Children and Youth Behavioral Health Work Group

Recommendations for the 2024 legislative session

CATEGORIES

New: New recommendation, not previously recommended
Legacy: Related to established legislation that requires further advancement to achieve its original aims
Previous: A recommendation previously put forward that has not yet advanced

$ < $500,000 **$$** = $500,000 -$999,000 **$$$** = $1 million - $10 million **$$$$** > $10 million **n/a** No cost

Budget Ask: Requires new funding to be allocated
Legislative Policy: Requires legislative action
Agency Policy Change: Requires agency action

Overarching recommendation (Link to detail, page 7)

Legacy **$-$$$** **Legislative Policy**	Update House Bill 1890 (2022) to reflect current work plan for the P-25 Behavioral Health Strategic Plan Update legislation directing development of the P-25 Strategic Plan to: Adjust delivery times, align advisory group membership, and update plan content to reflect learnings from the first year, and ensure this effort is included in the work of the Joint Select Committee on Health Care and Behavioral Health Oversight, the Joint Executive Legislative Committee on Behavioral Health – both established in 2023 – and the Substance Use Recovery Services Advisory Committee (SURSAC).

Subgroup recommendations

Behavioral Health Integration (Link to detail, page 10)

New **$$$** **Budget Ask** **Legislative Policy**	Finance behavioral health care coordination as performed by community health workers Fund care coordination activities performed by Community Health Workers (CHWs) under the supervision of licensed providers to address the behavioral, emotional, social, and developmental needs of children on Apple Health (Medicaid). Approximately 43% of children with mental health conditions[1] require coordination beyond what occurs during their visits to ensure they successfully navigate from screening to services, carry out the care plan, and adjust the care plan as needs change. Almost half of these needs are currently going unmet. Primary care providers and behavioral health professionals are straining to coordinate care for the kids who need it, which compromises the care delivered. CHWs, who bring a wealth of community experience and for whom no professional degree is required, can do much of this work and be a tremendous help to overwhelmed primary care providers and behavioral health professionals. By providing a sustainable source of funding for CHWs, the state could increase capacity and ensure that children are receiving care that is culturally appropriate and responsive to their needs.

[1] Brown, et. Al. *Need and Unmet Need for Care Coordination Among Children with Mental Health Conditions. PEDIATRICS 133:3* (2014). Care Coordination-Pediatrics 2014 (1).pdf

Prenatal through Five Relational Health (Link to detail, page 14)	
New **$$-$$$$** **Budget Ask** **Legislative Policy**	Expansion of the Early ECEAP (birth to three ECEAP) program *ECEAP (pronounced "e-cap") = Early Childhood Education and Assistance Program* P5RH recommends both a fiscal allocation and policy change to expand Early ECEAP (Early Childhood Education and Assistance Program) services. Budget request: We recommend an expansion of the Early ECEAP (aka birth to three ECEAP) program, a comprehensive, childcare partnership model for high-need children 0-3 who need both classroom and family support services. Early ECEAP is modeled after the federal Early Head Start childcare partnership program that has been shown to reduce families' involvement with child protective services (CPS). It combines robust trauma-informed approaches with children and parents with high quality early learning (ECEAP evaluative brief). Policy request: We also recommend a policy change to allow continued eligibility for Working Connections Child Care (WCCC), our state's childcare subsidy program, for ECEAP/Early ECEAP, counting the intensive family partnership requirement as 'work activity.'
Legacy **$-$$$** **Budget Ask**	Increase investment in Infant and Early Childhood Mental Health consultation (IECMH-C) Increase investment in Infant and early Childhood Mental Health consultants (IECMH-C) by $1.75 million annually to address unmet need and increase equitable access to IECMH-C for WA's children, families, and adult caregivers in childcare. Funds would be used to: 1. Expand capacity to provide individualized mental health consultation services to more providers; 2. Provide IECMH-C services by linguistically and culturally matched consultants; and 3. Address ongoing program needs to maintain quality and increase access.
Youth and Young Adult Continuum of Care (Link to detail, page 20)	
Legacy **$-$$** **Budget Ask** **Legislative Policy**	Deliver and sustain approved funding for BH360 (formerly Parent Portal) Fund development of BH360, previously known as the Parent Portal, by amending the 2023 budget proviso to use state funds for this purpose instead of the federal Mental Health Block Grant (MHBG) funds currently specified in the budget. Federal regulations prevent the use of MBHG funds for early intervention services like BH360, which are essential for preventing behavioral health conditions from escalating. BH 360 is a one-stop resource for families and caregivers of youth with behavioral health challenges. The design and implementation of the website will deliver educational content and information to help families access programs and providers statewide. To remain relevant, BH360 will require sustained funding to update and expand content regularly.
Previous **$-$$$** **Budget Ask**	Accelerate the adoption of technological innovations across the behavioral health continuum of care Create a pot of flexible funds to identify and pilot the utilization of technological innovations to scale access to a variety of services across the behavioral health continuum of care. Deployed properly, technological innovations improve equitable access to services, short- and long-term patient crisis management and stabilization, patient adherence to treatment plans, efficiency of clinician workflow, documentation compliance and continuity of care, all while reducing overall cost and liabilities across the behavioral health continuum of care from assessment and early intervention to treatment and recovery support services.

New **$$$** **Budget Ask** **Legislative Policy**	Ensure equitable access to and realize the intended outcomes of intensive programs serving youth and young adults with the most complex behavioral health needs Programs such as PACT (Program of Assertive Community Treatment), HOST (Homeless Outreach Stabilization Transition), WISe (Wraparound with Intensive Services), and New Journeys (for First Episode Psychosis) are intended to support individuals with complex behavioral health needs. These programs are not currently delivering the full continuum of care to all of the youth and young adults they are intended to serve. We recommend that the legislature: • Allocate funds and direct a task force to recommend concrete solutions to current challenges with access and implementation by December 31, 2024; • Remove the substance-use disorder (SUD) eligibility requirement of HOST to expand access; and • Increase funding to achieve parity across these programs while creating accountability for program effectiveness and accessibility. These improvements will ensure state standards are met to support better life outcomes for youth and young adults at the more intensive needs end of the continuum of care.
Workforce & Rates (Link to detail, page 27)	
New **n/a** **Legislative Policy**	Reduce administrative complexities in the Wrap-around with Intensive Services (WISe) program Direct the Health Care Authority (HCA) to create parity in clinical auditing practices between physical health and behavioral health providers. Process auditing is particularly burdensome for the Wraparound with Intensive Services (WISe) program. This burden is leading to a shortage of individuals willing to provide WISe services and to instability for youth engaged in this service. Achieving parity requires HCA to transition from audits focused on process to tracking three industry-standard, age-appropriate, outcome-based measures and conducting an annual youth/family satisfaction survey designed to demonstrate the effectiveness of this program for youth and families in Washington State.
New **$$-$$$** **Budget Ask** **Legislative Policy**	Public access to behavioral health data Access to data for workforce planning is a major challenge in the field of behavioral health. Washington is one of the few states in the nation where administrative data from multiple sources is systematically collected, yet we lack a comprehensive view of the many factors affecting the stability and effectiveness of the behavioral health workforce. The Workforce & Rates subgroup recommends that a centralized data repository be created using linked administrative data to create visualizations for a wide variety of non-technical end-users. The subgroup requests allocating funds and implementing a potential legislative requirement for sharing administrative data with the public, within the confines of confidentiality rules. Creating the repository will require two FTE.
Legacy **$$-$$$** **Budget Ask**	Certified community behavioral health clinic (CCBHC) bridge funding To ensure successful completion of implementation of a statewide CCBHC model, the state should support and sustain the current CCBHC expansion grant programs by providing bridge funding to current CCBHCs in Washington during the statewide planning process.

New **n/a** **Legislative Policy**	Allow funding for the Washington Health Corps Behavioral Health Program to be used for conditional scholarships Amend the current Revised Code of Washington (RCW) 28B.115 so that the Behavioral Health program funding language mirrors the language used for the general Washington Health Corps. This would enable Behavioral Health program funding to be used for conditional scholarships. The language is currently limited to loan repayment.
New **$** **Budget Ask** **Legislative Policy**	Evaluation of loan repayment programs As part of supporting the investments made in loan repayment programs in Washington, the Workforce & Rates subgroup recommends the Legislature require an evaluation of the Washington Health Corps' portfolio of loan repayment programs to understand outcomes. Assessment of the Washington Health Corps can determine if the Corps is meeting its statutory goal of encouraging more healthcare professionals to work in underserved areas. The evaluation can also help the state meet equity goals by determining if there are structural issues causing inequitable program access or outcomes for different communities or areas of the state.
New **$$$** **Budget Ask** **Legislative Policy**	Fund House Bill 1724 stipend program for recent graduates in the behavioral health field Allocate funds to the Washington State Department of Health (DOH) for the stipend program they were directed to establish per HB 1724[2] and amend statute as necessary to activate other models if recommended. Other emerging models to enable individuals to complete the necessary hours to obtain their credential include expanding the school social worker proviso[3] that was included in the 2023-25 budget and contracting directly with behavioral health professionals to provide supervision so individuals seeking supervision don't have to pay out of pocket for this service. These alternative models may be lower cost and lower in administrative burden or could combine with the stipend program to broaden access to a wider pool of recent graduates.
New **n/a-$$** **Budget Ask** **Agency Policy Change**	"Well-being specialist" designation Conduct a feasibility study (either through a legislative allocation or through HCA) of introducing "well-being specialists" into the clinical service array of community mental health agencies. This will inform two parallel policy efforts: 1) the Washington Council for Behavioral Health's anticipated recommendation for a teaching clinic rate for the 2025 legislative session, and 2) the HCA CMS state plan amendment part two in 2024.

[2] "The Department shall establish a stipend program to defray the out-of-pocket expenses incurred by associates completing supervised experience requirements under RCW 18.225.090." *HB 1724 (2023-2024).*
[3] SB 5187 Sec.510 (17) https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20231012004441

School-based Behavioral Health and Suicide Prevention (Link to detail, page 38)	
Legacy **$$$** **Budget Ask**	School-based behavioral health funding for school districts Provide funding directly to local education agencies (LEAs) to plan, coordinate, and/or provide school-based supports that address the emergent mental health crises in their student populations, specifically targeting funding for LEAs who have not been able to develop a plan for recognition, initial screening, and response to emotional or behavioral distress as required by RCW 28A.320.127.
New **$$-$$$** **Budget Ask**	Mental Health Training in School Communities Provide funding to school districts to provide culturally responsible, evidence-based and/or Professional Education Standards Board (PESB) approved mental health and suicide prevention training for certificated and classified staff and student families.
Previous **$$$-$$$$** **Budget Ask** **Legislative Policy**	Designating and funding a lead agency for school-based behavioral health Designate a statewide leadership authority for student behavioral health and well-being, with a mandate to ensure student access to a continuum of effective behavioral health services in school and interconnected community settings. Provide funding to the leadership authority to act on that mandate.
New **$** **Budget Ask**	Improving student access to mental health literacy education Provide funding to a state agency (Office of Superintendent of Public Instruction or Department of Health) to fund an FTE staff position to serve as a mental health curriculum lead responsible for reviewing, disseminating, and cataloging high-quality, mental health literacy instructional curriculum for the P-12 education system.

Overarching
2024 Recommendation

Overarching recommendation

Update House Bill 1890 (2022) to reflect current work plan for the P-25 Behavioral Health Strategic Plan

Legacy	**$-$$$**	**Legislative Policy**

Recommendation: Update legislation directing development of the P-25 Strategic Plan to: Adjust delivery times, align advisory group membership, and update plan content to reflect learnings from the first year, and ensure this effort is included in the work of the Joint Select Committee on Health Care and Behavioral Health Oversight, the Joint Executive Legislative Committee on Behavioral Health – both established in 2023 – and the Substance Use Recovery Services Advisory Committee (SURSAC).

