# Children and Youth Behavioral Health Work Group (CYBHWG)

**Zoom meeting:** [https://zoom.us/j/98435251838?pwd=UmtRdFVsdS9sUDlZZjg3aGRKLzhBQT09](https://zoom.us/j/98435251838?pwd=UmtRdFVsdS9sUDlZZjg3aGRKLzhBQT09)

(see last page for details)

## Attendees

| Representative Lisa Callan, Co-Chair | Dorothy Gordor | Cindy Myers |
| MaryAnne Lindeblad, Co-Chair | Dr. Robert Hilt | Michele Roberts |
| Dr. Avanti Bergquist | Kristin Houser | Joel Ryan |
| Tony Bowie | Averayl Jacobson | Noah Seidel |
| Representative Michelle Caldier | Kim Justice | Mary Stone-Smith |
| Diana Cockrell | Michelle Karnath | Representative My-Linh Thai |
| Senator Jeannie Darneille | Judy King | Jim Theofelis |
| Jamie Elzea | Steve Kutz | Dr. Eric Trupin |
| Representative Carolyn Eslick | Sarah Kwiatkowski | Sen. Judy Warnick |
| Dr. Thatcher Felt | Amber Leaders | Mandy Weeks-Green |
| Cory Gildred | Laurie Lippold | Lillian Williamson |
| Camille Goldy | Lauren Magee | Dr. Larry Wissow |
| | | Jackie Yee |

## Agenda Items

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<th>#</th>
<th>Agenda Items</th>
<th>Time</th>
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<tbody>
<tr>
<td>Pre</td>
<td>Zoom Meeting Active for Early-Sign On &amp; Technical Troubleshooting</td>
<td>12:45 – 1:00</td>
<td>Kimberly Harris/ Rachel Burke</td>
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<tr>
<td>1.</td>
<td>Introductions</td>
<td>1:00 – 1:15 pm</td>
<td>Rep. Lisa Callan/ MaryAnne Lindeblad</td>
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<td>2.</td>
<td>Landscape / Behavioral Health Forecast</td>
<td>1:15 – 1:35</td>
<td>Dr. Tona McGuire (DOH)</td>
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<td>3.</td>
<td>Subgroup updates</td>
<td>1:35 – 3:15</td>
<td>Co-Chairs</td>
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<td></td>
<td>Legislative/Budget &amp; considerations for recommendations</td>
<td>10 minutes</td>
<td>Laurie Lippold/Hugh Ewart</td>
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<td></td>
<td>Workforce and Rates</td>
<td>15 min. presentation; 5 min. Q&amp;A</td>
<td>Jamie Elzea</td>
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<td></td>
<td>Prenatal to Five Relational Health</td>
<td>15 min. presentation; 5 min. Q&amp;A</td>
<td>Camille Goldy</td>
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<td></td>
<td>School-based Behavioral Health and Suicide Prevention</td>
<td>15 min. presentation; 5 min. Q&amp;A</td>
<td>Rep. Lauren Davis</td>
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<td>Youth and Young Adult Continuum of Care</td>
<td>15 min. presentation; 5 min. Q&amp;A</td>
<td>Hugh Ewart</td>
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<td></td>
<td>Cross-cutting</td>
<td>5 min.presentation; 5 min. Q&amp;A</td>
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<td>- Referral Assistance Program, behavioral health rate increase, telehealth</td>
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<td>4.</td>
<td>Public Comment</td>
<td>3:15 - 3:30</td>
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<td>5.</td>
<td>Voting</td>
<td>3:30 – 3:40</td>
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<td>Voting (1st 5 minutes) and BREAK</td>
<td>3:30 - 3:45</td>
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<td>6.</td>
<td>Report: Voting results</td>
<td>3:45 - 3:50</td>
<td>HCA Staff</td>
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Join Zoom Meeting
https://zoom.us/j/98435251838?pwd=UmtRdFVsdS9sUDIIZjg3aGRKLzhBQT09

Meeting ID: 984 3525 1838
Passcode: 792187
One tap mobile
+12532158782,,98435251838# US (Tacoma)
+13462487799,,98435251838# US (Houston)

Dial by your location
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 669 900 6833 US (San Jose)
+1 312 626 6799 US (Chicago)
+1 929 205 6099 US (New York)
+1 301 715 8592 US (Germantown)

Meeting ID: 984 3525 1838
Find your local number: https://zoom.us/u/aclaaONybT
Upwards of three million Washingtonians will likely experience clinically significant behavioral health symptoms within the next 2-5 months.

- Depression, anxiety, and acute stress will likely be the most common
- PTSD less common, but concern among some populations (post-vent critical care, exposure to traumatic events)
- Significant decrease in depression and anxiety from July, trend likely short-term

Substance use related challenges are expected to significantly increase:

- Roughly 50% of individuals who experience behavioral health diagnoses develop a substance-related disorder, and vice versa
- Most, but not all, are an exacerbation of pre-existing problematic behavior
Reactions and Behavioral Health Symptoms in Disasters

Emotional Response – Lows to Highs

- Pre-Disaster
- Warning
- Threat
- Impact
- Heroic
- Honeymoon – Community cohesion
- Inventory
- Trigger Events

Discountment
- Setback
- Working through grief – Coming to terms
- Anniversary Reactions

Washington, as of 9/21/2020

Months Pre- and Post-Outbreak

Psychological Distress – Under 18 and All Groups, 2019-2020

- Under 18 (+78 per 10k, weekly avg)
- Over 18 (-59 per 10k, weekly average)
Suicidal Ideation—Under 18 and All Groups, 2019-2020

- Under 18 (+170 per 10k, avg weekly)
- Over 18 (-81 per 10k, avg weekly)

Suicide Attempt—Under 18 and All Groups, 2019-2020

- Under 18 (+86 per 10k, weekly avg)
- Over 18 (-9 per 10k, weekly avg)
Data from Washington Poison Control for Ages 13-17

Intentional self-harm/suicidal intent up by 5%
  o Over-the-counter medications
  o Misuse of prescribed medications (e.g., atypical antipsychotics)

Substance abuse (wanting to get “high”)
  o Over-the-counter medications, such as antihistamines, cough medicine
  o Illegal substances, such as alcohol and cannabis, up by 34%

Common Responses to Disaster for Children and Teens

Physical Symptoms
  • Headaches
  • Stomachaches
  • Trouble sleeping
  • Appetite changes

Changes in Behavior
  • Substance abuse
  • Increased risk taking
  • Acting like there is nothing good in the future
  • Acting immature or younger than their age
  • Increased tantrums
  • Increased clinginess
Common Responses to Disaster for Children and Teens (Cont.)

Changes in Mood
- Worried for the safety of others
- Cranky
- Worried the disaster will happen again
- Too agitated or hyper
- Feeling angry, sad, or fearful

Changes in Thinking
- Trouble concentrating
- Difficulty learning new things
- False belief that it is their fault
- Loss of trust that adults can protect them

Helping Teens
- Encourage teens to express their thoughts and feelings by being an active listener
- Educate them in common responses to trauma and ways to practice self-care
- Discuss (without lecturing) the dangers of unhealthy ways of coping
  - Alcohol or drug use
  - Getting involved in violent or illegal activities
  - Being in unhealthy relationships
- Provide information on healthy ways to deal with stress
Impact of COVID-19 on Education And Learning

- Difficulty paying attention, having a hard time focusing on schoolwork
- Trouble remembering what was learned and remembering to complete tasks
- Having too much energy, acting too silly
- Feeling really tired all the time
- Sleep and appetite disturbances
- Having headaches or stomachaches
- Being cranky, having outbursts, or crying often
- Impulsiveness or having a hard time thinking before speaking or taking action

Priorities For Dealing With The Impact of COVID-19

1. Helping with behavioral symptoms of regression, isolation, acting out or acting in
2. Educational deficits which need to be addressed
3. Need for structure and support (e.g., help contain negative behaviors, practice positive behaviors, and increase resiliency)
4. Recognizing that the ability to learn and retain new information is impacted by emotional state
5. Teaching tools for calming and emotional regulation for both parent and child
6. Help children and teens face fears and master them versus anxious avoidance
7. Parental self care is essential for their child’s well-being
Resources – Children & Youth:

Families, Children, and Teens
- Behavioral Health Toolbox for Families: Supporting Children and Teens During the COVID-19 Pandemic
- Behavioral Health Group Impact Reference Guide: Families and Children
- Supporting kids and teens: Infographic
- Helping kids to wear cloth face coverings: Infographic and article
- Emerging adults: Infographic and article

Resources - General:
DOH - Forecast and situational reports, guidance and resources:

WA State – General mental health resources and infographics:

Looking for support?
Call Washington Listens at 1-833-681-0211
Questions?

