30, 2023 (for the first 6 months of the calendar year / supplemental budget) for the MCO contract year and as an ongoing part of health care financing on Medicaid.

Continuing to delay or failing to treat children and families’ behavioral health needs has a significant cost to our society. Timely access to prevention and early intervention services is cost effective in children and teens, reducing the need for more costly emergency room and hospital care. HopeSparks and Pediatrics Northwest launched collaborative care in primary care pediatrics in January 2020 and none of the patients served in their program since its launch have had an emergency department visit for mental health reasons. An emergency department visit for mental health reasons costs about \$7,000 - \$9,000 and in the typical time it takes an emergency department to serve one child for mental health reasons, nine children with medical needs could have been served by that emergency department.

In a large-scale study of behavioral health integration for children in the greater Boston area, total emergency department behavioral health spending decreased by 19% and ED volumes remained flat for children who had BH integration, while ED visits for BH reasons increased 86% at another medical center serving children and adolescents who did not benefit from BH integration. These results appear to indicate that early identification and intervention in lower-cost primary care settings can decrease overuse of high-cost emergency BH services, although this remains to be definitively demonstrated. [Five-Year Outcomes of Behavioral Health Integration in Pediatric Primary Care](#) Pediatrics, 2018.

“Community health workers...are an integral part of the medical home team and serve as a bridge between the practice and the community and as a foundational point of trust and engagement with families and their children. The challenge now is to spread, scale, and sustain such efforts across many more medical homes and to incorporate their financing into public (and private) health coverage.”

Bruner, C.H., M, et al., Dismantling Racism: 10 Compelling Reasons for Investing in a Relational/Community Health Workforce for Young Children and Their Families. 2021: Des Moines, IA.

A key role that behavioral health integration programs and health navigators or community health workers can play in primary care pediatrics is to ensure that systematic and reliable screening is occurring for postnatal mood disorders at baby visits in the first 6 months of life and also for kids' behavioral health ages 11-18. Health navigators or community health workers can help ensure that new parents and kids get timely supports when screens show need.

Untreated postnatal mental health needs are the largest contributor to preventable maternal mortality in our state. Evaluating one U.S. birth cohort (2017) from conception to age 5, and found perinatal mood and anxiety disorders cost \$14.2 billion. (The authors projected a cost estimate range from \$2.5B to \$63.4B).

- The average cost per mother-child dyad was \$32,000
- 65% of the costs were incurred by the mother and 35% of the costs were incurred by the child. That is approximately \$19,500 per mother and \$12,500 per child.
- Most maternal costs were attributed to reduced economic productivity (\$4.7B), maternal health expenditures (\$2.9B) particularly with increased use of safety net services, suboptimal breastfeeding, and maternal suicide.
- Child costs were related to behavioral and developmental disorders (\$1.6B), low birth weight or preterm birth (\$3.3B), increased risk of SIDS, and an increased risk of worse child outcomes (injuries, asthma, obesity, fewer well-child visits)

Luca, D. L., Margiotta, C., Staats, C., Garlow, E., Christensen, A., & Zivin, K. (2020). Financial Toll of Untreated Perinatal Mood and Anxiety Disorders Among 2017 Births in the United States. *American journal of public health, 110*(6), 888–896.

<https://doi.org/10.2105/AJPH.2020.305619>. Integrated care with robust screening and care coordination can identify and treat maternal mood disorders and other problems for early childhood wellness that often go undetected, with significant impacts on families and society.

Reliable screening means catching issues earlier and supporting patients and parents as soon as possible

Children & Youth Behavioral Health Work Group: Behavioral Health Integration
Recommendation: Startup funds for behavioral health integration in primary care settings

Recommendations proposed from subgroups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)**
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Priority 1: Provide start-up funds to clinics which demonstrate objective and specific readiness to build collaborative care behavioral health integration programs in primary care settings.

Ask: Provide \$2 million to fund eligible clinics to put integrated care programs in place and for training and technical assistance provided by clinical programs which have established pediatric BHI in primary care to advise on start-up activities. Based on experience of several existing programs, \$200,000 in start-up funds is needed for a clinic to establish an integrated behavioral health program, including necessary training.