1. 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.

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 the 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 40th of 50[4], Washington is one of the worst states in the nation for youth mental health care. 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.

2. What do you recommend?

Update legislation directing development of the P-25 Strategic Plan to: Adjust delivery times, align

[4] Youth Ranking 2023. Mental Health America, https://mhanational.org/issues/2023/ranking-states#youth_data

advisory group membership, and update plan content to reflect learnings from the first year, and ensure this effort is included in the work of the Joint Select Committee on Health Care and Behavioral Health Oversight, the Joint Executive Legislative Committee on Behavioral Health – both established in 2023 – and the Substance Use Recovery Services Advisory Committee (SURSAC).

A limited amount of the budgeted funds for strategic plan development have been spent thus far as we evaluate the best use of scarce resources. We recommend extending the timeline for the project and using the previously allocated funds, along with a refined plan, to continue to move this work forward.

3. Why is this a smart move now?

What we are hearing from parents, young people, providers, and system partners is that the problems young people and families experienced during the pandemic continue. Ongoing challenges identified by the Strategic Plan Advisory Group include: (1) barriers to access, including prohibitive costs, limited insurance coverage, and long waiting lists; (2) concerns about the quality of providers; (3) gaps in the continuum of care; (4) accessibility and availability of services; and (5) the need for more comprehensive and diverse services.

Year 1 of the strategic planning effort resulted in much learning about what is needed to do this work, including what information is already available within the state and what's needed to do meaningful community engagement that reaches affected communities that are usually not included in these conversations. Significant research on initiatives in other states aimed at transforming behavioral health delivery for children, young people transitioning to adulthood, and their families was done; further research and evaluation of lessons that might apply to Washington state continues. In addition, there are now other legislative and advisory groups working on mental health more broadly that this work needs to coordinate with to leverage the work being done by all these groups to improve behavioral health access, services and support, and individuals' outcomes and well-being in Washington State.

4. What outreach has informed this recommendation?

Since August 2022, the Strategic Plan Advisory Group – composed of 16 youth and young adults, 30 parents or caregivers,
1 tribal representative, and 16 system partners – has held 9 meetings. The advisory group spent January-June looking at the current landscape. Since July 2023, the group has been building a future vision. In addition, the co-chairs, staff, and contractors have spoken with:

- Children's behavioral health research, policy, and systems experts within Washington state and throughout the nation, including those who have undertaken transformational change efforts in other states;
- Youth and parent advocates; and
- Community organizations.

The work has also been informed by the leads and members of the CYBHWG subgroups.

Behavioral Health Integration (BHI)
2024 Recommendation

Finance behavioral health care coordination as performed by community health workers

New	**$$$**	**Budget Ask: Legislative Policy**

Recommendation: The Behavioral Health Integration Subgroup recommends that the Legislature fund behavioral health care coordination in primary care settings as performed by community health workers (CHWs).

1. What is the issue?

There is currently no sustainable funding mechanism to reimburse providers for carrying out the critical tasks of care coordination, which include navigation to services after screening, carrying out the care plan, and adjusting the care plan as a child's needs change.

Navigation to services after screening. Currently, screening for behavioral health (BH) problems is being widely administered in primary care clinics. Ideally, when issues are identified, further assessment and care coordination is done to identify any emotional, behavioral, developmental, or social needs that can be addressed through treatment or social services. However, once needs are identified, there often aren't sufficient staff available in the clinics to do the necessary follow-up: finding the right resources and connecting children and families to those resources. Care coordination services have proven essential to completing the screening process so that identified needs are addressed through appropriate referrals.

Carrying out the care plan. When behavioral health needs or developmental issues are identified, a care plan should be developed for that child, determined by primary care and behavioral health providers. CHWs, under the direction of licensed professionals, can ensure that the plan is carried out. That may involve:

- Working with the child and family to set up therapy either in the primary care clinic or in a behavioral health or developmental clinic;
- Scheduling team meetings;
- Reaching out to schools or other providers to coordinate care;
- Ongoing engagement with the family regarding support they might need to follow through with the care plan.

Adjusting the care plan as a child's needs change. When a child isn't progressing, care coordination is important to ensure that a new plan is developed and carried out with sufficient collaboration and communication between the families and their entire care team. CHWs, who maintain engagement with kids and families, are instrumental in ensuring that clinics are aware of the child's changing needs and that care plans are adjusted to meet them.

2. What do you recommend?

The Behavioral Health Integration Subgroup recommends that the Legislature:

1. Renew funding of the CHW grant program for behavioral health services in primary care in the amount of $2.087 million over two years.

   The Washington State Legislature invested in the Pediatric CHW workforce through a two-year grant program led by the Health Care Authority (HCA) beginning in January 2023. As a result, there are now 40 CHWs working in 30 clinics (including 7 tribal clinics) across the state. Those clinics have already seen significant impacts in their ability to address families' health-related social needs, improve care coordination of children and teens' behavioral health services, and

build trusting, collaborative relationships with families.

HCA has decided not to include funding for these CHW positions in its budget request for FY 2024-25. We recommend that the Legislature continue funding this grant program for an additional two years, until sustainable funding mechanisms are put in place to support their work on an ongoing basis and expand the program statewide.

2. Allocate $6-7 million per year to increase rates for screening on Apple Health (Medicaid billing codes: CPT 96127, 96160, 96161) to cover the cost of coordinating additional steps in the screening process when there is a positive screen, including assessments, referrals, and follow-up to ensure services are obtained.

   Rates for screening are currently inadequate to ensure that all clinics are screening for behavioral, emotional, social, or financial issues affecting the health of the child, including both child, teen, and post-partum screening, and providing adequate follow-through. CHWs are qualified to perform screening and navigation assistance to ensure that families are connected to services. Adequate funding for screening will enable clinics to hire CHWs to perform these tasks.

3. Adopt and fund billing code CPT 99484 in the State Medicaid Plan, which would cover a portion of the cost of care coordination activities, in the amount of $1 million per year.

   Washington State currently does not include or fund CPT code 99484, which would reimburse clinics for some care management services for behavioral health conditions, including:

   - Facilitating and coordinating treatment under the care plan;
   - Care plan revision for patients not progressing; and
   - Continuous relationship with patient/family and the rest of the care team.

   Many of these tasks of care coordination could be performed by Community Health Workers.

   Note: This code can be billed by clinics not billing under the strict requirements of Collaborative Care codes.

3. Why is this a smart move now?

Care coordination acts and improves on multiple levers of the behavioral health system,[5] including:

Increasing capacity in primary care – When primary care providers and behavioral health professionals have the support of CHWs to do care coordination, they are freed up to help other patients with problems requiring use of their medical or other professional training.

Increasing capacity in specialty care – Slots are freed up in mental health specialty clinics when the mild to moderate behavioral health needs of patients are being met in primary care.

Reducing workforce burnout – There is greater recruitment, retention, and job satisfaction[6] by primary care providers and behavioral health professionals when they can work in integrated teams and are supported by care coordination resources.

Reducing workforce and overall care costs – Lower cost workers providing care coordination improves outcomes at low cost to the system. Additionally, every $1 spent on integrated care, saves $6.50 in health

[5] Craig C, Eby D, Whittington J. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

[6] CMCS Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth. EPSDT guidance from CMS on BH - bhccib08182022.pdf

care costs.[7]

Increasing the diversity of the workforce and helping to combat racism in the provision of healthcare – CHWs are non-licensed staff recruited from the community, reflective of the community, with knowledge of available community resources. Since no professional certification is required, hiring CHWs is the fastest way to improve the diversity of the behavioral health workforce. Furthermore, CHWs can serve as a bridge of trust between families and primary care providers and mental health professionals and can help increase the awareness, knowledge, and cultural competency of these providers through their collaboration.

Improving outcomes for kids with developmental delays – Care coordinators connecting with a family when the child is in infancy increases the chances that kids with developmental needs will receive care early, when it can do the most good, thus improving outcomes.[8]

Increasing patient satisfaction and improving behavioral health outcomes – Research has shown that patient experience is significantly improved by engagement with a CHW, which in turn improves patient engagement with, and the effectiveness of, care.[9] Research also shows that using lay care coordinators improves behavioral health outcomes in low-income children and youth with ADHD.[10]

Improving physical health – Recent research also found that incorporating CHWs in primary care increased the number of children receiving preventive care services, further demonstrating the importance of the CHW role for closing healthcare access gaps and achieving health equity.[11]

Utilizing existing resources in clinics – CHWs are located in existing primary care facilities and work in teams with existing providers.

Building on existing resources in the community – A critical part of the work of care coordinators is to ensure that kids and families are connected to resources in the community, based on needs identified in initial screenings.

4. What outreach has informed this recommendation?

The BHI subgroup has collaborated with other subgroups of the CYBHWG in the development of this recommendation, in addition to numerous community outreach efforts, including a major Managed Care Organization (MCO); staff from Childhaven, Harborview, Kent Des Moines Clinic, Hope Sparks; and WCAAP. All are extremely supportive of this proposal and believe it would greatly enhance the services they provide, ensure better connections with the communities they serve, and expand their capacity to meet the behavioral and other health needs of the children and families they work with.

---

[7] Tyler, Elizabeth Tobin; Hulkower, Rachel L; Kaminski, Jennifer W. B*ehavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers. (2017)* MMF_BHI_REPORT_FINAL.pdf

[8] ibid

[9] ibid

[10] ibid

[11] Coker, T. R., Liljenquist, K., Lowry, S. J., Fiscella, K., Weaver, M. R., Ortiz, J., LaFontaine, R., Silva, J., Salaguinto, T., Johnson, G., Friesema, L., Porras-Javier, L., Guerra, L. J. S., & Szilagyi, P. G. (2023). Community Health Workers in Early Childhood Well-Child Care for Medicaid-Insured Children: A Randomized Clinical Trial. JAMA, 329(20), 1757–1767. https://doi.org/10.1001/jama.2023.7197

Prenatal through Five Relational Health (P5RH)
2024 Recommendations

Children & Youth Behavioral Health Work Group Subgroup – P5RH

Expansion of the Early ECEAP (birth to three ECEAP) program

ECEAP (pronounced "e-cap") = Early Childhood Education and Assistance Program

New	**$$-$$$$**	**Budget Ask; Legislative Policy**

Recommendation: The Prenatal through Five Relational Health (P5RH) Subgroup recommends the legislature allocate funds to expand Early ECEAP program slots and change policy to allow expanded and continued eligibility for Working Connections Child Care (WCCC) in Early ECEAP.

1. What is the issue?

Lack of access to high intensity, family-supportive services for children 0-3 in center-based settings.

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

Loss of childcare subsidy leads to instability of care.

In order to serve a child and family in Early ECEAP (full-time, year-round childcare center-based care), the Early ECEAP rate is layered with the WCCC rate to cover the cost of care. When WCCC eligibility is lost mid-year due to a family's change in work activities, this creates instability of care for the child and financial instability for the program. The policy change would create stability of care for the child for one full year and provide financial stability for the program.

2. What do you recommend?

Expansion of Early ECEAP slots in high-need areas.

Early ECEAP was piloted to close that gap in services and was established as a permanent state program as part of the Fair Start for Kids Act. Currently there are 178 slots in 10 different programs around the state. DCYF provided an opportunity to apply for potential Early ECEAP expansion slots in December 2022, and 470 new slots were requested. There is particular interest in areas with high levels of CPS involvement; family and child trauma displayed in programs; and childcare deserts. 65% of children enrolled in Early ECEAP are children of color.