Washington State Department of Health is committed to providing customers with forms and publications in appropriate alternate formats. Requests can be made by calling 800-525-0127 or by email at civil.rights@doh.wa.gov. TTY users dial 711.
Children and Youth Behavioral Health Work Group

Summary: Proposed recommendations for 2021

Submitted by subgroups on October 21, 2020 for consideration of the work group as a whole

Workforce and Rates *(detailed proposals begin on page 8)*

<table>
<thead>
<tr>
<th>Proposal</th>
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| $ | Expand the Student Loan Repayment Program and reduce existing barriers to access in order to reach and retain more providers.增加学生贷款偿还/宽恕资金，以便为更多提供者提供服务。额外资金将被具体指定用于为社区行为健康机构或社区诊所工作人员与医疗援助计划（公共服务）中的青少年和他们的家庭（年龄0-24）提供服务。学生贷款偿还/宽恕项目将仅用于增加为年龄0-24的青少年和他们的家庭工作而取得执业资格的临床人员的保留率。

   Preference/Priority would be given to those applicants with diverse ethnic and cultural backgrounds (though not required). The WA State Achievement Council would be directed to ensure that the application process is streamlined and easy to navigate and that conditional complexity be kept to a minimum for both the individual and the agency to qualify. The required length of the conditional commitment should be 4-5 years of total services or 2-3 years post licensure.

   Specifics related to implementation will be developed in collaboration with the WA Student Achievement Council. Funding sources will be explored, including funding from the private sector and establishing a dedicated funding source. |

| $ | Establish a work group to develop a Behavioral Health Teaching Clinic enhancement rate for licensed and certified behavioral health agencies.建立一个小组来制定行为健康教学诊所的增强率，用于有执照和认证的行为健康机构。代表们将来自医疗保健管理局、卫生部、劳动力培训和教育协调委员会、行为健康委员会、有执照和认证的行为健康机构（BHA）以及高等教育机构。他们必须制定标准来确定一个教学诊所的增强率，为BHA的培训和监督学生以及那些正在寻求认证或执照的学生。他们必须制定标准来将BHA识别为教学诊所，包括为儿童和家庭服务的一定比例；确定教学诊所增强率的成本方法；以及一项实施的融资机制，包括可能的Medicaid/Medicare报销；以及一个实施的时间表。报告应由州长和州立法机构的相应委员会于2021年11月1日提供。 |

| $ | |

= Budget proposal  = Policy proposal  = Statement of support
Support legislation requiring that continuing education requirements for all licensed, certified, and registered behavioral health professionals include the provision of culturally and linguistically responsive treatment.

While it is critical that the behavioral health workforce become more diverse, behavioral health professionals who are working with children and youth of different races, ethnicities, cultures, religions and gender identities must have ongoing training in diversity, equity, and inclusion in order to be as effective as possible. Additionally, training should be available that focuses on the emotional well-being of children and youth of diverse backgrounds.

The relevant licensing boards and commissions shall develop standards and criteria for the training and will determine the number of required hours based on available research and evidence but will be no less than a minimum of 4 hours for every new and every license, certification or registration renewal.

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<tr>
<th>Work in partnership with the Behavioral Health Apprenticeship Coalition to advocate for legislative support for funding and the necessary statutory changes to develop and implement a registered behavioral health apprenticeship model.</th>
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<tr>
<td>This model will serve to diversify the workforce and increase access to critically needed behavioral health services, including services for children and youth ages 0-24. Funding is needed to enable employers to participate in the program. Additionally, legislative support and direction is necessary in order to ensure that rule changes to licensing eliminate onerous licensure requirements, which are barriers for individuals seeking dual SUDP and MH credentialing.</td>
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<td>The demand for behavioral healthcare - mental health and substance use disorder treatment - exceeds the availability of services throughout the state. The vision is to build a state-wide behavioral health educational pathway infrastructure launched through apprenticeship opportunities that is supported and endorsed by Washington State and employed by behavioral health employers across the region promoting accessibility, retention and stability within the behavioral health workforce.</td>
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Engage with and support the Workforce Training and Education Coordinating Board’s efforts to address barriers created through often-inflexible background checks as requirements for behavioral health professionals.

In the behavioral health field, lived experience is highly valued, there is considerable support for the use of peer counselors, and efforts are underway to establish an apprenticeship program. There is also a great need to increase and diversify the workforce, making it even more important than ever to eliminate barriers and open up the field to individuals who have a tremendous amount to offer and should be provided opportunities to do so.
| proposals begin on page 2 |

**Change Medicaid policy so that best practices for mental health assessment and diagnosis of children birth through 5 years old can be implemented and diagnosis and treatment disparities reduced.**

Change Medicaid policy to allow three-five sessions (including in natural settings) utilizing the DC:0-5 manual so that misdiagnosis and subsequent ineffective/harmful treatment are avoided, thereby reducing diagnosis and treatment disparities currently experienced (particularly by boys of color) and cost of ineffective treatment.

1. Allow three to five sessions for intake and assessment of children 0-5
2. Allow children 0-5 to be served in their home or other natural settings, and reimbursing clinicians for necessary travel to natural settings
3. Require clinicians to use the developmentally appropriate standard of practice for diagnosing children 0-5, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)[i], rather than the Diagnostic and Statistical Manual of Mental Disorders.

**Medicaid match**

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**Establish a complex needs fund to address the behavioral health challenges experienced by children ages 0-5 and their families so that children, families, and early learning providers can experience reduced bias and have immediate relief.**

Establish an account to help address the behavioral health challenges children ages 0-5 experience. This account is for: (a) early learning providers to get support to pay for infant and early childhood mental health consultants; and, (b) infant and early learning childhood mental health consultants to pay for behavioral health, anti-bias, and anti-racist coaching that will make an immediate impact on their practice.

With the added (and in some cases severe) trauma due to the pandemic, children, families, child care providers, and the mental health consultants working with them urgently need more support. Research shows infant and early childhood mental health consultation is an effective strategy that leads to improvement in children’s social and emotional functioning, early learning providers’ relationships with families, and in dyadic relationships. It is effective in reducing racial disparities in children’s socio-emotional functioning and teacher-child relationship, suspensions and expulsions, and missed work days for parents.

This account will help increase access to unbiased consultation and evaluation services, taking into account child development and family experience for Black/African American children and families, specifically, and children and families of color, in general, to decrease the numbers and ameliorate the impacts of preschool suspensions and expulsions as well as child welfare involvement. Additionally, this account will help increase access to mental health consultation for families experiencing poverty and those living in rural and under-resourced communities. In turn, equitable and expanded access to unbiased mental health consultation and evaluation services will also improve the quality of services provided to children and families.
Preservation Statement: Support existing investments in infant and early childhood mental health consultation so that children in early care and education experience reduced bias that leads to expulsions and suspensions.

The Prenatal-5 Relational Health Subgroup (P5RHS) supports full preservation of the state investments in infant and early childhood mental health consultation (IECMH-C) which is an annual investment of $773,000 GF-S.1. The state funding supports six mental health consultants to support early providers in addressing challenging behaviors.

These consultants are situated at the six regional affiliates of Child Care Aware Washington. As of September 15, 2020, there were 3,271 child care providers who are serving 107,678 children who can access one of these six consultants. That leaves 1,721 providers serving 54,883 children who do not have access to these consultants.

Thus there is high unmet need and in order to someday address that unmet need, we must preserve what we have in order to build upon it in the future. Additionally, the state investment leverages private funding for things the state investment does not cover. IECMH-C is one of the few evidence-based interventions that we have found that can have an impact on the disproportionate expulsion of boys of color.

Remove clinical barriers to postpartum mood and anxiety screening so that health disparities can be eliminated.

Support the exploration of the Washington Chapter of the American Academy of Pediatrics’ “learning collaborative” (held September 2020 – June 2021) so that we can identify and prepare to remove clinical barriers and eliminate racial disparities in routine postpartum mood and anxiety disorder screening and treatment.

School-based Behavioral Health and Suicide Prevention
(detailed proposals begin on page 42)

Provide support for districts to implement equity-based Multi-tiered Systems of Support (MTSS), including the Interconnected Systems Framework (ISF) for behavioral health, through training, coaching, and technical assistance using a consistent, statewide framework. MTSS uses data-based decision making to support improved student outcomes and accountability at each level of the system (state, district, school, classroom, and student).

A multi-tiered system of supports (MTSS) is a framework for enhancing the adoption and implementation of a continuum of evidence-based practices to improve important outcomes for all students and decrease adverse outcomes for student groups who experience opportunity gaps. MTSS integrates both academic and non-academic supports to meet the needs of the whole child. By integrating these supports, schools may also increase the efficiency, effectiveness, and sustainability of their services (McIntosh, K., & Goodman, S. 2016). As students (and adults) are experiencing the additional traumatic effects of a global pandemic, MTSS also provides a framework for more effectively integrating behavioral health supports into the school setting.