Eligibility for funding would be targeted at those clinics deemed by HCA to have a viable plan for implementation of integrated care, that includes, but would not be limited to, the following:

- A primary care champion or proponent of the program
- Support for implementation at the highest level of clinic leadership
- A behavioral health professional located at the clinic
- An arrangement for psychiatric consultation and supervision
- A registry tracking the symptoms of patients
- A team approach to care
- Universal screening for behavioral health issues and social determinants of health
- Provision of care coordination, including coordination with schools, ED's, hospitals, and other points of care
- Family and child engagement
- The ability to bill under the collaborative care codes (this is not to preclude billing under other codes in addition, such as those for psychotherapy)
- Ensuring "closed-loop" referrals and engagement in specialty behavioral health care when indicated

Start-up costs covered would include:

- Training, including in such operational elements of integration as developing work flows to ensure that team-based care is provided, and in evidence-based practices, including brief interventions for children with mild to moderate behavioral health challenges
- Development of reliable and systematic workflows, including a multi-disciplinary team approach to screening parents postnatally and children and teens ages 11 and older as indicated by Bright Futures standard of care
- Commitment to monitor screening rates and modify workflows as needed to ensure universal screening
- On-boarding of behavioral health professional, with salary support while developing a caseload
- On-boarding of psychiatric support person (M.D. or ARNP), including initial salary support
- Clinical oversight
- Development of partnerships with community mental health centers for referral of patients with higher level needs
- IT infrastructure, including necessary EHR adjustments and creation of a registry

- Space needs for additional staff

Recommendation re BHI Training Centers

The subgroup recognizes that there are organizations with significant expertise based on experience in setting up BHI programs tailored to the unique needs of pediatric populations, that are evidence-based and effective. We believe that there will be significant benefits, including cost-savings, from supporting centralized training and technical assistance to clinics in implementing pediatric-specific BHI programs.

**Children & Youth Behavioral Health Work Group: Behavioral Health Integration
Recommendation: Reimbursement for non-licensed staff in primary care settings**

Recommendations proposed from subgroups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)**
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative-policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Priority 2: Reimbursement for non-licensed staff like Community Health Workers, navigators and care coordinators to support kids' behavioral health in primary care settings.

Ask: Fund per member per month for children insured on Apple Health adequate for clinics to provide these critical support services.

Specific Activities that a non-licensed support staff does or should do to support BH in primary care

- 1- Support families to connect with and access services for specific family needs, including:
 - Financial, food, housing, and other social determinants of health resources
 - Insurance coverage enrolling/reenrolling
 - WIC and newborn resources
 - ABA, birth to three referrals, early intervention
 - Child Find, ECAEP, Head Start, school district services
 - Postpartum resources
- 2- Support care navigation process for primary care, mental health care, schools, or care elsewhere, such as:
 - Coordinate scheduling for appointments and services
 - Remind patients of upcoming appointments
 - Connect with patients after appointments to determine and remind of next steps, as needed
 - Follow families after specialty mental health care at 30, 60, and 90 days
 - Coordinate PCP appointments, collaborating with patients to access PCP scheduling and addressing barriers and concerns
 - Collaborate with DDA case managers to help families seek resources for in home services or determine who their case worker is
 - Follow up on birth to three referrals to ensure connection for children needing early intervention.
 - Refer to school districts and educate parents on Child Find services as well as ECAP and Head start
 - Obtain releases of information to obtain records from school and other providers
 - Communicate updates to behavioral health provider, psychiatrist
- 3- Offer specific patient education
 - What to do in crisis situations
 - Basic mental health coping strategies for parents and children

Specific Activities that a non-licensed support staff does or should do to support BH in primary care (cont.)

- Parenting strategies and skills
- 4- Oversee monitoring, communication, and outreach related to
 - Community availability of health and mental health resources
 - Registries of families who have not connected with care teams
 - High-risk families who do not show for appointments

- 5- Complete screenings and forms as needed, including:
- 6- Identify behavioral, developmental, and/or social determinants of health using a validated instrument
- 7- Document referrals and connection to services in the electronic health record
- 8- Administrative support for Licensed Mental Health Professional
- 9- Transmit time-sensitive documents at the request of LICSW managing CPS cases, school coordination, CoCM, and all other records requests.
- 10- Organize, scan and track all documents including but not limited to: school release (ROI's), completed rating scales (e.g. Vanderbilt, SDQ, SMFQ, SCARED), and any documents that arrive from CPS or foster care.
- 11- Manage and support LICSW BHIP and psychiatry schedule as directed by LICSW after full assessment and triage is completed by LICSW.
- 12- Organize, manage, schedule, and facilitate Care Management meetings with pediatric and family physicians. Manage patient list as directed by entire team.
- 13- Work weekly and closely with LICSW to work BHIP/SW/Psychiatry queue

Children & Youth Behavioral Health Work Group: Workforce & Rates**Recommendation: Explore development of Certified Community Behavioral Health Clinics**

Recommendations proposed from subgroups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- ? **Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation (budget and policy)

- Legislative - policy only Budget ask Agency policy change Rule change

Is this a previous priority of the work group or is it new?