This model is the intersection of early learning and mental and behavioral health supports. It will serve our highest need babies whose families aren't eligible or able to engage in home visiting or other approaches.

Cost/Scope: Early ECEAP investment can be scaled to meet what the legislature can afford to fund. Slots are $24K each and provide full day/full year classroom services and wraparound family support, health, and mental health services. Meeting the existing demand (400 slots) would cost approximately $9.6 million. The policy change for WCCC (for ECEAP and Head Start programs, not just Early ECEAP) would cost $2.226M for FY25 per the decision package from the Department of Children, Youth, and Families.

3. Why is this a smart move now?

The legislature supported a significant rate increase for Early ECEAP in 2023 (20%), indicating strong support for the program. Lawmakers understand the need and the gap that Early ECEAP fills and there is a high level of interest in expansion. This is a focused intervention with some of the highest need children

and families in the states, families who need more than basic childcare services.

In addition, DCYF is implementing a new model to expand therapeutic childcare (Early Childhood Intervention and Prevention Services, aka ECLIPSE) outside of the two programs, in King and Yakima counties, that have offered this service for many years. It has long been a goal to scale these services up - by layering ECLIPSE dollars with Early ECEAP, ECEAP, Head Start, Early Head Start and WCCC, children diagnosed as needing a very high level of mental and behavioral support, family and classroom coaching outside of King and Yakima counties can be served. Of the 470 requested Early ECEAP slots, 99 are for layered Early ECEAP /ECLIPSE for these very high need families.

4. What outreach has informed this recommendation?

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

Additionally, Kristin Wiggins (support to P5RH Subgroup), spoke with three different parent groups four times, engaging 55-60+ unique parents across the state in conversation about prenatal through 5 relational health and this recommendation. Parents, including alumni from Early ECEAP and Early Head Start and current ECEAP families (ECEAP is for three- and four-year-olds), expressed strong support for increased access to Early ECEAP. Some parents shared the differences between the more comprehensive, intensive Early ECEAP program and typical childcare, noting that some families need more intensive supports to thrive and be set up for success in the K-12 public education system. Some parents shared how their time in Early ECEAP, Early Head Start, and ECEAP has empowered them to be more engaged and a stronger, more informed advocate for their child in the public education system.

Increase investment in infant and early childhood mental health consultation (IECMH-C)

Legacy	**$-$$$**	**Budget Ask**

Recommendation: The Prenatal through Five Relational Health (P5RH) Subgroup recommends that the Legislature increase investment in infant and early childhood mental health consultants (IECMH-C) by $1.75 million annually to address unmet need and increase equitable access to IECMH-C for Washington's children, families, and childcare providers. Funds will be used to (1) expand capacity to provide individualized mental health consultation services to more providers; (2) provide IECMH-C services by linguistically and culturally matched consultants; and (3) address ongoing program needs to maintain quality and increase access.

1. What is the issue?

More funding is needed to help children, families, and caregivers in Washington.

Child Care Aware of Washington's (CCA of WA) Holding Hope IECMH-C program currently employs a diverse and talented team of Mental Health Consultants (MHCs) statewide, with 9 of 15 consultants representing various communities of color and 6 fluent in languages other than English, including Spanish and Somali. As of June 2023, there are 5,542 licensed childcare providers statewide with a capacity to serve 194,052 children.[12] At current funding levels, this means that we have one MHC for every 370 licensed childcare providers, or one MHC for every 12,937 children in care. With full caseloads, the team

[12] Child Care Aware of Washington (August 2023)

of MHCs can typically serve around 110-130 providers at a time, roughly 2% of licensed providers. Most childcare sites served have multiple child/family concerns and classroom/programmatic needs which consultants are supporting in partnership with Early Achievers Coaches.

MHC caseloads are currently full and there are 97 providers waiting for IECMH-C services as referrals continue to come in.

This additional investment will allow us to serve our waitlist which is a critical short-term goal. Additionally, based on the data below, we know that the actual need for Mental Health Consultation in the childcare community is much greater, and our longer-term goal is to have enough IECMH-C funding to serve 10% of childcare providers at a time.

Childcare providers in Washington report a critical need for IECMH-C services.

Per the 2022 survey of all licensed childcare providers statewide:[13]

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

High and disproportionate rates of suspension and expulsion impact Black and dual language learning students as well as students with disabilities.

Black children's preschool expulsion rate is nearly two times as high as Latino and white children.[14] And while Black children represent 19% of preschool enrollment, they account for 47% of preschool children receiving one or more out-of-school suspensions. In comparison, white children represent 41% of preschool enrollment, but 28% of preschool children receiving one or more out-of-school suspensions.[15] Federal data indicates that a disproportionate number of male students representing minority populations are expelled, along with English Language Learners and students with disabilities, all of whom could benefit from daily attendance in preschool programs.[16] Because Holding Hope IECMH-C is built on a national evidence-based model that is proven to reduce suspension and expulsion, we are asking for expansion funds to serve underserved communities, assure fidelity to the national model, and disrupt expulsion practices and trends here in Washington.

Loss of childcare subsidy leads to instability of care.

In order to serve a child and family in Early ECEAP (full-time, year-round childcare center-based care), the Early ECEAP rate is layered with the WCCC rate to cover the cost of care. When WCCC edibility is lost mid-year due to a family's change in work activities, this creates instability of care for the child and financial

[13] The Athena Group, CCA of WA 2022 Provider Survey

[14] National Center of Early Childhood Wellness. Understanding and Eliminating Expulsion in Early Childhood Programs. https://eclkc.ohs.acf.hhs.gov/publication/understanding-eliminating-expulsion-early-childhood-programs

[15] U.S. Department of Education, Office of Civil Rights. (2016). 2013-2014 Civil Rights Data Collection. A First Look. Key Data Highlights on Equity and Opportunity Gaps in Our Nation's Public Schools.

[16] Institute for Child Success. (December 2018). Preschool Suspension and Expulsion: Defining the Issue. https://www.instituteforchildsuccess.org/wp-content/uploads/2018/12/ICS-2018-PreschoolSuspensionBrief-WEB.pdf

instability for the program. The policy change would create stability of care for the child for one full year and provide financial stability for the program.

2. What do you recommend?

The P5RH Subgroup recommends increased investment in IECMH-C, to address the concerns stated above.

IECMH-C is an evidence-based prevention-oriented, multilevel intervention that results in improved caregiver social-emotional support for young children and improved children's social-emotional well-being.[17] It is also an effective practice to interrupt bias and disproportionate expulsions and suspensions of young children of color in childcare and early learning, providing more equitable opportunities for children to participate in high-quality childcare and early learning experiences.[18] IECMH-C leads to many positive results for children and families including: increased social-emotional skills and self-regulation, reductions in challenging behavior, and reduced expulsion rates.[19] For caregivers, it increases positive interactions with children, reduces stress and turnover, and improves caregiver self- efficacy and knowledge, among other positive results.[20]

3. Why is this a smart move now?

The pandemic has taken a toll on child, family, and caregiver well-being and the childcare community is still trying to recover.

14% percent of parents report that their children have developed more serious mental health and behavioral challenges since the start of the pandemic.[21] During the pandemic, verbal, motor and social-emotional development for the youngest children was negatively impacted - the number of words spoken by parents to children was lower than in the past two years; opportunities for physical play and interaction with peers was reduced; and parents experienced high levels of stress, depression, anxiety, social isolation and a reduction in personal and family interaction.[22] Additionally, rates of social-emotional and behavioral challenges were one to four times higher among racial and ethnic minorities.[23]

Rates of caregiver depression are extremely high, and caregivers report significant increases in young children's behavioral challenges.

A recent national study revealed that 55% of Washington childcare providers screened positive for symptoms of clinical depression.[24] These symptoms among caregivers result in less responsive and attuned interactions with young children and indicate a need for increased caregiver support. This same study also revealed an alarming increase in young children's challenging behaviors. 65% of early childhood

---

[17] Davis, A., Perry, D. & Tidus, K. (2020) Center of Excellence for Infant and Early Childhood Mental Health Consultation (2020). *Annotated Bibliography: The Evidence Base for Infant and Early Childhood Mental Health Consultation (IECMHC).* https://www.iecmhc.org/documents/CoE-Evidence-Synthesis.pdf

[18] Shivers, E.M., Farago, F., Gal-Szabo, D. {2021). The Role of Early Childhood Mental Health Consultation in Reducing Racial and Gender Discipline Disparities Impacting Black Preschoolers. *Psychology in the Schools Journal.*

[19] Shivers, E.M., Farago, F., Gal-Szabo, D. {2021). The Role of Early Childhood Mental Health Consultation in Reducing Racial and Gender Discipline Disparities Impacting Black Preschoolers. *Psychology in the Schools Journal.*

[20] ibid

[21] Patrick, S. W., Henkhaus, L. E., Zickafoose, J. S., Lovel I, K., Halvorson, A., Loch, S., Letterie, M., & Davis, M. M. (2020). Well-being of parents and children during the COVID-19 pandemic: A national survey. Pediatrics, 146(4), e2020016824.

[22] McGuire, Tona, WA Department of Health {2022). Update on Youth Behavioral Health During COVID.

[23] Panchal, N., Kamal, R., Cox, C., & Garfield, R. {2021). The implications of COVID-19 for mental health and substance use: An issue brief. https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[24] Palomino, C., Oppenheim, J.,Gilliam, W., Cobanoglu, A., Catherine, E., Bucher, E., & Meek, S. (2003) Examining the Mental Health of Early Childhood Professionals and Children Early in the Pandemic. The Children's Equity Project.

education professionals in Washington reported that they had children with increased externalizing and internalizing behaviors in their classrooms or programs since the pandemic.[25] Further, there was significant staff turnover of childcare providers during the pandemic, resulting in a less experienced, newer workforce that needs training, professional development and ongoing support to offer quality social emotional learning experiences and environments for young children.[26] As the Holding Hope IECMH-C model is built on the national model with evidence of reduced staff stress and turnover and reductions in children's challenging behaviors, we believe that increased investment will have a positive impact on these trends in Washington.

The need for mental health support for Washington's caregivers, children and families is significant, and IECMH-C is an evidence-based prevention-oriented, multilevel intervention that results in improved caregiver social-emotional support for young children and improved children's social-emotional well-being.[27]

4. What outreach has informed this recommendation?

In years past, the Prenatal through 5 Relational Health Subgroup has had extensive exploration and outreach on IECMH-C which involved learning from a national expert, several subgroup conversations involving diverse perspectives, and outreach to non-members like ECEAP and childcare providers, along with parents and caregivers with lived experience with children with complex and relational health needs.

This year, Kristin Wiggins (support to P5RH Subgroup) spoke to two different groups of childcare providers, including family home providers, center-based providers, and Spanish-speaking and Somali-speaking providers who serve their communities. Additionally, Kristin spoke with three different parent groups four times, engaging 55-60+ unique parents across the state in conversation about prenatal through 5 relational health and this recommendation. What providers and parents shared anecdotally is more support is needed to attend to children's mental health needs and to support the adult's caretaking young children. Parents and providers also noted how acute the need is.

Further, CCA of WA has solicited direct feedback from providers and families served through Holding Hope IECMH-C, showing high levels of satisfaction with services, positive changes for staff and children, and recommendations from providers for increased funding for IECMH-C services.

[25] Ibid.