For the purposes of this recommendation, the School-Based Behavioral Health and Suicide Prevention Subcommittee recommends the CYBHWG support the MTSS Decision Package submitted to the 2021 Legislature by the Office of Superintendent of Public Instruction:

The package funds 12 regional implementation specialists to train, coach and support districts in order to align policies, personnel, and other resources so that their schools can implement and sustain MTSS with fidelity.

Increase staffing levels in schools to support the social/emotional/behavioral health of students. Increasing staffing will improve tier 1 universal supports for students, as well as provide increased staffing to provide individual and targeted supports to students with more significant behavioral health needs.

The subcommittee recommends that the Work Group endorse the staffing enhancements proposed by the Office of Superintendent of Public Instruction (OSPI) to support the social/emotional/behavioral well-being of students. The OSPI decision package, “Building Staffing Capacity to Support Student Well-Being,” requests increased staff allocations in the prototypical school funding model for school counselors, school nurses, social workers, psychologists, family engagement coordinators, and student, and staff safety personnel no later than the 2024-25 school year.

The subcommittee recommends support for Components 1 and 2:

Component 1 of the Decision Package includes more appropriate staffing allocations to help ensure students are in healthy, safe, and productive learning environments.

Component 2 includes additional days of professional development for certificated and classified staff. This increase phases in over three years, with the end result of six days for certificated instructional staff and classified staff, and three days for certificated administrative staff. The professional development would include, in part, mandatory learning focused on racial literacy and cultural responsiveness. This focus is necessary to accelerate the closure of persistent opportunity gaps. Training on these topics is critical for serving all students, regardless of race. Professional development for racial literacy will be expected of all district personnel statewide on an ongoing basis. Request for the 2022-2023 School and Fiscal Year: $194,831,000.

The subcommittee did not discuss and did not make a recommendation on components three or four of the decision package.

With the support of HCA, OSPI, and other relevant agencies and organizations, the subcommittee would like to examine funding streams (including Medicaid, private insurance benefits, K-12 funding, and other federal, state and local funds) which contribute or could contribute to supporting the emotional well-being and behavioral health care of students in K-12 schools.

The committee would like to receive presentations, reports and other relevant information from HCA staff who are specialists in Medicaid funding, including covered services for children and youth, and from specialists familiar with coverage requirements for commercially available insurance plans, including individual and employer-based coverage.

The committee would also receive presentations from OSPI staff who are specialists in state and federal funds provided to schools by OSPI. The committee would also invite experts to discuss the prevalence of mild, moderate and severe behavioral health disorders and symptoms among children and youth between the ages of 6-21.
Using this information, the committee would examine available resources, systems of support and service delivery, and the prevalence of behavioral health needs, including needs exacerbated by the COVID-19 pandemic, among children and youth in K-12 schools in Washington. The committee would also access existing and previous reports which contain the information necessary to conduct this assessment in an efficient manner.

Youth and Young Adult Continuum of Care *(detailed proposals begin on page 55)*

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| **Youth and family peer access and workforce** | Expand the availability of youth and family peer services across the continuum of care, remove barriers to entry and improve retention of peers in the workforce, enhance diversity in the peer workforce, and ensure peers are supported in their own recovery.  
  *Note: Further discussion is needed to distill which elements would be incorporated into a bill or budget proviso and what those precise asks would be.*  
  *Possible Medicaid match.* |
| **Youth mobile crisis services** | Expand youth mobile crisis services statewide and ensure existing teams can meet the significant increase in demand exacerbated by the pandemic.  
  *Medicaid match* |
| **Respite care for youth with behavioral health challenges and their families** | Direct HCA to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the DDA and DCYF respite waivers.  
  *Medicaid match* |
| **Improve transitional care for youth discharging from state systems** | Support the work of the SB 6560 work group in Improving transitional care for youth discharging from inpatient behavioral health and juvenile justice settings, including ensuring that young people do not end up experiencing homelessness post-discharge. |

Cross-cutting *(detailed proposals begin on page 65)*

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| **Continue the state’s child mental health referral service.** | Continue funding the “Washington State Mental Health Referral Service for Children and Teens,” to prevent program shut-down in July 2021. Request is for $850,000 annual total service budget. Beginning in 2021, when commercial carriers begin paying for this service, annual state cost (including Medicaid match) will be $425,000.  
  *Medicaid match* |
| **$** | Advance timely and equitable access to behavioral health services grounded in best practices by ensuring that Medicaid rates are sufficient to increase access and support competitive salaries.  

Support inclusion of the 2020 budget proviso (SB 6168, Sec. 211 (78), passed by the Legislature but vetoed by the Governor due to financial implications of the COVID-19 global pandemic.  

*Medicaid match*

| **Support** | Support telehealth for behavioral health services.  

Support and advocate for the use of telehealth for behavioral health services, including audio only, for children and youth 0-24 that are appropriately compensated, consistent with standards of practice, maximize the effectiveness of the tool, ensure accessibility for individuals of varying income levels, abilities and available bandwidth, and build on lessons learned.  

2020 has been an unplanned and at-scale pilot of the telehealth models that have been long-discussed. While there has not been a chance to systematically review the experience, one immediately promising finding has been that our clients can benefit from some tools in the telehealth toolkit. It is critical, though, to not jump too soon or assume that tactics can be broadly applied. Behavioral health stakeholders need the chance to struggle through the pandemic demands and then evaluate the lessons learned. This will likely result in findings that some telehealth tools are appropriate and should be secured and expanded, and other things cannot be digitized but depend on in-person, contemporaneous interaction.  

**A)** Charge a current or new committee to develop standards of practice for audio and video telehealth services so that racial and income disparities in behavioral health service access are eliminated and virtual services provided clinically effective relief for children and families.  

**B)** Require state-funded programs to publicize the availability of Washington Lifeline, ask families about the need for digital access, and make appropriate referrals so that low income families can effectively access appropriate virtual behavioral health services. |
Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

**Service continuum (check all that apply):**
- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

**Age continuum (check all that apply):**
- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

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

**Type of Recommendation**
- Legislative-policy only
- Budget ask
- Agency policy change
- Rule change

**Is this a previous priority of the work group or is it new?**
- Previous recommendation
- New recommendation
Workforce and Rates Subgroup Recommendation Brief

Student Loan Repayment Program

Policy Brief: Expand the Student Loan Repayment Program and reduce existing barriers to access in order to reach and retain more providers.

Request:

Increase funds for Loan Repayment/Forgiveness in order to serve 100 additional individuals. The funds would be specified specifically for Community Behavioral Health Agencies or Community Clinic staff working with the Medicaid population (public service) in exchange for retention. Student loan repayment/forgiveness program would be for the exclusive purpose of increasing retention rates of licensed clinical staff that work with youth and their families (age 0-24) in Washington State.

Preference/Priority would be given to those applicants with diverse ethnic and cultural backgrounds (though not required). The WA State Achievement Council would be directed to ensure that the application process is streamlined and easy to navigate and that conditional complexity be kept to a minimum for both the individual and the agency to qualify. The required length of the conditional commitment should be 4-5 years of total services or 2-3 years post licensure.

Specifics related to implementation will be developed in collaboration with the WA Student Achievement Council. Funding sources will be explored, including funding from the private sector and establishing a dedicated funding source.

What is the issue?

There is a significant workforce shortage in public health for behavioral health services and a high turnover rate in therapists once they obtain licensure which affects quality and cost. These issues are primarily due to the fact that behavioral health is underfunded so salaries are not competitive enough to retain quality staff willing to serve in Medicaid funded agencies that do not compensate for the level of severity, complexity of cases as well as the demands (required documentation, etc).