- Previous recommendation New recommendation

Children & Youth Behavioral Health Work Group – *Workforce/Rates Subgroup* Recommendations Brief – Certified Community Behavioral Health Clinic (CCBHC)

Recommendation:

Develop a sustainable, alternative payment model for comprehensive community behavioral health services by studying the Certified Community Behavioral Health Clinic (CCBHC) model, conducting related actuarial analysis, and proposing a pathway for statewide implementation. Transformative action is needed to stabilize the behavioral health safety net and ensure access to care.

1. What is the issue?

Community behavioral health agencies (BHAs) are the essential safety net providers for children, youth, and families experiencing mental health and/or substance use disorders. Chronically low Medicaid rates leave BHAs unable to offer competitive salaries and compensation to their employees. This historical baseline has been exacerbated by a growing national behavioral health workforce shortage and simultaneous loss of workers due to pandemic-related concerns (e.g., no childcare, family illness, vaccine mandates). Competition for behavioral health workers is extreme and accelerating, and the compensation gap is growing.

The Washington Council for Behavioral Health recently reported these alarming trends:¹

- Over half of surveyed provider agencies have closed or limited access to outpatient services
- Vacancies for master level clinical staff average 30% and are as high as 60% in rural communities
- All-staff vacancy rates have increased by 38% in the past five months
- Annual turnover rates have climbed to 30%
- More treatment beds have been taken offline and branch office sites have closed

Low Medicaid rates paid to BHAs are directly tied to low wages and the current workforce drain. Many BHAs are struggling to remain viable. Medicaid rate increases and/or provider relief funds can help stem the tide; however, these have been piecemeal, short-term approaches, and a longer term, transformational solution is needed. The CCBHC model would accomplish this by bringing consistency in program standards and accountability for quality metrics while establishing a payment model that is tied to actual costs of providing care.

2. What is the impact on the state budget and society?

Access is severely limited across the state. It is unprecedented that BHAs are limiting or closing admissions for basic outpatient services to new patients. In addition, clinic branch offices are closing; treatment bed capacity has been reduced (CLIP, E&T, SUD residential); and waitlists are growing. People cannot receive routine, ongoing treatment. Therefore, crisis calls are surging, as are referrals for WISE services. System partners are frustrated and overburdened.

Quality is impacted: Other impacts include staff turnover and multiple changes in assigned clinician, longer waits between appointments, and loss of same-day appointments.

Use of more costly acute care resources including emergency room visits, hospitalization, and encounters with law enforcement.

Most disturbing is the inability to respond promptly to individuals and families seeking and needing behavioral healthcare.

¹Washington Council for Behavioral Health, workforce survey of licensed behavioral health agencies completed in August 2021.

Our state is in the midst of key system reform and transformation initiatives that depend on a thriving, accessible community behavioral health safety-net, including:

- Pandemic-related increases in behavioral health needs, particularly among children and youth.
- Coming implementation of Washington’s 988 line, and planned expansion of the behavioral health crisis response system, which is primarily located in the behavioral health safety-net system.
- Governor Inslee’s state psychiatric hospital transformation, transitioning civil commitments out of the current large state hospitals with a goal of building out capacity for long-term inpatient detention in smaller community settings.
- Police reform initiatives that re-imagine policing and diminish or remove law enforcement’s role in behavioral health crisis intervention; successful implementation of alternative models calls for a more robust community treatment and crisis intervention system, proactive identification, outreach, engagement, and early intervention to get help to people sooner and keep people safe.
- Achieving the promise of integrated whole person care to improve the overall health status of children, youth, and families.

3. What options do we have to change this?

We recommend a planning workgroup to develop a sustainable, alternative payment model for comprehensive community behavioral health services by studying the Certified Community Behavioral Health Clinic (CCBHC) model, conducting related actuarial analysis, and proposing a pathway for statewide implementation. Funds are needed to secure actuarial expertise; conduct research into national data and other state models, including resources from the National Council for Mental Wellbeing CCBHC Success Center; and staff a planning workgroup inclusive of BHA participation and input. We anticipate a proviso request of \$200,000 for fiscal year 2023.

The CCBHC model offers a promising alternative to alleviate decades-old challenges that have resulted in the current crisis in access to mental health and addiction treatment. As an integrated and sustainably financed model for care delivery whereby CCBHCs:

- **Ensure access** to integrated, evidence-based addiction and mental health services, including 24/7 crisis response, integration with primary care, and medication-assisted treatment (MAT).
- **Meet stringent criteria** regarding timeliness of access, quality reporting, staffing, and coordination with social services, criminal justice, and education systems.
- **Receive funding** to support the real costs of expanding services to fully meet the need for care in their communities.