[26] Child Care Aware of Washington (August 2023)

[27] Davis, A., Perry, D. & Tidus, K. (2020) Center of Excellence for Infant and Early Childhood Mental Health Consultation (2020). *Annotated Bibliography: The Evidence Base for Infant and Eorly Childhood Mental Health Consultation (IECMHC).* https://www.iecmhc.org/documents/CoE-Evidence-Synthesis.pdf

Youth and Young Adult Continuum of Care (YYACC)
2024 Recommendations

Children & Youth Behavioral Health Work Group Subgroup – YYACC

Deliver and sustain approved funding for BH360 (formerly Parent Portal)

Legacy	**$-$$**	**Budget Ask; Legislative Policy**

Recommendation: The YYACC Subgroup recommends that the Legislature fund BH360, formerly known as the Parent Portal, with general fund state (GFS) allocations and support HCA to identify sources for the portal's long-term financial sustainability.

1. What is the issue?

In 2022, the Washington State Legislature approved House Bill 1800 (2022), which created a parent portal, now called BH360, to support parents and caregivers at all stages of the behavioral health journey. In 2023, the legislature allocated $400,000 in federal Mental Health Block Grant (MHBG) funds for implementation of BH360. However, the funds were not accessible because BH360 does not meet federal requirements for use of MHBG funds.

To remain relevant, BH360 will need to continuously update and expand content. This will require sustained funding. Private donations or grants may be a viable source of long-term support, but there is not currently a dedicated administrative home for such funding.

2. What do you recommend?

The YYACC Subgroup recommends that the Legislature fund BH360 by:

- Allocating funding through the Washington State General Fund;
- Creating an account in the Washington State Treasury capable of receiving private donations to BH360; and
- Directing the HCA to propose long-term financial sustainability measures to support implementation and maintenance of the parent portal.

This recommendation is intended to increase access to support for all children, youth, and families in our state.

3. Why is this a smart move now?

Without timely access to care, children with behavioral health conditions may experience more severe symptoms, which could lead to an array of negative outcomes, including learning loss, substance misuse, entanglement with the juvenile legal or child welfare systems, and – in severe cases – suicide and overdose. We must invest in early intervention services – which include providing educational content and information to help families access programs and providers statewide. BH360 is intended to be accessible to all communities. It will advance equity by demystifying both the challenges families are facing and Washington State's complex behavioral health system.

This recommendation is realistic and straightforward. Funding this work through the Washington State General Fund will ensure that the Health Care Authority can fulfill its mandate under HB 1800. Creating an account in the Treasury is the formal mechanism to create a repository to receive donations from non-state funders for BH360.

4. What outreach has informed this recommendation?

The development of this recommendation was informed by extensive outreach efforts. These efforts included meetings with subgroup members, input from subject matter experts, particularly those from the Health Care Authority (HCA), and insights from individuals with lived experience with developmental

disabilities and behavioral health disorders.

The outreach efforts allowed for a comprehensive understanding of the funding challenges and the critical need for behavioral health services for minors. The input from subject matter experts helped to identify the specific funding challenges that need to be addressed, and the insights from individuals with lived experience helped to illustrate the urgency of the need for easy access to comprehensive information.

Accelerate the adoption of technological innovations across the behavioral health continuum of care

Previous	**$-$$$**	**Budget Ask**

Recommendation: The YYACC Subgroup recommends that the Legislature create a pot of flexible funds to identify and pilot the utilization of technological innovations to enhance access to a variety of services across the behavioral health continuum of care.

1. What is the issue?

The Washington State behavioral health system is overwhelmed and unable to meet current needs, especially for people in crisis. The problems to be addressed are multiple, including workforce shortages, limited rural access, waitlists, lack of BIPOC providers and culturally appropriate services, over-capacity in emergency departments (EDs) and substance-use disorder (SUD) facilities, and inadequate utilization of evidence-based practices (EBPs). As a result of these factors, people in crisis are often forced to wait long periods of time for care, or they may be turned away altogether. This can have a devastating impact on their individual health and well-being and on the well-being of our communities. Meanwhile, many proven technological innovations already exist that increase access to effective services across the continuum of care.

2. What do you recommend?

The YYACC Subgroup recommends that the Legislature provide a pot of flexible funds to pilot the utilization of technological innovations. The HCA should be directed to convene a diverse panel to prioritize use cases, consider the broad landscape of available technologies, allocate funds, and track performance of funded technologies.

This recommendation is intended to immediately expand behavioral health system capacity and improve productivity and effectiveness of existing capacity for all children, youth, and families in our state.

3. Why is this a smart move now?

Data shows that using technological innovations to supplement or replace in-person care, support, and follow-up has multiple benefits across the behavioral health continuum of care - from assessment and early intervention to treatment and recovery support services.

- **Rapid deployment and scalability:** This recommendation can be easily scaled very rapidly. A myriad of proven technological innovations already exists and can be deployed immediately.
- **Equity**: Digital applications reduce barriers to accessing health information and resources, including culturally-appropriate information and services that support BIPOC clients and traditionally-underserved youth. Digital applications can also provide an option for immediate care in rural areas where access to in-person services can be limited.
- **Accessibility**: Digital applications increase access to emergency crisis care, making it easier for patients to receive immediate help and reducing mounting wait times. Technological innovations,

being low-cost and low-burden, enhance continuity of care by enabling ongoing engagement and follow-up for individuals, regardless of their location.

Technological innovations can be deployed to address the various factors contributing to the current overwhelm of Washington State's behavioral health system. For example:

- **Workforce crisis:** Digital applications can address the worker shortage by extending clinicians' bandwidth and ensuring they are practicing at the top of their license.
- **Rural access:** The incorporation and dissemination of digital applications can assist with rural equity in the face of a huge shortage of behavioral health providers in rural areas.
- **Waitlists:** COVID has led to exponentially long waitlists to access behavioral health care and has caused some community behavioral health providers to stop accepting new referrals altogether. Technological innovations can be utilized with limited clinician oversight to provide a modicum of treatment for individuals waiting to access inpatient or outpatient care.
- **Lack of BIPOC providers and culturally appropriate services:** Numerous applications have been developed by and for BIPOC folks. Such tools improve the cultural relevance of services in the absence of BIPOC providers.
- **Over-capacity emergency departments (EDs):** Emergency departments are overwhelmed with behavioral health patients, many of whom are experiencing suicidal crises. Psychiatric patients spend longer in emergency departments than any other patient population, and EDs can be significantly detrimental place for individuals in psychiatric distress. EDs are the opposite of a therapeutic environment. Furthermore, data suggests that individuals experiencing suicidal ideation are more likely to answer truthfully on an electronic platform, as opposed to an in-person screening. A suicide crisis care application for use in emergency departments, designed by people with lived experience, could improve the effectiveness of screening and support EDs in channeling patients to more appropriate resources.
- **Shortage of substance-use disorder (SUD) beds**: Washington has inadequate SUD residential capacity compared to increasing demand for this service. There are digital applications that can supplant the intensive content taught in a typical 28-day residential program.
- **Limited proliferation of evidence-based practices (EBPs)**: Though there are many effective EBPs, few patients have access to services that implement those practices with fidelity. There are digital applications and prescription digital therapeutics that utilize EBPs, like cognitive behavioral therapy and contingency management, with great efficacy. Broader deployment of these tools would enable more patients to benefit from evidence-based care.

Flexible funding will enable the panel to use the broad suite of available technologies creatively to address the multiple issues enumerated above.

4. What outreach has informed this recommendation?

The subgroup put forward this recommendation for the first time for the 2023 legislative session. It has conducted outreach and information gathering with multiple users and developers of digital applications, including hospitals and other crisis services. Most recently, the subgroup has connected with individuals conducting research into digital behavioral health solutions at UW.

Ensure equitable access to and realize the intended outcomes of intensive programs serving youth and young adults with the most complex behavioral health needs

New	**$$$**	**Budget Ask; Legislative Policy**

Recommendation: The YYACC Subgroup recommends that the legislature 1) establish and fund a task force to recommend concrete solutions to address current challenges with access and implementation across the suite of intensive programs serving youth and young adults with complex behavioral health needs; 2) remove the HOST substance use disorder (SUD) eligibility requirement to expand access; and 3) increase funding to achieve parity across these programs while reducing administrative burden and creating accountability for program effectiveness.

1. What is the issue?

A suite of programs including WISe (Wraparound with Intensive Services), PACT (Program of Assertive Community Treatment), HOST (Homeless Outreach Stabilization Transition), and New Journeys (for First Episode Psychosis) exist to provide intensive case management services to individuals with complex behavioral health needs.

In theory, these programs are part of a continuum of care that supports all individuals with complex needs. A commitment to equity demands that we allocate resources proportional to the challenge of bringing the individuals who are worst off back to thriving, while also providing prevention and maintenance services to keep folks well. Providers of these programs do heroic work with many high-need patients, but gaps remain in access to the continuum of care and the quality of support is inconsistent. Challenges that need to be addressed include:

- **Lack of accountability**: Providers do not consistently deliver the range, depth, and quality of services promised by these programs' unique charters.
- **Eligibility requirements**: The programs' eligibility requirements currently exclude some individuals that they are intended to serve. For example, HOST serves young adults aged 18 -25 that are unhoused or at imminent risk of losing housing. However, the program requires participants to have a substance use disorder (SUD). This leaves a gap in high-need young adults (those whose challenges do not include SUD) that are excluded. Additionally, technicalities in the interpretation of eligibility too often impede individuals' access to care.
- **Inequity in funding**: The programs are funded at different levels in different regions, without consideration for the relative demand among the specific populations they are each designed to serve. This results in disparities in available services among individuals with complex behavioral health needs.
- **Lack of a continuum of care**: The programs are not sufficiently integrated to create a seamless transition between these and other services (such as residential treatment or assisted outpatient treatment) as people's eligibility or needs change.
- **Lack of resources**: These intensive programs currently have long wait lists, reflecting the fact that they are not resourced to meet the demand for these services in our state.
- **Administrative burden**: The level of paperwork, administrative data, and auditing required by these programs limits access to timely services and reduces their effectiveness, as illustrated by the WISe focused recommendation put forward by the Workforce & Rates subgroup. It can be intrusive to the individuals seeking services and it takes providers' focus away from delivering outcomes.

- **Workforce issues**: There are not enough qualified staff and appropriate oversight to provide effective services.
- **Crisis response**: People who are receiving care under the programs do not always get the help they need quickly enough when they are in crisis. For this population, delays in care can lead to devasting consequences, including death.

2. What do you recommend?

The YYACC Subgroup recommends funding a task force of relevant stakeholders, including individuals and family members who have utilized these programs, to recommend solutions to address the challenges and current limitations in their implementation. This task force should be directed to work quickly to deliver a report of concrete improvement measures by December 31, 2024, for consideration by the legislature in the 2025 session. Where solutions do not require legislative action, the task force should be empowered to work directly with relevant agencies and providers to implement them immediately.

This recommendation is intended to increase access to intensive services for individuals in Washington State with complex behavioral health needs and increase the effectiveness of the services offered.

This recommendation complements the recommendation put forward by the Workforce & Rates subgroup to streamline audit activities associated with the WISe program and focus on outcomes. The recommended task force may offer a platform for acting on the Workforce & Rates recommendation. The task force will need to consider the administrative implications of any solutions it puts forward, with the aim of reducing the administrative burden experienced by providers currently.

3. Why is this a smart move now?

Although the legislature has allocated increased funding to intensive programs in recent years, there is still unmet demand and inconsistent implementation. While much of the work being done by these teams is exemplary, many individuals and families continue to suffer, and unmet needs are being exacerbated by the limited availability of appropriate services.

The origin of WISe was a 2009 lawsuit in which Washington State settled a claim that it had not adhered to federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) statutes, requiring states to provide any medically necessary services and treatment to youth. As part of its settlement agreement, Washington committed to build a mental health system that would bring this law to life for all young Medicaid beneficiaries who need intensive mental health services in order to grow up healthy in their own homes, schools, and communities and not be forced into institutional care settings.