Limitations of current Loan Repayment Programs

Barriers in Qualifying

- No more than one award per site of the same profession (i.e. only one therapist)
- Must work only on site with scheduled appointments (home visiting does not qualify so WISE programs would not be eligible)
- Designed for geographic “shortage areas” only (using “rural’ markers to determine shortage areas in an attempt to target underserved populations)
- Federal match program requires federal Health Professional Shortage Area designation and have a Sliding Fee Schedule
- Timeline: Some Federal Loan Repayment requires 10 years of service
- Some loan repayment programs require loans be federal direct loans vs. guaranteed
Limited Funding

- A 2018 report indicated the vast majority (almost 99 percent) of applications for public service loan forgiveness programs are rejected.
- The Washington Student Achievement Council reported that in 2019, the existing loan repayment program for healthcare workers was only able to assist 100 people with their loans and the demand far exceeds existing funding. So in addition to the recent change of including behavioral health agencies, the funding of this program needs to expand significantly in order to impact the level of workforce shortage we are seeing in Washington State Medicaid funded programs.
Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

**Service continuum (check all that apply):**
- ☒ Prevention
- ☒ Early Intervention
- ☒ Identification
- ☒ Screening
- ☒ Assessment
- ☒ Treatment & Supports

**Age continuum (check all that apply):**
- ☒ Prenatal - 5
- ☒ 6-12
- ☒ 13-17
- ☒ 18 up to 25

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

**Type of Recommendation**
- ☐ Legislative-policy only    ☒ Budget ask    ☐ Agency policy change    ☐ Rule change

**Is this a previous priority of the work group or is it new?**
- ☐ Previous recommendation    ☒ New recommendation
Policy Brief: Establish a work group to develop a Behavioral Health Teaching Clinic Enhancement Rate for licensed and certified behavioral health agencies

Request: Representatives from the Health Care Authority, Department of Health, the Workforce Training and Education Coordinating Board, the Washington Council for Behavioral Health, licensed and certified behavioral health agencies (BHAs), and higher education must collaborate to develop a teaching clinic enhancement rate for BHAs training and supervising students and those seeking their certification or license. They must develop standards for classifying a BHA as a teaching clinic, including serving a certain percentage of children and families; a cost methodology to determine a teaching clinic enhancement rate; a financing mechanism, including potential Medicaid/Medicare reimbursement; and a timeline for implementation. A report is due to the Governor and the appropriate committees of the Legislature on November 1, 2021.

Issue/Problem/Challenge:

A. What is the issue?

Community behavioral health agencies (BHAs) serve a vulnerable population of people living with serious mental illness, serious emotional disturbance, and/or substance use disorder. Children and youth served by BHAs struggle with substantial behavioral health needs, frequently complicated by issues related to poverty such as housing, food insecurity, transportation needs, insecure or underpaid employment of a parent, etc. In addition to clinical care and care coordination, BHAs often serve as the training ground for the entire behavioral health workforce by providing the clinical supervision needed for new graduates to obtain licensure. There is a significant cost related to supervising interns and new graduates, as it takes clinicians away from providing billable direct services to patients.

Because BHAs rely primarily on Medicaid reimbursement, they are unable to offer competitive salaries to better recruit and retain their workforce. Once licensed, clinicians leave for private practice, or better paying positions with hospitals or managed care organizations. We should recognize that this churn happens and support the infrastructure of the community behavioral health system. A teaching clinic designation would be one way to recognize that, much like a teaching hospital, these BHAs are training the broader behavioral health workforce in cutting-edge treatments, including crisis interventions, wraparound care, and other evidence-based practice treatment modalities.

By formalizing the teaching role, a teaching clinic enhancement rate would improve quality of care for those patients being served in the public behavioral health system and incentivize clinical supervisors to...

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1 A 2017 workforce report submitted to the Governor and Legislature found that BHAs “serve as de facto training sites, a role which is not compensated and has a disproportionate impact on the ability of these sites to meet their primary mission: to provide behavioral healthcare services. Recognizing and compensating these sites for this function may help community-based settings better retain workers.”

2 For example, one BHA in Kitsap County calculated the total costs for onboarding, training, and supervising a post-graduate, pre-licensure Master’s-level clinician as $17,762 in Year 1, $16,082 in Year 2, and $17,047 in Year 3. A BHA in Pierce County provided similar calculations, averaging $21,060 for each of the first three years of employment, and also estimated the costs associated of internships for Master’s students as $6780 for a six-month internship and $10,020 for a nine-month one.

3 We have also asked BHAs to provide data related to their turnover rates once Masters-level clinicians have been licensed.
continue their careers training our future behavioral health workforce. It would also reduce some of the stigma around behavioral health by recognizing the innovation occurring every day in community behavioral health agencies across the state.

B. What is the problem and how does it affect children, youth, families, and communities?

The community behavioral health system provides care to an underserved health disparities population—people with a serious mental illness or substance use disorder who experience premature mortality. There is a 10- to 25-year life expectancy reduction in patients with severe mental disorders. In addition, people of color are disproportionately represented in the public behavioral health system due to the impacts of poverty, racism, and other social determinants of health. By providing upstream identification and intervention to children, youth, and families, we can get help to our patients sooner. A teaching clinic designation and rate enhancement would promote system stability and capacity by compensating essential but non-reimbursable supervisory-related tasks required to appropriately train clinicians to work with this complex population.

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

As the COVID-19 pandemic continues and children attend school remotely, there are dire predictions that we will see a significant increase of individuals and families needing behavioral health treatment. This recommendation would help support the infrastructure of the community behavioral health system, allowing us to better meet this future demand for services while developing and expanding a workforce of young professionals who may choose to continue their careers in these settings.

D. How does this change address equity and health disparities?

Again, the community behavioral health system serves a highly vulnerable health disparities population who have physical co-morbidities and often touch more than one state system (e.g., child welfare; justice system). By supporting the infrastructure of the public behavioral health system, we can help ensure better and more equitable access to behavioral healthcare for those who need it most.

E. History:

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

This is a new recommendation for the work group to consider.

F. What options do we have to change this?

This concept has worked well for teaching hospitals, and in fact, it is being proposed for UW’s new behavioral health teaching facility that will be serving patients on 90- to 180-day civil commitment orders. The 1109 Work Group led by HCA is proposing that the new teaching facility should receive a 15% enhancement in the base rate for the facility in order to compensate it for the additional costs associated with teaching and training a workforce. We can envision a pipeline between the UW teaching hospital and behavioral health teaching clinics; together, they could develop best practices related to care transitions, diversion, peer bridgers, and more.

In addition, the Health Resources & Services Administration (HRSA) supports with federal funds Teaching Health Center programs that focus on training in community-based primary care settings, such as Federally Qualified Health Centers (FQHCs), rural health clinics, and tribal health centers. HRSA has found that these training programs are a “vital supply line” to meet the increasing demand for primary care providers.4

4 https://bhw.hrsa.gov/grants/medicine/thcgme
Knowing what we know about the increasing demand for behavioral health services, we should establish a similar program for BHAs.

G. Given current limitations, why is this something we should pay attention at this time?

The concept of a teaching clinic designation would allow us to use existing workforce capacity of clinical supervisors who redirect time from patient care to observing and training interns and new graduates. This will not only increase the quality of care and supervision, but we believe it could also make working within the community behavioral health system more attractive and allow us to better recruit and retain a qualified workforce.
Recommendations proposed from subgroups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

**Service continuum (check all that apply):**
- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

**Age continuum (check all that apply):**
- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

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

**Type of Recommendation**
- Legislative-policy only
- Budget ask
- Agency policy change
- Rule change

**Is this a previous priority of the work group or is it new?**
- Previous recommendation
- New recommendation
Workforce and Rates Subgroup Recommendation Brief
Continuing education – Culturally and linguistically responsive treatment

Policy Brief: Recommendation Statement

We recommend that continuing education requirements for all licensed, certified, and registered behavioral health professionals include the provision of culturally and linguistically responsive treatment. While it is critical that the behavioral health workforce become more diverse, behavioral health professionals who are working with children and youth of different races, ethnicities, cultures, religions and gender identities must have ongoing training in diversity, equity, and inclusion in order to be as effective as possible. Additionally, training should be available that focuses the emotional well-being of children and youth of diverse backgrounds.

Request: Brief detailed description of the legislative or agency request. Include what is requested (funds, statutory change, rule change, etc.) for WHOM so that WHAT good thing happens. [Consider this the bottom line up front. Be clear, concise, and use non-wonky language. Include your best arguments on equity and ROI.]

Continuing education requirements for all licensed, certified and registered behavioral health professionals under RCW_______ shall include the provision of culturally and linguistically responsive treatment. The relevant licensing boards and commissions shall develop standards and criteria for the training and will determine the number of required hours based on available research and evidence but will be no less than a minimum of 4 hours for every new and every license, certification or registration renewal.

[Please note that a review of the appropriate providers and RCWs has not yet been completed.]

Issue/Problem/Challenge: Add footnotes¹ (optional depending on subgroup; remember the reader – be brief)

A. What is the issue?

Many individuals struggle to find providers from their cultural community. BIPOC, LGBTQ and others must receive services from individuals outside of their own communities, making it difficult for those individuals and families to receive appropriate and relevant care. Requiring this additional training for behavioral health providers will help providers better serve pat

B. What is the problem and how does it affect children, youth, families, and communities?

Briefly and persuasively describe the problem or issue and the current impact on different groups and current inequitable outcomes. Use data graphics, and images to describe the scope of the problem. Add footnotes

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

There will be no fiscal impact to the state. All behavioral health providers are already required to take continuing education, and this proposal will not add to those total hours, so it should not cost providers more than they are spending on CE now.

¹
D. **How does this change address equity and health disparities?**
   
   By requiring cultural competency training a largely white workforce can better serve the diverse communities in Washington State.

E. **History:**
   
   - Is this a previous priority of the work group, or is it new?
   - Was this recommendation previously presented as a priority to the work group but not selected?
   - Any idea why this was the case?