Specifically, the CCBHC model addresses historical financing shortfalls by paying clinics a Medicaid rate **inclusive of anticipated costs of expanding service lines, adding staff and/or increasing staff salaries to address recruitment and retention, and serving new consumers.** This is done through a prospective payment system (PPS) similar to one already in place for other safety-net providers like FQHCs and RHCs. **A PPS model is fundamentally different** because it is forward-focused, not based primarily on (and therefore limited by) historical utilization levels and outdated cost assumptions that are part of the existing Medicaid managed care rate structure.

For states that pursue the CCBHC evidence-based model, there are expanded federal resources that could be leveraged to support CCBHC development and operation.

4. Given current circumstances, why is taking the recommended a smart move now?

The need for behavioral health treatment is accelerating while the access to care and capacity to provide treatment are diminishing. Washington cannot afford to lose additional system capacity and infrastructure of the behavioral health safety-net. It is time for longer term, transformational approach and investment. In addition:

- National momentum for expansion of the CCBHC model is growing, with support from the Biden administration, multiple state level initiatives, and current congressional proposals to expand the Excellence in Mental Health and Addiction Treatment Act ([H.R. 4323/S. 2069](#)) which established the CCBHC model.
- There is a growing body of strong evidence and outcome studies in other states where this model has been implemented including a just-released [Transforming State Behavioral Health Systems: Findings from States on the Impact of CCBHC Implementation](#). This report details CCBHC impact on cost and outcomes in the eight demonstration states. Another recent CCBHC impact report, [Leading a Bold Shift in Mental Health and Substance Use Care](#), documents nationwide results for demonstration and other states.
- Washington is currently home to twelve CCBHC programs funded by expansion grants. While other providers are shrinking, these programs are building valuable experience, increasing access to care and expanding service offerings, and having a positive impact on health and behavioral health quality metrics for their patients. Sustainability of this progress must be supported especially while we begin building a statewide approach for CCBHCs.

Investing in a planning process now will contribute to long-term stability and viability of essential behavioral health safety net providers and a strong, accessible community behavioral health system.

5. Describe any outreach that helped to develop this recommendation.

The effects of COVID have had a disproportionate impact on the populations served by the Medicaid program, especially among communities of color and in rural areas of the state. BHAs are by far the largest provider network responding to Medicaid enrollees in need of mental health and addiction treatment and recovery supports, and the state depends on these essential safety-net providers to meet the needs of those in underserved communities. The Health Care Authority has submitted a related decision package request to explore the CCBHC model because it is increasingly clear that if the state continues to underfund the community behavioral health system and does not implement a sustainable financing mechanism, access to treatment and recovery supports for individuals and communities will keep diminishing.

Children & Youth Behavioral Health Work Group: *Workforce & Rates*
Recommendation: Clinical supervision work group

Recommendations proposed from subgroups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)
- Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy** (Medicaid and private insurers)
- Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
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- Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

- Legislative - policy only** **Budget ask** **Agency policy change** **Rule change**

Is this a previous priority of the work group or is it new?

- Previous recommendation** **New recommendation**

Children & Youth Behavioral Health Work Group – Workforce / Rates Subgroup**Recommendation:**

Recommend a bill creating a clinical supervision workgroup. This workgroup shall be made up of individuals with clinical supervision experience to make recommendations for all three masters level licenses on the number of supervision hours, and any specific specialty supervision hours needed. Some funding will be needed to support the workgroup.

1. What is the issue?

Prior to full licensure, all associate level behavioral health licenses require a certain amount of supervised clinical practice. Ranging from 3000-4000 hours. This is an enormous hurdle to cross for individuals entering the workforce. This workgroup will make recommendations on the quantity and quality of supervision hours for each of the 3 masters level credentials (Social Workers, Mental Health Counselors, and Marriage and Family Therapists).

2. What is the impact on the state budget and society?

Increasing our workforce will make it easier for people to find treatment.

3. What options do we have to change this?

The workgroup will include experts in clinical supervision from all three licenses, representatives and from community behavioral health agencies and hospitals. It shall also include consultation with the relevant graduate degree programs. The workgroup shall report back to the legislature their recommendations on streamlining supervision requirements.

4. Given current circumstances, why is taking the recommended a smart move now?

Supervision is a known challenge, but intense work is needed to find a solution that works for all the masters level behavioral health credentials, and yields actionable recommendations.

5. Describe any outreach that helped to develop this recommendation.

The recommendation was developed by the associations representing the impacted professions in consultation with folks at the rates / workforce subcommittee.