Although the settlement agreement was deemed satisfied and dismissed in September 2021, the State should continue to maintain its commitment to its children and youth, which is a commitment to equity. This means growing and adapting these three programs to ensure they meet the growing demand for their offerings among youth and young adults with complex needs, ensuring the programs are implemented as designed, and establishing strong integration between programs to enable youth and young adults to move seamlessly between programs if their needs change.

4. What outreach has informed this recommendation?

The recommendation was informed by extensive outreach efforts, including meetings with subgroup members, input from subject matter experts at the Health Care Authority (HCA), the PACT family advocacy group, and insights from individuals with lived experience. Discussions are underway with members of the Workforce & Rates subgroup to ensure that this recommendation does not work at cross-purposes to their recommendation to reduce the administrative burden associated with the WISe program.

Input from individuals with lived experience illuminated the urgency of the need for these services and their current shortcomings. In one case, a young adult was removed from a program because they declined to engage on a particular day, although this is characteristic behavior of the individuals these programs are meant to support. In another case, a young adult – who had been stable for some time and had a PACT team assigned to them – was unable to get support from their team while traveling out of state, resulting in a fatal outcome.

Members of the Youth and Young Adult Continuum of Care subgroup expressed concern about the recommended task force delaying the deployment of immediate solutions where the challenges are already identified and well understood. This is the driver behind 1) the relatively short timeline recommended for the task force to deliver its findings, and 2) the subgroup's assertion that – where uncontroversial solutions do not require legislative action – the task force should work directly with relevant agencies and providers to implement them immediately.

During the September 22nd CYBHWG meeting, a member raised the question of whether these programs support individuals with developmental disabilities. The recommended Task Force should review the current eligibility, consider the appropriateness of these programs for that population, and evaluate what it would take to effectively and sustainably incorporate them.

Workforce & Rates (W&R)
2024 Recommendations

Children & Youth Behavioral Health Work Group – W&R

Reduce administrative complexities in the Wrap-around with Intensive Services (WISe) program

New	**n/a**	**Legislative Policy**

Recommendation: The Workforce and Rates (W&R) subgroup recommends that the legislature direct the Health Care Authority to 1) transition from evaluating the Wrap-around with Intensive Services (WISe) program using audits focused on process to identifying and tracking three industry-standard, age-appropriate, outcome-based measures and 2) conduct an annual youth/family satisfaction survey designed to demonstrate the effectiveness of this program for youth and families in Washington State.

1. What is the issue?

Washington State has committed to moving toward physical health and behavioral health parity through Integrated Managed Care. However, behavioral health providers are routinely subject to significant process-based auditing practices not required by physical health providers. Parity needs to be created between physical health and behavioral health auditing practices. Currently WISe providers are subject to significant process auditing practices. This administrative burden contributes to workforce instability, which in turn impacts the quality and access to this critical program. Additionally, our systems are not closely monitoring the clinical outcomes and effectiveness of the WISe program, and we have not yet addressed two critical questions: 1) How effective is the WISe program in improving behavioral health conditions and overall health for youth? and 2) Is WISe successful in helping to prevent children and youth from entering more restrictive levels of care?

Our vision is to change how WISe is monitored in Washington State by moving away from extensive monitoring of processes through chart reviews, and instead focus on data to better understand access and clinical outcomes. By making this change, we will improve the quality and consistency of WISe, and move toward behavioral health parity. This will reduce the provider's administrative burden and contribute to continuous improvement of program quality and outcomes for youth and families.

2. What do you recommend?

We recommend the following changes to the administration of WISe services:

- Revise Washington Administrative Code (WAC) 182-505-0210 to ensure WISe Quality Plan and oversight cannot create significant administrative burden on provider agencies or staff and are consistent with industry standards for oversight and parity with physical health outcomes.
- Eliminate current auditing practices that focus on process – Quality Improvement Review Tool (QIRT) and individual chart review – and do not align with industry standards of methodology for outcomes-based data collection consistent with physical healthcare.
- Identify three quality-focused, industry-standard measures such as those used for value-based contracting and to demonstrate physical health outcomes.[28] Data collection methodology must use available claims or encounter-based information that is readily available.
- Direct HCA (or a designee) to conduct an open and transparent process to identify performance data and outcomes to be monitored. This review should involve stakeholders such as WISe provider agencies, other behavioral health providers, Managed Care Organizations, quality experts, and

[28] E.g., Health Effectiveness Data and Information Set (HEDIS) or other established standards.

people with lived experience. Results from these and future efforts shall be reported to the executive and legislative branches.

- Use an annual youth/family satisfaction survey to assess whether the program is meeting their needs.

We support the proposal put forward by the Youth and Young Adult Continuum of Care (YYACC) subgroup, expressing the need for increased accountability paired with a decrease in administrative burden for multiple programs that offer intensive services to individuals with complex behavioral health needs, including WISe, PACT (Program of Assertive Community Treatment), First Episode Psychosis (FEP) and HOST (Homeless Outreach Stabilization Transition).

3. Why is this a smart move now?

WISe provides the highest level of outpatient services available for children and youth. WISe workforce turnover rates are higher than other behavioral health services due to the amount of time spent performing administrative work (non-clinical documentation, data collection, auditing, participation in oversight reviews) versus direct client care. Continued reductions in staffing threaten the long-term viability of this program. Clinicians cite administrative burdens as a primary reason for leaving. Workforce turnover leads to access and quality challenges.

The intent of WISe is to meet the needs of the youth and family. Instead, we ask the youth and family to spend hours meeting our administrative demands before we address their needs. Decreasing administrative workload will allow the WISe workforce to focus on the youth and provide the individualized support they need.

4. What outreach has informed this recommendation?

Community behavioral health agencies in Washington State were surveyed to understand their clinical auditing burdens. Respondents identified WISe as an area of prime concern (the other being audits conducted by the Department of Health). DOH has recently decreased their auditing requirements through WAC revisions, so the workgroup chose to focus on WISe. In a recent WISe provider survey, 11 out of 14 WISe providers reported this administrative burden negatively impacts youth care. This issue has been recognized as an ongoing concern through numerous interactions with WISe providers by the MCO WISe Collaborative.

Public access to behavioral health data

New	**$$-$$$**	**Budget Ask; Legislative Policy**

Recommendation: The Workforce & Rates subgroup recommends that the legislature allocate funding to create a centralized data repository for behavioral health administrative data and include a potential legislative requirement for sharing administrative data with the public to create a more accessible and comprehensive system for the betterment of the behavioral health workforce.

1. What is the issue?

Access to data for workforce planning is a major challenge in the field of behavioral health. Washington is one of the few states in the nation where administrative data from multiple sources is systematically collected, yet we lack a comprehensive view of the many factors affecting the stability and effectiveness of the behavioral health workforce. While available administrative data can't answer all our questions, by linking and organizing the available data we can plan more effectively, make more informed policy decisions, and make public investments with greater confidence. Administrative data can now provide information about:

- The size, location and qualifications of the various disciplines and employee types represented.
- Demographic characteristics, time to licensure, rates of attrition and career pathways.
- Services provided by location, time spent with clients, and areas of practice.
- Where employees are trained, where they are needed and how they are distributed statewide.
- How workforce characteristics change over time.
- How changes in licensing processes, compensation, supervision, educational practices, and new initiatives affect the stability of the BH workforce over time.

In each legislative session policymakers are asked to consider a wide range of improvements to the behavioral health system, often without sufficient information about the long-term impact or about potential unintended consequences. Although these data are collected by public agencies, they are derived from a variety of formats, and they must be organized and modernized to make them accessible. By using administrative data, we can detect important changes in key metrics like workforce diversity, workforce turnover, wait-time for critical services, and racial disparities in the licensing process. Also, there are several anecdotal assumptions about the workforce that have yet to be tested, such as:

- Is attrition among all employee categories on the rise? If so, is it affecting only some areas of practice and not others?
- When clinical staff leave their positions, do they take more lucrative positions, or do they leave the field entirely?
- If our goal is to increase capacity for training clinicians in Washington, what proportion of the workforce is trained in-state now?

2. What do you recommend?

The W&R Subgroup recommends creating a centralized data repository using linked administrative data to create visualizations for a wide variety of non-technical end-users. Data will be refreshed automatically and will be available free of charge to the public in a web-based format. Typical users will be policy-makers, program administrators, private philanthropists, public agency staff, service providers, and advocates. No specialized technical skills or permission will be required to access these data.

The Center for Social Sector Analytics and Technology (CSSAT) at the University of Washington-Seattle School of Social Work has a team of data analysts and computer scientists with extensive experience linking public administrative data to create visualizations for a wide variety of end users. CSSAT is currently working in partnership with private philanthropy and state agencies on several data-related projects. Several relevant data-sharing agreements are already in place. CSSAT has a web-based platform flexible enough to ingest data from a variety of sources.

3. Why is this a smart move now?

Analyzing administrative data is a cost-effective strategy for building actionable, ongoing data capacity rather than investing sporadically in workforce surveys and other one-time observations. This approach will also allow us to detect progress towards the goal of stabilizing the BH workforce while establishing a better foundation for diversifying the workforce, providing enhanced supervision, and ensuring that newly trained clinicians have the necessary skills when they join the BH workforce.

4. What outreach has informed this recommendation?

The School of Social Work at the University of Washington-Seattle has been working with researchers, graduate students, practitioners, data scientists, public agencies, law enforcement, crisis responders, legislators, and all the higher education programs in the state of Washington who confer clinical degrees. The School of Social Work works closely with private philanthropy and is a participant in several behavioral health policy reform efforts. Several behavioral health advisory councils are maintained, as is a

network of over 100 community behavioral health agencies who participate in the Workforce Development Initiative funded by the Ballmer Group. While there are several opinions about what data are needed, there is general agreement that improving our information about the behavioral workforce should be a part of any effort to improve the behavioral health system.

Certified community behavioral health clinic (CCBHC) bridge funding

Legacy	**$$-$$$**	**Budget Ask**

Recommendation: To ensure successful completion of implementation of a statewide certified community behavioral health clinic (CCBHC) model, the state should support and sustain the current CCBHC expansion grant programs by providing bridge funding to current CCBHCs in Washington during the statewide planning process.

1. What is the issue?

Certified community behavioral health clinics (CCBHCs) provide critical care for people with mental health and substance use disorder (SUD) challenges. Launched in 2017, the CCBHC model is now operating in 46 states, with 17 CCBHC expansion grant sites in Washington. CCBHCs dramatically increase access to mental health and SUD treatment, diverting individuals in crisis from already-burdened systems such as hospitals and jails. The CCBHC model also helps to alleviate the impact of the crisis-level workforce shortage we face in community behavioral health by enabling participating agencies to increase hiring; on average, 41 new jobs per clinic are created. As a conduit for integrated behavioral and physical health, CCBHCs are responsible for engaging in care coordination and developing partnerships with primary care providers to ensure clients' access to services that meet their full range of health care needs.

CCBHCs are funded either through the federal Medicaid demonstration program or via two-year SAMHSA (Substance Abuse and Mental Health Services Administration grants. Currently, Washington's CCBHCs are funded via these SAMHSA grants, including initial two-year expansion grants and subsequent two-year extension grants. CCBHCs in the Medicaid demonstration are paid using a prospective payment system (PPS), which supports the actual cost of care, including expanding services and increasing the number of clients served while improving flexibility to deliver
client-centered care.