F. **What options do we have to change this?**

   Briefly and persuasively describe and footnote what evidence (research, experience of other states/countries, pilot results) we have that taking the recommended action would help. Use data graphics, and images to describe the potential solution (closed health outcome gap, cost savings, etc.). Add footnotes.

G. **Given current limitations, why is this something we should pay attention at this time?**

   This will improve services to children, youth and parents, but will not cost the state money, so this is a good time for this proposal.

   Briefly and persuasively describe the recommended solution/risk, what existing capacity can be leveraged, and how this could sustain or transform Washington’s ability to quickly and effectively make a difference? [Use affirmative talking points as well as opportunity costs. Given the budget climate we are in, also highlight any opportunity costs if cuts were made is also important. Particularly for CBH, is there anything we see manifested down the line which increases costs to the state, strains program bandwidth, and is tough on kids and families?] Add footnotes:

   a. **Example affirmative talking point focused on future costs savings** - The right evidence-based treatment provided early can save later costs. For example, Parent-Child Interaction Therapy (PCIT) has been found to effectively address trauma and return $3.64 per dollar of cost.

   b. **Example talking point about opportunity costs if cuts are made** - A $300,000 cut in Reach Out and Read services puts at risk a significant private match of $6.5M annually in volunteer services from doctor’s offices – each $1 the state invests leverages a $20 value in donated services.

   c. **Example talking point for return on investment (ROI)** - Near-term (X# of kids will continue getting services, we know demand exceeds this); opportunity costs (limiting the services at this point will created X, Y, Z problems in child care, K12 system, and strain the CBH response system immediately).
Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

**Service continuum (check all that apply):**
- □ Prevention
- □ Early Intervention
- □ Identification
- ☑ Screening
- ☑ Assessment
- ☑ Treatment & Supports

**Age continuum (check all that apply):**
- □ Prenatal - 5
- ☑ 6-12
- ☑ 13-17
- ☑ 18 up to 25

**Strategies to increase access & parity (check primary focus of your recommendations):**
- ☑ Capacity and access to services (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- ☑ Equity/Disparities (i.e., addresses systemic inequities and health disparities of people of color, indigenous people,
- □ Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- □ Network adequacy (Medicaid and private insurers)
- □ Payment and funding (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- □ Quality of services and supports (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- □ Cross-system navigation and coordination (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- □ Trauma-informed care (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)
Policy Brief: The demand for behavioral healthcare - mental health and substance use disorder treatment - exceeds the availability of services throughout the state. This situation is largely driven by the lack of a qualified workforce by providers who have difficulties recruiting, educating, training, and retaining a qualified behavioral healthcare workforce. The need for qualified behavioral health staff comes at a time of significant systems integration, an epidemic of opioid and methamphetamine use and an increase in suicide rates – these complicating factors have been exacerbated by the current pandemic, which is projected to have a crippling impact on the state’s population with regards to behavioral health. The vision is to build a state-wide behavioral health educational pathway infrastructure launched through apprenticeship opportunities that is supported and endorsed by Washington State and employed by behavioral health employers across the region promoting accessibility, retention and stability within the behavioral health workforce.

Request: Work in partnership with the Behavioral Health Apprenticeship Coalition to advocate for legislative support for funding and the necessary statutory changes to develop and implement a registered behavioral health apprenticeship model that will serve to diversify the workforce and increase access to critically needed behavioral health services, including services for children and youth ages 0-24. Funding is needed to enable employers to participate in the program. Additionally, legislative support and direction is necessary in order to ensure that rule changes to licensing eliminate onerous licensure requirements, which are barriers for individuals seeking dual SUDP and MH credentialing.

Issue/Problem/Challenge:

A. What is the issue?

Washington State has a behavioral health workforce crisis. The demand for behavioral healthcare - mental health and substance use disorder treatment - exceeds the availability of services, including services to children and youth; Black, Indigenous, and People of Color (BIPOC); and Lesbian, Gay, Transgender, and Queer (LGBTQ) throughout the state. This situation is driven by a shortage of qualified behavioral health workers, in particular workers who share the same characteristics as the community they may work in, resulting in providers who struggle to recruit, educate, train, and retain a qualified behavioral healthcare workforce.

B. What is the problem and how does it affect children, youth, families, and communities?

The need for qualified and diverse behavioral health staff comes at a time of significant systems integration, an epidemic of opioid and methamphetamine use, and increasing suicide rates. The COVID-19 pandemic has not only compounded these challenges, but has elevated adverse mental health conditions in younger adults, racial and ethnic minorities, essential workers, and unpaid caregivers, where data shows disproportionately worse mental health outcomes, increased substance abuse and elevated suicidal
ideation for these populations. The impact of systemic racism and racial violence for BIPOC communities directly impacts the mental health of community members.

Accessing behavioral healthcare for children and young adults was hard before the pandemic, with roughly about 20 percent of children who need services getting them. Long waiting lists, provider turn over, and the lack of a diversified workforce combine to further negatively impact children, youth, and families getting the behavioral services they need will get worse unless there are diverse pathways into the behavioral health workforce. The American Psychiatric Association finds that the lack of diversity among providers is one factors affecting access to treatment by members of diverse racial and ethnic groups.

The existing, traditional behavioral health career pathway is riddled with challenges that have further exacerbated workforce problems. For example, the cost of education is astronomical, and therefore inequitable. Many end up owing so much money in student loans that they are forced to leave community based organizations, the very ones that serve our most vulnerable populations, for private practice, larger hospitals, or state/county agencies that pay higher wages than community organizations.

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

Not having an adequate workforce to serve vulnerable populations results in lack of access to services, gaps in the continuum of care, and lower quality of services. Anecdotally, large and growing numbers of vacancies exist across community behavioral health organizations.

This behavioral health workforce crisis is compounded by the pandemic. It is anticipated to worsen as behavioral healthcare workers are asked to increasingly shoulder the behavioral health implications for the populations they serve while managing their own stress and anxiety.

As discussed above, much of the behavioral health workforce is forced to leave employment with community based organizations for higher wage jobs. Ultimately, this results in a smaller workforce stretched thin in organizations where youth and families and other vulnerable populations cannot get the same access to care or quality of care.

D. How does this change address equity and health disparities?

“Apprenticeship is a powerful tool for training workers and meeting the needs of industries. With a focus on equity, apprenticeship becomes a powerful tool for building a more just society.”

A registered behavioral health apprenticeship program is a means for behavioral health organizations to grow their workforces and capacity through workforce development and retention that helps to meet ever-growing demand for services. In addition, apprenticeships have been shown to increase diversity in the workforce. A diverse work force increases equitable service delivery - where service providers share characteristics of the communities in which they work- thus lessening the health disparities gap for underserved and marginalized populations.

4 Dresser, Laura; Mackey, Michele; Young-Jones, Mariah; Equity in Apprenticeships, COWS Center, University of Wisconsin-Madison, 2018. https://equityinapprenticeship.org/case-studies/principles-for-equity-in-apprenticeship
Health care apprenticeships in Los Angeles provide the clearest example of this program principle. In these apprenticeships, the very attributes that are commonly considered barriers to employment are recognized and utilized as real, tangible assets. The program has capitalized apprentices' knowledge of and legitimacy in specific neighborhoods, fluency in languages other than English, and their lived experience of having, or caring for someone who has, a chronic condition or disability. These attributes, so often viewed negatively, are strengths in the WERC apprenticeship. WERC apprentices develop their occupational skills on the foundation of experiential knowledge and understanding of the trauma faced by patients in the healthcare system.

This is a radical approach. WERC’s program recognizes apprentices’ socio-economic and cultural backgrounds as relevant capital—capital generated in specific places and specific populations. Race, disability, gender identity and/or expression, sexuality and socioeconomic status are considered, and cultural understanding of and affinity for the patient population becomes an advantage. With this re-imagined understanding of capital, the program is able to place apprentices in environments where their unique experiences can enhance their ability to connect. 5

Data from the US Department of Labor finds that apprenticeship programs provide the following benefits:6

- **Enhanced employee retention**: 91% of apprentices that complete an apprenticeship are still employed nine months later.
- **A systematic approach to training** that ensures employees are trained and certified for the highest skill levels required for the occupation.
- **Customized training** that meets industry standards, tailored to the specific needs of industry/business, resulting in highly-skilled employees.
- **Increased knowledge** transfer through on-the-job learning from an experienced mentor, combined with education courses to support work-based learning.

According to a 2017 report, workers who complete apprenticeships programs earn more than $300,000 more than their peers over a lifetime.7

E. **History:**
   
   Is this a previous priority of the work group, or is it new?
   
   Was this recommendation previously presented as a priority to the work group but not selected?
   
   Any idea why this was the case?
   
   N/A

F. **What options do we have to change this?**

The goal is to create a build a state-wide behavioral health educational pathway through apprenticeship programs supported and endorsed by Washington State. The apprenticeship program would be utilized by behavioral health employers, promoting accessibility, retention, and stability within the behavioral health workforce. Pathways will be created for most, if not all, behavioral health occupations and will be available to all healthcare employers in Washington State.

5 IBID
6 US Department of Labor Apprenticeship Toolkit [website link].
There is much to document the value of apprenticeship. This is from the Washington State University’s Social & Economic Sciences Research Center (SESRC) in 2017 submitted by Alan Hardcastle, Ph.D, “In Washington state, past performance reviews conducted by the Workforce Training and Education Coordinating Board have confirmed the economic and employment benefits of apprenticeship for participants, and show that there is also a positive return on investment for the public. ....A more recent analysis projected that the lifetime net benefit to taxpayers has increased: for every dollar invested apprenticeship generates an estimated return of $36 to the public.”

G. Given current limitations, why is this something we should pay attention at this time?

Given the current workforce crisis, now is the time to seek out innovative solutions. The workforce literally holds the health and wellbeing of our youth and families in their hands. There is little denying that we do not currently have a workforce that is robust and diverse enough to meet the needs of our communities and this disparity is only heightened in the state of the pandemic where access to care has become increasingly difficult. There is little risk beyond the initial cost of establishing apprenticeship programs and the return on investment of apprenticeship programs is well documented.
Support Item
Background Checks

Statement of support: Engage with and support the efforts of the Workforce Training and Education Coordinating Board to address barriers created through often inflexible background check requirements. In the behavioral health field, lived experience is highly valued, there is considerable support for the use of peer counselors, and efforts are underway to establish an apprenticeship program. There is also a great need to increase and diversify the workforce, making it even more important than ever to eliminate barriers and open up the field to individuals who have a tremendous amount to offer and should be provided opportunities to do so.
October 7, 2020

To: Children & Youth Behavioral Health Work Group

Re: Prenatal through 5 Relational Health Sub Group (P5RHS) Recommendations

Dear members of the Children and Youth Behavioral Health Work Group,

As co-chairs of the prenatal through five relational health sub group (P5RHS), we are pleased to present the subgroup’s recommendations to the Work Group. These recommendations are the result of six months of thoughtful, robust deliberations involving diverse stakeholders and parents with lived experience.

The work of our subgroup to engage an array of 77 stakeholders (representing behavioral health, professional associations, agencies, practitioners, and community members) has paid off. We secured funding to provide a stipend to the 5 parents who had no other compensation to participate. We respect their diverse experience in regard to race, income, family situation, and family behavioral health challenges. Their input has been invaluable to our deliberations. Their insights have focused our attention on those things that can deliver results for families. Because of this, we believe our recommendations can:

- **Close health disparities** for families of color (for example, infant and early childhood mental health consultation is one of the few evidence-based interventions that we have found that can have an impact on the disproportionate expulsion of boys of color
  
  
  \[1\]
  

- **Provide immediate relief** for behavioral health needs for families, especially those who are most vulnerable

- **Focus on the urgent needs of children ages 0-5**, and their families, during this time of great potential and vulnerability

Since April, our sub group has been hard at work, meeting monthly and also held issue groups to explore potential recommendations that we believe meet the following five criteria:

1. REALISTIC – Size and scope are appropriate for Washington’s budget context
2. CAPACITY – Implementation could be described and executed well and quickly
3. ADVANCES EQUITY – Closes gaps in health access and outcomes
4. STRENGTHENS/TRANSFORMS – Helps to build, sustain, or transform foundational systems
5. FIT - Within the P5RHS and CYBHWG scope, and does not duplicate the work of other groups

We know the 2021 session will be challenging for legislators to balance many needs of families that count on them given it is a time of diminished resources. We believe these recommendations can help families during the critical window of prenatal through age five when there is great potential and vulnerability. We are proud to work with all of you to elevate the need for more behavioral health supports across Washington, particularly early in family development. We appreciate your thoughtful consideration and urge your support of the P5RHS recommendations.

With respect and appreciation,

Representative Debra Entenman,  
47th Legislative District, Co-Chair

Jamie Elzea  
Washington Association for Infant Mental Health, Co-Chair
The P5RHS has worked hard to engage diverse stakeholders, parents, and partners to select recommendations that:

- Close health disparities for families of color
- Provide immediate relief for behavioral health needs for families, especially those who are most vulnerable
- Focus on the urgent needs of children ages 0-5, and their families, during this time of great potential and vulnerability

**Budget Request 1:** Change Medicaid policy so that best practices for mental health assessment and diagnosis of children birth through 5 years old can be implemented and diagnosis and treatment disparities reduced.

**Request:** Change Medicaid policy to allow the three-five sessions (including in natural settings) utilizing the DC:0-5 manual so that misdiagnosis and subsequent ineffective/harmful treatment are avoided, thereby reducing diagnosis and treatment disparities currently experienced (particularly by boys of color) and cost of ineffective treatment.

1. Allow three to five sessions for intake and assessment of children 0-5
2. Allow service to children in their home or other natural settings, and reimburse clinicians for travel to natural settings
3. Requiring clinicians to use the developmentally appropriate standard of practice for diagnosing children 0-5, *the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)*[i], rather than the *Diagnostic and Statistical Manual of Mental Disorders*.

**Budget Request 2:** Establish a complex needs fund to address the behavioral health challenges experienced by children ages 0-5 and their families so that children, families, and early learning providers can experience reduced bias and have immediate relief.

**Request:** Establish an account to help address the behavioral health challenges children ages 0-5 experience. This account is for: (a) early learning providers to get support to pay for infant and early childhood mental health consultants; and, (b) infant and learning childhood mental health consultants to pay for behavioral health, anti-bias, and anti-racist coaching that will make an immediate impact on their practice.

With the added (and in some cases severe) trauma due to the pandemic, children, families, child care providers, and the mental health consultants working with them urgently need more support. Research shows infant and early childhood mental health consultation is an effective strategy that leads to improvement in children’s social and emotional functioning, early learning providers’ relationships with families, and in dyadic relationships. It is effective in reducing racial disparities in children’s socio-emotional functioning and teacher-child relationship, suspensions and expulsions, and missed work days for parents.

This account will help increase access to unbiased consultation and evaluation services, taking into account child development and family experience for Black/African American children and families, specifically, and children and families of color, in general, to decrease the numbers and ameliorate the impacts of preschool suspensions and expulsions as well as child welfare involvement. Additionally, this account will help increase access to mental health consultation for families experiencing poverty and those living in rural and under-resourced communities. In turn, equitable and expanded access to unbiased mental health consultation and evaluation services will also improve the quality of services provided to children and families.
Children & Youth Behavioral Health Work Group: Prenatal to Five Relational Health Sub Group

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

Service continuum (check all that apply):
- [ ] Prevention
- [ ] Early Intervention
- [ ] Identification
- [ ] Screening
- [x] Assessment
- [ ] Treatment & Supports

Age continuum (check all that apply):
- [x] Prenatal - 5
- [ ] 6-12
- [ ] 13-17
- [ ] 18 up to 25

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

Type of Recommendation
- [ ] Legislative-policy only
- [x] Budget ask
- [x] Agency policy change
- [ ] Rule change

Is this a previous priority of the work group or is it new?
- [x] Previous recommendation (builds on 2020 HCA cost analysis request from the CYBHWG)
- [ ] New recommendation
**Policy Brief: Budget Request 1:** Change Medicaid policy so that best practices for mental health assessment and diagnosis of children birth through 5 years old can be implemented and diagnosis and treatment disparities reduced.

**Request:** Change Medicaid policy to allow the three-five sessions (including in natural settings) utilizing the DC:0-5 manual so that misdiagnosis and subsequent ineffective/harmful treatment are avoided, thereby reducing diagnosis and treatment disparities currently experienced (particularly by boys of color) and cost of ineffective treatment.

Our state has the opportunity to align behavioral healthcare policy with best practice for serving very young children. Changes to our state’s Medicaid policies for mental health assessment, diagnosis, and treatment of our youngest Washingtonians are needed to improve child and family outcomes and optimize practice conditions.

1. Allow three to five sessions for intake and assessment of children 0-5
2. Allow children 0-5 to be served in their home or other natural settings, and reimbursing clinicians for necessary travel to natural settings
3. Requiring clinicians to use the developmentally appropriate standard of practice for diagnosing children 0-5, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)[i], rather than the Diagnostic and Statistical Manual of Mental Disorders.

**Cost Estimate:** The Health Care Authority (HCA) is currently undergoing cost modeling analysis of these policy change recommendations due December 1, 2020

**A. What is the issue?**

Approximately 9.5-14.2 percent of children birth to 5-years-old experience emotional, relational, or behavioral disturbance[ii]. In light of the impending statewide increase in behavioral health impacts and expected increased in child abuse occurrences resulting from the Covid-19 pandemic [iii], it is urgent that the birth-to-five mental health system have developmentally appropriate assessment, diagnosis, and treatment protocols that have flexibility to support families where they are in communities to ensure equitable, adequate care and prevent long-term social-emotional health impacts of our state’s youngest children.