Washington and a growing number of states are moving to implement the model independently, via a state plan amendment (SPA) or a Medicaid waiver. In 2022, the Legislature funded a CCBHC budget proviso to support the Health Care Authority (HCA) in planning for this statewide implementation process. That same year, the Legislature also appropriated $5 million for CCBHC bridge funding to help sustain CCBHC grantees while the state began this planning process. HCA applied for, but did not receive, a $1 million CCBHC planning grant from SAMHSA; this planning grant is a prerequisite to be able to apply to become a demonstration state. In 2023, the Legislature appropriated $1 million to replace the assumed federal funding that would have resulted from receiving a SAMHSA planning grant; the implementation of this work is in its early stages at HCA.

2. What do you recommend?

As part of its work related to implementing a statewide CCBHC model, the state should support and sustain the current CCBHC expansion grant programs with bridge funding throughout the statewide planning process. As with the previous round of bridge funding, this would come via budget proviso of appropriated funds to HCA (Sec. 215 of the operating budget). HCA would administer the bridge funding grants to individual CCBHCs. This model of appropriation and distribution was effective in 2022 and should be replicated in the 2024 and future sessions.

3. Why is this a smart move now?

For the past two sessions, the Legislature has made investments to begin developing and implementing the CCBHC model statewide. In the meantime, many existing CCBHC expansion sites are set to run out of initial or extension federal grant funding. These existing clinics are increasing access to care, expanding services, and demonstrating the effectiveness of the CCBHC model which, when paired with a PPS, will transform our public behavioral health system. Bridge funding is necessary to sustain CCBHC services through a proposed two-year period while the state continues its implementation of a statewide CCBHC model. Without bridge funding, CCBHC programs absorb substantial financial losses; one clinic reported an average loss of $30,000 each month.

Additionally, competition for federal grant funding from SAMHSA is high and not all existing sites will continue to receive funding in subsequent application periods. The continued work of these clinics is also imperative to support and inform current efforts to develop and implement CCBHCs and a PPS throughout Washington. Loss of funding could also lead to a loss of meaningful data that would assist the state in its current planning process.

The Children & Youth Behavioral Health Workgroup (CHYBWG) has been a strong supporter of expanding the CCBHC model in Washington for the past several years, with the Workforce & Rates Subgroup frequently identifying CCBHCs as a priority or support item. Not only does the CCBHC model allow for greater recruitment and retention of a well-qualified workforce, but it also provides significant value to the broader behavioral health system by relieving strain on other systems, like law enforcement and emergency departments.

4. What outreach has informed this recommendation?

The Washington Council for Behavioral Health (the Council), whose members include 13 of the 17 current CCBHC grantees in Washington, conducted specific outreach to those CCBHC members to request the following information:

- Are existing CCBHCs still in need of continued bridge funding?
- An estimate of funding amounts needed over a two-year period.
- How would the funds be spent within the CCBHCs?

Responses were unanimous that current CCBHC expansion sites need bridge funding, with estimates ranging from $750,000 to $2.5 million over a two-year period. Examples of how bridge funding would be used included:

- Enhancing primary care services, care coordination, data collection, and reporting;
- Supporting federally qualified health center (FQHC) partners providing primary care services to CCBHC clients;
- Increasing access to care via reorganization/expansion of clinical spaces;
- Scaling integrated care to cover a larger percentage of the client base, not just a smaller “pilot” group; and
- Closing the gap on CCBHC programming’s staff salaries and providing retention bonuses.

Allow funding for the Washington Health Corps Behavioral Health Program to be used for conditional scholarships

New	**n/a**	**Legislative Policy**

Recommendation: The Workforce & Rates Subgroup recommends amending the current RCW to enable Behavioral Health Corps monies to be utilized for conditional scholarships by mirroring the language used for general Health Corps funding.

1. What is the issue?

The Children and Youth Behavioral Health Work Group advanced a recommendation in 2023 to fund conditional scholarships for behavioral health. The work group decided to first address barriers to using funds in in the general Health Corps for conditional scholarships. HB 1763 passed unanimously and was signed by the Governor. The bill made conditional scholarships a more realistic option for individuals by reducing the penalties for default. It also established that Health Corps funding could be used for various wrap-around services and supports.

While the general Health Corps funding can be used for either loan repayment or scholarships, funding from the Behavioral Health program can only be used for loan repayment. Loan repayment is a good tool for retaining the workforce who are already trained. Scholarships incentivize new individuals to consider the field. With a strong need to diversify the workforce, as well as to increase services in certain geographic areas and various settings, scholarships help focus recruitment efforts on the greatest needs.

2. What do you recommend?

The Workforce & Rates Subgroup recommends amending RCW 28B.115 so that the language allowing funding for both loan repayment and conditional scholarships per the general Washington Health Corps is included in the sections of the RCW dealing with the Behavioral Health program. At present, funding that goes to the Behavioral Health program can only be used for loan repayment.

3. Why is this a smart move now?

Additional funds were provided by the legislature in the 2023-25 budget for both the Health and Behavioral Health programs. Being able to use the behavioral health resources for either loan repayment or conditional scholarships would support both recruiting and retaining a diverse workforce.

The WA State Behavioral Health Workforce Development Initiative (WDI) has been using private funding to demonstrate the effectiveness of conditional scholarships in diversifying the workforce. The data from that program indicates that defaults on conditional scholarships are very low. Additionally, individuals receiving a scholarship are required to be placed in and work at a community behavioral health agency. In this way, the program is positively impacting the capacity of the overall behavioral health system before these students even graduate. As this program is time-limited, the legislature has an opportunity to incorporate this promising approach into its education debt strategies.

4. What outreach has informed this recommendation?

Discussions with the Behavioral Health Council, Workforce Board, WDI, Washington Student Achievement Council (WSAC), the Workforce & Rates subgroup of the Children and Youth Behavioral Health Work Group, legislators and others have been ongoing. There is general agreement that we need to both recruit and retain a diverse, well-trained workforce, as well as increase services in rural and other underserved communities. This legislation would widen the applicability of already-designated funding by removing the limitation that prohibits funding from being used for conditional scholarships.

Evaluation of loan repayment programs

New | **$** | **Budget Ask; Legislative Policy**

Recommendation: The Workforce & Rates subgroup recommends the legislature require an evaluation of the Washington Health Corps' portfolio of loan repayment programs to better understand outcomes and determine if the Corps is meeting its statutory goal of encouraging more healthcare professionals to work in underserved areas.

1. What is the issue?

The Washington Student Achievement Council (WSAC) manages the Washington Health Corps, the most recent iteration of the state's health professional loan repayment programs, which have existed since 1989. The legislative intent of the program is to encourage more healthcare professionals to work in underserved areas by providing loan repayment and conditional scholarships in return for completing a service commitment. The state-funded program was fully defunded during the recession years (a small federally matched program continued). Since 2015, Washington has made significant investments in loan repayment as a tool to incentivize the health workforce to work in certain areas/practice types. Although it has the option on the physical health side, the program has not awarded scholarships since state funding was restored, choosing instead to prioritize loan repayment.

The Washington Health Corps was significantly expanded in 2019 to increase participation by behavioral health professionals. Use of loan repayment as a workforce policy tool continues to expand to different parts of the health sector, most recently nurse educators and forensic pathologists. An evaluation of the Washington Health Corps will help the state determine what is working and potentially support further investment or suggest changes that would increase program effectiveness. Assessment of the program can also seek to identify structural issues that might be causing inequitable program access.

2. What do you recommend?

In 2022, the Workforce Board's Behavioral Health Workforce Assessment and Health Workforce Council both recommended evaluation of the state loan repayment programs. The 2022 recommendations did not include a specific mechanism for evaluation. Conversations are currently underway regarding two potential avenues to complete an evaluation, both independent of WSAC itself.

Option 1: Budget proviso to WSAC to fund a third-party evaluation of the Washington Health Corps, including both behavioral health-specific and general programs. Guaranteeing third-party access to state administrative data to match WSAC records with employment information would likely require direction in the proviso to involved agencies, as data is not typically accessible.

> Pro: A contract with a third-party evaluator would allow for greater WSAC input into development of research questions and more of a partnership approach.
>
> Con: Budget provisos are not always funded to a level that covers the desired level of work. This proposal would likely require an RFP (request for proposal) process, which can add several months to any timeline, unless an evaluator was named in the budget.

Option 2: Request for Joint Legislative Audit & Review Committee (JLARC) evaluation of the Washington Health Corps, including both behavioral health-specific and general programs. This can be achieved via JLARC member request, policy bill or budget proviso.

> Pro: JLARC is a highly credible institution whose evaluations and audits are well regarded in the Legislature. A JLARC evaluation would not require an RFP process. The Committee can have an easier time accessing data from their position inside state government, simplifying the quantitative portion of a Washington Health Corps evaluation. JLARC is funded to complete

evaluations each year and the Legislature would need to fund the requested scope of the project.

Con: JLARC's workplan is currently full through 2025, meaning that work would not be able to start for several years. JLARC approaches projects as an independent auditor and will only answer the research questions requested by the Legislator/proviso. This could mean that important research questions could be outside the scope of the evaluation. The evaluation could effectively evaluate specific outcomes of the program but would not make policy evaluations regarding other alternative approaches to address educational debt in the health workforce.

3. Why is this a smart move now?

Enough time has elapsed since funding was restored in 2015 that health care professionals from several different application cycles have completed their 3- to 5-year service obligations. It will be possible to assess if professionals completed their service obligations, extended their service periods, changed employers during their service period, and/or have remained at the employers where they were originally funded, among many potential research questions of interest. Loan repayment continues to be a popular and growing policy tool. An evaluation of program outcomes can help support wise future investments or, if necessary, modification of the program to address any challenges or inequities discovered.

4. What outreach has informed this recommendation?

The Behavioral Health Workforce Advisory Committee and Health Workforce Council gave significant input on the development of the full suite of educational debt recommendations made in 2022. Workforce Board staff have discussed the need for program evaluation with the Washington Student Achievement Council in 2022 and 2023. WSAC staff concur that an evaluation of the program could help the state fully understand both the outcome for the public dollars invested as well as offer support and ideas for any needed adjustments to the program to ensure equity. As of October 11, WSAC has not expressed a preference between the evaluation options.

Outreach also included discussion of the importance of evaluation when discussing health workforce incentive programs with legislators both in session 2023 and during the intersession period.

Fund House Bill 1724 stipend program for recent graduates in the behavioral health field

New	**$$$**	**Budget Ask; Legislative Policy**

Recommendation: The Workforce & Rates Subgroup recommends that the Legislature allocate funds to the Washington Department of Health (DOH) to implement the stipend program for behavioral health professionals and to amend the statute to activate other emerging models if recommended.

1. What is the issue?

To become a credentialed behavioral health professional (such as a licensed social worker) a certain number of hours of supervision are required. Many individuals must purchase such supervision and the cost of doing so can be exclusionary and prohibitive. Recognizing this, as part of HB 1724, the Legislature directed the Department of Health (DOH) to establish a program to help associates defray expenses incurred in obtaining required supervision. However, this program was not funded as part of the 2023-25 budget.

Meanwhile, experts are exploring other models besides stipends to support individuals in completing the necessary hours to obtain their credential, including: 1) expanding the school social worker proviso that was included in the 2023-25 budget and 2) contracting with behavioral health professionals to provide

supervision so individuals seeking supervision don't have to pay out of pocket for this service. These alternative models may be lower cost and lower in administrative burden or could combine with the stipend program to broaden access to a wider pool of recent graduates. If either of these are projected to reduce cost or increase access, and if the current language in HB 1724 does not allow for such models to be employed by the DOH, the Legislature could amend the statute to broaden the tools available to DOH as they seek to help recent graduates achieve certification.

2. What do you recommend?

The Workforce & Rates Subgroup recommends including funding in the FY25 budget for the stipend program so that it can be established by July 2024, as legislated, and utilized immediately by individuals seeking their credential. If alternative models prove to be lower cost and lower in administrative burden or could combine with the stipend program to broaden access to a wider pool of recent graduates, the subgroup also recommends amending the statute to support these other models.