**B. What is the problem and how does it affect different groups of children, families, and communities?**

Even very young children -- babies, toddlers, preschoolers -- can suffer from mental health conditions. Young children who live in families dealing with parental loss, substance abuse, mental illness, or exposure to trauma are at heightened risk of developing infant/early childhood mental health disorders [iv]. Identifying and treating these conditions early is critical to changing the trajectory of these children’s lives and those of their families and communities. Infant and early childhood mental health services are delivered to the parent-child dyad, which means that better assessment can help ease the pathway for getting parents and caregivers better adult mental health care, which can help break cycles of intergenerational adverse childhood experiences (ACES). Appropriate assessment leads to more effective multigenerational treatment and reduces behavioral, school, and physical health risk factors over the long term.

Unfortunately, our current behavioral health system has not been designed or optimized for assessing infant and early childhood mental health needs. The current system was designed for older children and adults, with many mental health clinicians relying on the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), which includes diagnostic criteria applicable to children and adults above age 6. Its use for young children makes misdiagnosis and selection of the wrong treatment more likely due to the lack of age-appropriate developmental symptom mapping with disorders. Some diagnoses that show up in early childhood aren’t even found in the DSM. Minimally, it may provide inaccurate care or unnecessarily prolong treatment. At worst, it substitutes the wrong treatment because the diagnosis was wrong in the first place (for example, treating phantom ADHD or autism rather than trauma). Additionally, Use of the wrong assessment and diagnostic tool increases liability risk for providers who may base treatment on these inaccurate diagnoses.

**One assessment visit is not enough.** Properly assessing children birth to five for behavioral health services requires more than a single assessment session [vi]. The nationally accepted [v] DC:0-5 includes gathering of comparative information in 3-5 home and office visits and exploration of sensitive topics (like exposure to domestic violence) to accurately diagnose. Without the multi-session assessment process, there is limited opportunity to build needed engagement of families or to determine child functioning across settings/caregivers. This is precluded by reimbursement for a single assessment session. Mental health clinicians report feeling rushed...
to give the required diagnosis due after just one session. Without the full assessment picture, there is higher risk of misdiagnosis which can lead to ineffective treatment planning.

**Current Medicaid reimbursement policy underfunds needed services actually delivered.** Where therapists are committed to the DC:0-5 and applying the practice of 3-5 assessment sessions, they are forced to bill for these sessions under general therapy session codes rather than as assessment sessions, inadequately reimbursing for this more complex service of assessment.

**Lack of travel reimbursement makes assessment in the home or natural environment unlikely.** Very young children learn, explore their environments, form attachments, grow and develop inside their earliest caregiver relationships. Very young children are pre-verbal or early in their verbal development. The mental health assessment process must therefore involve caregivers and must include observing children in their natural environments such as their home or child care setting. Sadly, key data for an accurate assessment and diagnosis are often missing from the equation when natural environment assessments and travel are not allowed for billing reimbursement.

C. **What is the impact on the state budget and society?**

There is a human cost to undiagnosed and/or untreated conditions which can promote greater behavioral health challenges and increased health disparities.

- We know effective early childhood treatment can **play a key role in overall developmental progress and prevent need for lifelong mental health services.**
- With infant and early childhood mental health being dyadic in nature there is an opportunity to address two generations, supporting both parent and child wellbeing.

D. **How does this change address equity and health disparities?**

Children of color, particularly African American boys, are disproportionately labelled in early learning settings as having behavior challenges and are at higher risk of being suspended. The same implicit biases that label children of color in school settings can lead to misdiagnosis of mental health disorders when mental health assessment is not done in a developmentally appropriate and culturally sensitive way. The DC:0-5 is an assessment approach that looks at the whole child in their context and offers developmental symptom profiles to understand when a child under 5 does or does not meet criteria for a diagnostic category.

E. **History in the Children & Youth Behavioral Health Work Group (CYBHWG):**

The CYBHWG has recognized since its founding the need to address children’s mental health needs from birth, supporting the formation of the prenatal to five relational health subgroup in order to convene experts to develop policy recommendations that meet the unique needs of pregnant parents and babies and very young children in the context of their caregiving relationships.

For the 2020 legislative session, the CYBHWG voted to include a request for the Health Care Authority to conduct a cost model analysis of these recommendations. This proposal is meant to build on that initial effort of the CYBHWG.

F. **What options do we have to change this?**

- States across the nation are making the shift to adopt DC:0-5 as the developmentally appropriate tool for birth to five clinicians and we are seeing increasing policy changes to support its use similar to recommendations offered here. A 2018 survey found that 19 states allowed, recommended or required use of the DC:0-5 for birth to five serving mental health providers.[vii]

- Several states have moved to a 3-5 assessment session model with allowances to submit diagnosis at completion of assessment sessions.

G. **Given current limitations, why is this something we should pay attention at this time?**

- Covid has highlighted the urgent need for mental health supports. Parents in our communities are under extreme duress. Families furthest from opportunity are stacking those stressors (i.e., employment losses, child care/schooling at home) on top of existing stressors/hardships being experienced before Covid.
• There is anticipated to be an epidemic of mental health disorders in children and in adults. University of Washington data suggests that currently 30-60% of adults in the United States are experiencing depression. Globally nations that had higher rates of COVID-19 infections have reported this increase in mental health concerns. The negative impact of adult depression upon young children is well documented.

• A public health approach will be key in addressing the anticipated needs of young children and their families during this time of increased mental health concerns.

• Early and appropriate assessment leads to more effective intervention and outcomes for children and families.

• A dyadic and two generation approach is needed as the youngest children are entirely dependent on their primary caregivers. The expanded WA DC:0-5 assessment allows for adequate evaluation of the child and the dyadic relationship.


[vi] Footnote: Providers can currently only bill 90791 once per client per calendar year, a requirement included in Washington's Medicaid State Plan. June 2019 Maximum Allowable state cost schedule shows 90791 code max at $69.36

Children & Youth Behavioral Health Work Group: Prenatal through 5 Relational Health Sub Group

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

**Service continuum (check all that apply):**
- X Prevention
- ☐ Early Interventions
- ☐ Identification
- ☐ Screening
- ☐ Assessment
- X Treatment & Supports (NOTE: Not treatment, but supports.)

**Age continuum (check all that apply):**
- X Prenatal - 5
- ☐ 6-12
- ☐ 13-17
- ☐ 18 up to 25

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

**Type of Recommendation**
- ☐ Legislative-policy only
- X Budget ask
- ☐ Agency policy change
- ☐ Rule change

**Is this a previous priority of the work group or is it new?**
- ☐ Previous recommendation
- X New recommendation (NOTE: IECMH-C was a previous recommendation; this recommendation builds upon the IECMH-C investment the state currently makes)
Budget Request 2: Establish a complex needs fund to address the behavioral health challenges experienced by children ages 0-5 and their families so that children, families, and early learning providers can experience reduced bias and have immediate relief.

Request: Establish an account to help address the behavioral health challenges children ages 0-5 experience. This account is for: (a) early learning providers to get support to pay for infant and early childhood mental health consultants; and (b) infant and learning childhood mental health consultants to pay for behavioral health, anti-bias, and anti-racist coaching that will make an immediate impact on their practice.

With the added, and in some cases severe, trauma due to the pandemic, children, families, child care providers, and the mental health consultants working with children, families, and child care providers urgently need more support. Research shows infant and early childhood mental health consultation is an effective strategy that leads to improvement in children’s social and emotional functioning, early learning providers’ relationships with families, and in dyadic relationships. It is effective in reducing racial disparities in children’s socio-emotional functioning and teacher-child relationship, suspensions and expulsions, and missed work days for parents.

This account will help increase access to unbiased consultation and evaluation services, taking into account child development and family experience for Black/African American children and families, specifically, and children and families of color, in general, to decrease the numbers and ameliorate the impacts of preschool suspensions and expulsions as well as child welfare involvement. Additionally, this account will help increase access to mental health consultation for families experiencing poverty and those living in rural and under-resourced communities. In turn, equitable and expanded access to unbiased mental health consultation and evaluation services will also improve the quality of services provided to children and families.

Issue/Problem/Challenge:

A. What is the issue?

Early learning providers have limited access to mental health consultation.

- Currently, in the Child Care Aware program, only licensed child care providers who participate in Early Achievers (the state’s quality rating and improvement system) have access to the six mental health consultants situated at the six regional affiliates of Child Care Aware Washington. As of September 15, 2020, there were 3,271 child care providers who are serving 107,678 children who can access one of these six consultants. That leaves 1,721 providers serving 54,883 children who do not have access to these consultants.