3. Why is this a smart move now?

In 2023, the legislature passed HB 1724 that includes the requirement to establish a stipend program by July 2024 but did not fund it in the budget.

Given the urgency of the workforce shortage in behavioral health, it is critical that the program begin deploying stipends or other support as soon as possible. Having just paid for their education, paying for supervision can be overwhelming and unrealistic. This program (or programs) will offset some of these costs and help ensure that a diverse set of newly degreed individuals get the hours necessary to obtain their credentials. It will also help them stay in the field by reducing the debt they carry after they get their credential.

The 2023-25 budget also included funding (the school social worker proviso mentioned above) for a small pilot that placed individuals working on their degree or credential into schools – either as part of their practicum or as employees of a community behavioral health agency. This pilot is currently being implemented and will likely be put forward for expansion in the 2024 session. If so, this presents another model for helping students and recent graduates achieve certification.

4. What outreach has informed this recommendation?

This proposal was vetted during the 2023 legislative session. Individuals from the Behavioral Health Council, University of Washington, and various professional organizations were involved in discussions that led to the stipend program's inclusion in HB 1724.

"Well-being specialist" designation

New	**n/a-$$**	**Budget Ask; Agency Policy Change**

Recommendation: The Workforce & Rates Subgroup recommends that a feasibility study be conducted (either through a legislative allocation or through HCA) of introducing "well-being specialists" into the clinical service array of community mental health agencies. This will inform two parallel policy efforts: 1) the Washington Council for Behavioral Health's anticipated recommendation for a teaching clinic rate for the 2025 legislative session, and 2) the HCA CMS state plan amendment part two in 2024.

1. What is the issue?

Lack of access to child mental health services (long waitlists), lack of culturally congruent mental health services (lack of engagement and dissatisfaction with care), lack of workforce in public mental health (crisis in hiring and retaining masters-level workforce). The CARE project and well-being specialist pilot study seeks to directly address these three emergencies in community mental health.

2. What do you recommend?

1) Conduct a demonstration study pilot with the intent of informing the BH Council's teaching clinic pilot to inform the anticipated 2025 recommendations for teaching clinics including the enhanced **rate needed** to support the therapeutic activities and career pathway for "well-being specialists" within community mental health agencies. The study would convene community mental health agencies who participate in an organizational and training initiative to support the expansion of the following services:

    - Screening and training in core therapeutic competencies (e.g., empathy, listening, group facilitation)
    - Structured psychoeducational groups aimed at specific child/youth mental health needs, e.g., "Responding to your child's anxiety"
    - Transdiagnostic groups aimed at building foundational mental health skills, e.g., "Parent mindfulness", "Healing from trauma"
    - Coaching skills focused on transdiagnostic skills, e.g., problem-solving, emotional coping, self-care, healing
    - Standing up community advisory boards to inform agency programs and procedures

2) Direct HCA to conduct an analysis as part of phase two of the CMS state plan revision to determine whether it is preferable to use the existing Agency Affiliated Counselor role as a mechanism to hire "well-being specialists" with High School + competency-based training, or to create a new workforce type. And to explore how to create more parity between the SUD and mental health SERI (Service Encounter Reporting Instructions) by opening up more billable therapeutic services **pre-diagnosis** – potentially beginning with services delivered with or exclusively by well-being specialists as identified in #1.

3. Why is this a smart move now?

As noted above, our state is grappling with three interrelated emergencies. This approach is expected to expand the capacity of the public mental health system to offer clinical mental health support (i.e., support expected to directly improve mental health symptoms/recovery) while providing a career ladder for a more culturally diverse mental health workforce.

4. What outreach has informed this recommendation?

This recommendation comes from the legislatively funded CARE project and the CARE codesign team. This is a highly engaged process guided by a multisector codesign team (consumers, advocates, social workers, psychologists, psychiatrists, WA state community mental health providers) with outreach across Washington state through a community sounding board (>300 enrolled board members) and a multisector advisory team including health equity experts, nontraditional mental health providers, BIPOC-led organizations, implementation and clinical intervention treatment scientists, payors, and Accountable Communities of Health. The specific wording of the above policy recommendations was vetted and informed by conversations with the Behavioral Health Institute, Bachelor's Certification Program, Behavioral Health Council, Health Care Authority, and the CARE codesign team, although UW CoLab takes responsibility for any specific wording choices.

School-Based Behavioral Health and Suicide Prevention (SBBHSP)

2024 Recommendations

School-based behavioral health funding for school districts

Legacy	**$$$**	**Budget Ask**

Recommendation: Provide funding directly to local education agencies (LEAs) to plan, coordinate, and/or provide school-based supports that address the emergent mental health crises in their student populations, specifically targeting funding for LEAs who have not been able to develop a plan for recognition, initial screening, and response to emotional or behavioral distress as required by RCW 28A.320.127.

1. What is the issue?

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

The Office of the Superintendent of Public Instruction (OSPI) conducted a survey of all 321 Local Education Agencies (LEAs) in the state between March 2022 and February 2023 to gauge compliance with the RCW 28A.320.127.[29] Data collected from the survey found that only 172 LEAs (54%) reported that they had an EBD plan in place. **149 LEAs reported they did not have an EBD plan in place**. The survey asked LEAs about barriers they encountered in developing an EBD plan. Lack of time or adequate staff was the most mentioned barrier, cited by 84 LEAs in the survey. Lack of funding and/or resources was the second most commonly cited barrier. Many LEAs mentioned that they needed more funding to ensure proper training and professional development, both to create the plan and train their staff to support the plan once it was created. Several LEAs also mentioned that they would need funding for an additional staff member to create the plan, since they felt their current staff didn't have the time or the proper expertise. Similarly, some LEAs said that they would need money to hire behavioral health staff to support the plan once it was created. Other LEAs pointed to a lack of behavioral health resources in their community as a barrier to putting this plan in place and/or emphasized, in general, that the EBD RCW, as it stands, is "another unfunded mandate."

2. What do you recommend?

The legislature should allocate $5 million to establish a statewide grant targeted toward local education agencies (LEAs) who have **not** been able to develop a plan for recognition, initial screening, and response to emotional or behavioral distress as required by RCW 28A.320.127. Funding should prioritize the following activities:

- Technical assistance, training, resources and/or staff support to adequately meet the behavioral health needs of all students, including creating and/or strengthening a plan for recognition,

[29] This data collection effort was legislatively mandated via RCW 28A.300.645

screening, and response to emotional or behavioral distress in students

- Creating a tiered approach to suicide prevention inclusive of prevention, intervention, and postvention

The grant program should pair grantees with a state-level and regional support/accountability structure to guide LEA planning, connect LEA staff to effective training and technical assistance, and ensure community-centered implementation. This recommendation seeks to further invest in local capacity to achieve the functions of high-quality school mental health supports that improve student well-being.

3. Why is this a smart move now?

OSPI survey data from the last 19 months shows a clear picture of where LEAs need support with planning and coordinating for effective screening, recognition, and response to emotional and behavioral distress in students. **149 LEAs (46% of those across the state) self-reported that they did not have an EBD plan in place.** Within that context, we know that WA students are experiencing a mental health crisis. 19% of 8th graders, 20% of 10th graders, and 20% of 12th graders said they **considered** suicide in the past year. 9% of 8th graders, 8% of 10th graders, and 7% of 12th graders said they **attempted** suicide in the past year. Among 12th grade students, 74% said they felt nervous or anxious in the past two weeks, 63% said they were unable to stop or control their worrying in the past two weeks, 48% reported feeling sad or hopeless in the past year, and 15% felt they had no adult to turn to for support when feeling sad or hopeless.[30] The data on these mental health indicators show significant disproportionality by race, sexuality, and disability status. In one tragic example, the 2022 COVID-19 Student Survey found that 20% of students that – when asked their gender – identify as transgender, 10% of students that identify as "questioning or unsure of their gender," and 12% of students that marked "Something else fits better," said they **attempted** suicide in the past year, compared to 3% and 5% of their peers that identified as male or female, respectively. It is imperative that we address the mental health crisis that WA students are facing by providing crucial funding support for LEAs to use to create and strengthen their EBD plans and mental health support systems. We acknowledge that the Legislature made a significant investment in the funding allocations for physical, social, and emotional (PSES) support staff through House Bill 1664 (2022). This funding will move our system towards a longer-term "righting" of the school staff capacity we need for prevention/education. However, schools need dedicated funding right now to address the mental health crisis WA students are facing.

4. What outreach has informed this recommendation?

The School-Based Behavioral Health & Suicide Prevention Subcommittee is made up of 37 members, including family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations, along with a Youth Advisory Committee that includes 11 youth and young adults with lived experience interacting with behavioral health supports in WA K-12 schools. The Subcommittee developed recommendations across five Zoom workshops and three Zoom Youth Advisory Committee meetings. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here reflects the **top ranked priority** in the survey.

Mental Health Training in School Communities

New	**$$-$$$**	**Budget Ask**

Recommendation: Provide funding to school districts to provide culturally responsible, evidence-based and/or

[30] Data from this section is from the Healthy Youth Survey that surveyed students across WA in October 2021; see askhys.net for more information on the data and the process used to collect it.

Professional Education Standards Board (PESB) approved mental health and suicide prevention training for certificated and classified staff and student families.

1. What is the issue?

WA state's requirements for school staff mental health training include the following:

- Staff with Education Staff Associate credentials (including school nurses, social workers, psychologists, and counselors) must complete a three-hour training on youth suicide screening and referral every five years.
- An applicant for a new teaching credential must complete a course on issues of abuse; the course must include information regarding recognition, initial screening, and response to emotional or behavioral distress in students, including youth suicide.

There are no other requirements in place that require training related to behavioral health for staff in schools. The state does provide funding for school districts for three professional learning days for certified instructional staff every year. However, only one of those three days every other year must be focused on a social emotional learning (SEL) topic. The law includes mental health literacy and other topic areas related to mental health & suicide prevention in its definition of SEL, but it does not grant state oversight to ensure that trainings for instructional staff meet the threshold of PESB approval. As a result, schools are largely left on their own to identify effective, evidence-based, and culturally responsive options for training on this crucial topic and the funding for the staff time necessary to enable staff to participate in those opportunities.

Parent, guardian, and family education within school communities is also a significant part of the need around the state. Families need more support and resources for understanding and responding to the mental health needs of their students and for preventing and responding to the impacts of adverse childhood experiences (ACEs). As with staff training, there are many effective training opportunities that already exist across for families, but access to them needs to be expanded, especially for families that don't speak English at home or face other barriers to access.

2. What do you recommend?

The legislature should allocate $1,000,000 dollars to establish a statewide grant targeted toward local education agencies (LEAs) to provide culturally responsive, evidence-based and/or PESB-approved mental health and suicide prevention training for certificated and classified staff. Funding should encourage LEAs to use the funding to provide trainings and resources on mental health literacy or suicide prevention that also engage parents, guardians, and other family members of students in their school community and/or to implement parent-driven training curricula.

Allowable grant-funded activities should include:

- Contracting with an organization to provide free training for staff and/or families,
- Paying for staff time to attend existing mental health training opportunities or develop their own training opportunities for staff and parents, guardians, and families,
- Purchasing curriculum for staff and family mental health & suicide prevention trainings, and
- Establishing and/or expanding access to peer mental health & suicide prevention programs in schools.

3. Why is this a smart move now?

Staffing for behavioral health clinicians in schools remains limited. Many districts lack funding for needed

clinical staff time and those that do have funding for clinical staff face challenges hiring and retaining staff in the face of deep behavioral health workforce shortages across the state. As a result, there is a lack of clinical staff hours available to meet behavioral health needs in schools, increasing the imperative to provide information to non-clinical staff in schools, including instructional staff, with actionable knowledge about mental health literacy, supporting protective factors in students, identifying behavioral health needs in students and triaging concerns to those that can provide appropriate clinical interventions.

Education on mental health literacy is important for school staff because it enables early intervention and prevention, improves emotional well-being, reduces stigma, benefits the entire community, enhances academic success, prevents long-term consequences, strengthens school-home partnerships, eases the burden on schools, and contributes to overall public health. Education opportunities for parents, guardians, and families are a crucial component of identifying and addressing youth mental health needs across the state. By expanding resources and support throughout our school communities, we can create a more informed and engaged society that prioritizes the mental health of its youth, ultimately leading to healthier and more resilient future generations.

2021 Washington Healthy Youth Survey data underlines the need for bold action to improve school-based behavioral health supports. 19% of 8th graders, 20% of 10th graders, and 20% of 12th graders said they **considered** suicide in the past year. 16% of 8th graders and 10th graders and 15% of 12th graders said they **made a suicide plan** in the past year. 9% of 8th graders, 8% of 10th graders, and 7% of 12th graders said they **attempted** suicide in the past year. Other mental health indicators tell a similarly dire story. Among students in 12th grade, 74% said they felt nervous of anxious in the past two weeks, 63% said they were unable to stop or control their worrying in the past two weeks, 48% reported feeling sad or hopeless in the past year, and 15% felt they had **no** adult to turn to for support when feeling sad or hopeless. These numbers are only slightly lower for students in 8th and 10th grade[31]. The data on these mental health indicators show significant disproportionality by race, sexuality, and disability status. In one tragic example, the 2022 COVID-19 Student Survey found that 20% of students that identify as transgender, 10% of students that identify as Questioning or unsure of their gender, and 12% of students that marked "Something else fits better" when asked their gender, said they **attempted** suicide in the past year, compared to 3% and 5% of their peers that identified as male or female, respectively.

4. What outreach has informed this recommendation?

The SBBHSP Subcommittee is made up of 37 members, including family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations, along with a Youth Advisory Committee that includes 11 youth and young adults with lived experience interacting with behavioral health supports in WA K12 schools. The Subcommittee developed recommendations across five Zoom workshops and three Zoom Youth Advisory Committee meetings. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here includes elements of the group's **second and tenth** ranked priorities on the survey, which were (2nd) strengthening mental health training requirements for staff working with students in schools and (10th) expanding opportunities for parents/guardians to receive training and resources on mental health preventative skills that can support and benefit students and families before crisis occurs.

[31] Data from this section is from the Healthy Youth Survey that surveyed students across WA in October 2021, see askhys.net for more information on the data and the process used to collect it.

Designating and funding a lead agency for school-based behavioral health

Previous	$$$-$$$$	Legislative Policy; Budget Ask

Recommendation: Designate a statewide leadership authority for student behavioral health and well-being, with a mandate to ensure student access to a continuum of effective behavioral health services in school and interconnected community settings. Provide funding to the leadership authority to act on that mandate.

1. What is the issue?

Behavioral health and wellness supports for K-12 students in Washington are fragmented and uncoordinated. The Office of the WA State Auditor's 2021 Performance Audit on K-12 Student Behavioral Health in WA provided the basis for this recommendation.[32] Their audit found that:

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

The SBBHSP Subcommittee has spent significant time discussing these issues over the last two years. Members emphasized that the state does not have a comprehensive, unified working plan for school-based behavioral health with corresponding organizational oversight. No state agency is accountable or responsible for ensuring, facilitating, or supporting student access to school-based behavioral health services. As a result, WA youth are being left underserved in a critical time of their development. Behavioral health prevention, intervention, and treatment services offered in the state are siloed. Schools struggle to coordinate across billing systems, care settings, and inconsistent funding streams (i.e., Medicaid, insurance, grants, and federal dollars). Members noted that the state lacks a dedicated financial infrastructure to support school-based behavioral health. Grants and time-bound funding are not a viable solution. Effective and equitable statewide coordination for student behavioral health services requires a behavioral health lead agency with resources, knowledge, and capacity to connect state, regional, and local stakeholders related to school-based services.

2. What do you recommend?

The legislature should designate a statewide leadership authority for student behavioral health and well-being, with a mandate to ensure student access to a continuum of effective behavioral health services in school and interconnected community settings.

Upon doing so, the legislature should allocate $10 million to the lead authority with requirements to:

1. Establish and maintain an advisory council with representatives from HCA, OSPI, educational service districts, school districts, and other key partners such as managed care organizations and community providers. The council's responsibilities should include:

[32] You can find the full report on the Office of the WA Auditor's website, at https://sao.wa.gov/performance_audit/k-12-student-behavioral-health-in-washington/

a. Developing a Washington State framework for comprehensive, interconnected school-based behavioral health (SBBH) based on evidence for effective systems, programs, and data systems,

b. Developing recommendations for a statewide SBBH training and technical assistance (TA) entity that can aid districts to design, fund, and implement comprehensive, interconnected SBBH based on the Washington State SBBH framework and train relevant leaders and practitioners on effective SBBH systems, practices, and data systems; and

c. Creating an accountability system for SBBH based on the Washington State SBBH framework that includes outcome and quality/fidelity measures at the state, district, and school levels.

2. Establish strategic direction and goals for programming around the full continuum of SBBH services funded under this legislation.

3. Develop a comprehensive workforce development strategy addressing needs across the SBBH continuum and align with the CYBHWG's Prenatal-25 Strategic Plan Advisory Group's work in this area.

    a. Create resource(s) to provide clear definitions for Education Staff Associate (ESA) roles and provide guidance for coordination between ESA roles to meet comprehensive SBBH needs in schools.

4. Create and make available and accessible comprehensive information on well-supported Tier 1 (including mental health literacy), Tier 2, and Tier 3 programs/curricula that are relevant to districts as they develop their comprehensive SBBH strategy and for which training, and implementation support can be readily provided by the Washington SBBH training and TA Center (WSTTAC).

5. Establish an initial grant program to aid districts to develop comprehensive SBBH systems based on assessment of their strengths and needs for development using the Washington State SBBH framework and TA from the statewide SBBH training and TA entity.

6. Report results from the Washington State SBBH accountability system to the Legislature annually.

3. Why is this a smart move now?

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

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

The National Assembly on School-Based Health Care emphasizes the role state leadership can play in its *10 Critical Factors to Advancing School Mental Health* brief[33] as such – "State leaders across child-serving public sectors must establish a cohesive and compelling vision and shared agenda for school mental health that can inspire localities to act."

The Subcommittee is hopeful that this recommendation will be prioritized given the Governor's directive to take action to address the behavioral health crisis so many children and youth are facing. 2021 Washington Healthy Youth Survey data underlines the need for bold action to improve school-based behavioral health supports. 19% of 8th graders, 20% of 10th graders, and 20% of 12th graders said they **considered** suicide in the past year. 16% of 8th graders and 10th graders and 15% of 12th graders said they **made a suicide plan** in the past year. 9% of 8th graders, 8% of 10th graders, and 7% of 12th graders said

[33] Challenges and Opportunities (nasbhc.org)

they **attempted** suicide in the past year. Other mental health indicators tell a similarly dire story. Among students in 12th grade, 74% said they felt nervous of anxious in the past two weeks, 63% said they were unable to stop or control their worrying in the past two weeks, 48% reported feeling sad or hopeless in the past year, and 15% felt they had **no** adult to turn to for support when feeling sad or hopeless.[34]

4. What outreach has informed this recommendation?

The School-Based Behavioral Health & Suicide Prevention Subcommittee is made up of 37 members, including family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations, along with a Youth Advisory Committee that includes 11 youth and young adults with lived experience interacting with behavioral health supports in WA K12 schools. The Subcommittee developed recommendations across five Zoom workshops and three Zoom Youth Advisory Committee meetings. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here was the **third ranked priority** in the survey.

Improving student access to mental health literacy education

New	**$**	**Budget Ask**

Recommendation: Provide funding to a state agency (Office of Superintendent of Public Instruction or Department of Health) to fund an FTE staff position to serve as a mental health curriculum lead responsible for reviewing, disseminating, and cataloging high-quality, mental health literacy instructional curriculum for the P-12 education system.

1. What is the issue?

Washington schools need to provide strong prevention support for students, and the foundation of prevention support is dedicated instruction to students on mental health literacy and suicide prevention. Mental health education is more proactive and cost-effective than waiting for needs to arise to the level of concern where treatment is required. Education on mental health literacy helps create informed students who know how to understand and respond to concerns they notice in themselves and in their peers.

Current Washington P-12 Health Education standards are insufficient. While schools may include mental health literacy topics in health education classes, there is no state requirement to do so. School districts have the authority to meet health and fitness requirements as they see fit, which may or may not include instruction on mental health literacy or suicide prevention. When schools do choose to provide mental health literacy and suicide prevention instruction to students, there is no state oversight to ensure that the curriculum they use is culturally responsive and research-informed and that those tasked with teaching it has the competency to do so effectively. Peer-to-peer mental health and suicide prevention groups can be empowering, student-driven structures to encourage students to use the tools they gain from instruction effectively, but schools need more support in connecting with appropriate curriculum.

Data from the 2019-21 Behavioral Health Navigator Survey indicated that only 68% of districts surveyed were providing student instruction on mental health or substance use at the time they were surveyed. Again, there is no mechanism at the state level to assess the effectiveness of the instruction districts are providing at the state-level. There are many evidence-based options for schools to refer to and use for mental health curriculum already available; however, many schools don't know about them or have an

[34] Data from this section is from the Healthy Youth Survey that surveyed students across WA in October 2021, see askhys.net for more information on the data and the process used to collect it.

efficient way to sort through them for use.

2. What do you recommend?

The legislature should allocate $150,000 to a state agency (Office of Superintendent of Public Instruction or Department of Health) to fund an FTE staff position to serve as a mental health curriculum lead responsible for reviewing, disseminating, and cataloging high-quality, mental health literacy instructional curriculum for the P-12 education system. The staff member in this new state lead position should work to connect and support the ongoing the work of the Mental Health Literacy Library and act as a proactive liaison providing implementation support to education service districts (ESDs) and school districts looking to provide effective curriculum for students

3. Why is this a smart move now?

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

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

There was consensus among School-based Behavioral Health & Suicide Prevention (SBBHSP) Subcommittee members this year that Washington should mandate mental health literacy education for all students and update state health class standards to include mental health literacy standards. This recommendation seeks to strengthen state capacity to provide resources and guidance to school districts on selecting and implementing research-informed mental health literacy curriculum, with an eye toward the building the necessary local, regional, and state capacity to provide the level of instruction that a state-wide mandate would require.

Mental health literacy instruction must be trauma-informed and culturally-responsive – instruction that isn't can actively cause harm to students, especially those who have been subjected to historical, systemic trauma. Efforts to increase the number of classrooms across the state where MHL instruction is taught must be paired with increased opportunities for staff training on how to teach and reinforce MHL concepts.

4. What outreach has informed this recommendation?

The SBBHSP Subcommittee consists of 37 members, including family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations, and a Youth Advisory Committee consisting of 11 youth and young adults with lived experience interacting with behavioral health supports in WA K12 schools. The Subcommittee developed recommendations across five Zoom workshops and three Zoom Youth Advisory Committee meetings. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here includes elements of the group's fourth and seventh ranked priorities on the survey; (4th) improving the adoption of mental health literacy curriculum in school and (7th) creating a mental health curriculum champion at a state agency to promote awareness of available teaching resources, respectively.

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