- Child care providers serving children under three years of age participating in the Birth to Three Quality Initiative have access to 10 infant and early childhood mental health endorsed consultants. This is funded through the infant toddler quality set aside in the Child Care and Development Fund (a state and federal partnership program).

- State and federal preschool programs, ECEAP and Head Start/Early Head Start contractors, hire mental health consultants but most are underserved in terms of the demand from teachers for mental health and behavioral support for a population that prioritizes children experiencing trauma, developmental issues, and previous expulsion.

- Head Start includes mental health consultation services within the required comprehensive services in the Head Start Program Performance Standards. In surveys and discussions with Head Start programs in Washington, the need for additional support for mental health consultation and connection to mental health services is listed as a top priority and the current capacity does not meet the need.

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1 Child Care Aware Washington, 9/15/20.
2 Child Care Aware Washington, 10/1/20. Of the 1,721 providers, 657 are centers serving 44,117 children and 1,064 are family home providers serving 10,766 children.
Driving short-term standards on quality of mental health consultation services.

- Providing coordinated, standardized support to existing mental health consultants across the state who work with center-based, family home, and FFN child care providers, can ensure more even quality of services at the present nascent stage of Washington's mental health consultation system development during this time of social and economic uncertainty for young children and families navigating the pandemic.

- The complex needs fund will expand access to mental health consultation support services to exponentially more child care providers across the state of Washington who may also be struggling with multiple stressors including those related to the pandemic negatively impacting the quality of care and increasing the rate of workforce turnover. Access to mental health consultation services has empirically demonstrated significant decrease in the number of suspensions and expulsions in general, and decreases the disproportionate numbers of suspensions and expulsions of preschool aged Black boys.

This complex needs fund would support the following:

- Early learning providers. Center-based, family home, and family, friend, and neighbor (FFN) child care providers can access mental health consultation services to address social-emotional well-being and support for challenging behaviors so that: (a) children and their families can more optimally benefit from early care and education services with fewer incidents of preschool suspension and expulsions; (b) child care providers can receive the support needed to decrease the likelihood of experiencing burnout factor associated with lower quality of care and high levels of turnover; and (c) early care and education centers, family home, and FFN providers can continue to create caregiving environments that nurture children’s social and emotional learning and development.

- Mental health consultants. Mental health consultants, including the six consultants employed through the Child Care Aware WA program and other professionals providing mental health consultation services across the state, who work with center-based, family home, and FFN child care providers to address challenging behaviors may receive behavioral health, anti-bias, and anti-racist support so that: (a) an immediate impact can be made with the existing mental health workforce who works with child care providers; (b) child care providers can be supported in their practices; and (c) disproportionate suspensions and expulsions can be reduced.

B. What is the problem and how does it affect children, families, and communities?

Before COVID, there were major threats to children’s well-being and development.

- 17.4 percent of children aged 2- to 8-years-old have high rates of mental health, behavioral health, and/or developmental disorders.3

- 14.8 percent of children who are expelled from care prior to entering our state preschool program for 3- and 4-year-olds called ECEAP experienced two or more adverse childhood experiences.4

The pandemic is adding stress for children, families, early learning providers, and mental health consultants.

- Families are struggling. There was a historic decline in employment in March and April of 2020. According to the quarterly revenue forecast released on September 22, 2020 by the Economic and Review Forecast Council, August unemployment was 8.5 percent.5 Additionally, according to the Washington State Department of Health, the COVID-19 pandemic is having a significant impact on the mental health of families. It is predicted that three million Washingtonians will experience clinically significant behavioral health symptoms from September 2020 to January 2021. Symptoms of depression will likely be most common followed by acute stress and anxiety.6

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3 CDC’s MMWR, https://www.cdc.gov/mmwr/volumes/67/wr/mm6750a1.htm
Early learning programs are struggling. As of October 5, 2020, 831 licensed child care sites reported temporary closure due to COVID-19 with a total capacity of 37,536 slots. For those programs that are open, there is a 119-123 percent increase in the cost of doing business due to accommodating important spacing and health guidelines while having

Children and early learning providers have new sources of distress.

- Children are: isolated from friendships and familiar routines and need support to process new or strong feelings; responding to adults anxiety, frustration, and anger; facing increased risk of abuse and neglect; and communicating unmet needs through behaviors adults may find challenging.

- Teachers and caregivers are: expected to stay six feet away and unable to nurture in the usual ways; struggling with COVID health guidance that is contrary to developmentally appropriate practice; and wearing masks that interfere with children’s learning and understanding of caretaker emotions. In early May 2020, 3,355 members of New York’s early childhood workforce responded to a survey about the impacts of COVID-19. Ninety-one percent of respondents report their emotional well-being had been affected which 38 percent said it had been affected greatly or a lot. The pandemic has caused substantial stress and anxiety for early learning providers. Their mental health impacts their engagement with children and families.

- Mental health consultants supporting children, families, and child care providers need ongoing support to navigate the stress, fear, and anxiety related to the pandemic experienced by children, families, child care providers and themselves.

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

Consultation supports emotional health and an infant’s overall growth and well-being. Babies who engage with responsive, nurturing caregivers and who live in safe and economically secure environments are more likely to have strong emotional health. As they mature, their strong emotional health fosters vigorous physical development and health, cognitive skills, language and literacy, social skills, and even their approach to learning and school readiness.

Poor behavioral health inhibits other areas of child development. Studies show that when emotional health is compromised, overall development suffers, leaving children more susceptible to poor health, poor educational performance, and involvement in the criminal justice system.

Unaddressed behavioral health challenges are costly. The annual cost of behavioral health disorders among young people in the U.S. is $247 billion.

Increased turnover rates of child care providers. Replacing and retraining child care providers is very costly for an already economically stressed child care system.

D. How does this change address equity and health disparities?

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

- Black children’s preschool expulsion rate is nearly two times as high compared to Latino and white children.
“Black children represent 19% of preschool enrollment, but 47% of preschool children receiving one or more out-of-school suspensions; in comparison, white children represent 41% of preschool enrollment, but 28% of preschool children receiving one or more out-of-school suspensions.”

Federal data indicate 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.

Infant and toddlers with mild developmental delays are at high risk of expulsion, exclusion from early learning programs, and lack of early screening and intervention services.

Research shows us mental health consultation is an effective strategy in reducing preschool expulsion particularly among young children of color. Additionally, early childhood mental health consultation and the consultative alliance support the reduction of implicit bias which impacts expulsion rates among young children of color.

It works...

Evidence of Provider Outcomes

States with similar outcomes: AR, AZ, CA, CT, DC, LA, MD, MI

Enhanced Teacher Perspectives & Competencies
- Knowledge of children’s social-emotional development
- Teacher self-efficacy
- Teacher capacity for reflection on how internal processes and biases shape perceptions of child behavior
- Awareness of biased interactions with children

Improved Classroom Quality, Seen in
- Teaching practices
- Teacher-child interactions
- Staff-staff interactions
- Behavior management of children
- Enhanced emotional climate in classroom

Improved Outcomes
- Reduced staff stress & turnover
- Classroom quality
- Organizational climate

Evidence of Child- & Family-Level Outcomes

- Improvements in children’s social and emotional functioning
- Reduced racial disparities in children’s socio-emotional functioning and teacher-child relationships
- Prevention of suspensions/expulsions
- Improvements in dyadic relationships
- Improved relationships with families
- Reductions in missed workdays for parents

E. History in the Children & Youth Behavioral Health Work Group (CYBHWG):

The work group has supported infant mental health consultation in the past. This recommendation builds on that and aims to strengthen mental health consultation.


Children & Youth Behavioral Health Work Group: Prenatal through 5 Relational Health Sub Group

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

**Service continuum (check all that apply):**

- X Prevention
- X Early Interventions
- X Identification
- X Screening
- □ Assessment
- X Treatment & Supports (NOTE: Not treatment, but supports.)

**Age continuum (check all that apply):**

- X Prenatal - 5
- X 6-12 (NOTE: Some school-agers may be served by providers participating in consultation.)
- □ 13-17
- □ 18 up to 25

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

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

**Type of Recommendation (NOTE: This is not a new budget ask; it is a request to preserve an existing state investment)**

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

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

- X Previous recommendation    □ New recommendation
Prenatal through 5 Relational Health Subgroup Recommendation Brief

Policy Brief: Support Request 1: Preservation statement: Support existing investments in infant and early childhood mental health consultation so that children in early care and education experience reduced bias that leads to expulsions and suspensions.

Request: The Prenatal-5 Relational Health Subgroup (PSRHS) supports full preservation of the state investments in infant and early childhood mental health consultation (IECMH-C) which is an annual investment of $773,000 GF-5.

The state funding supports six mental health consultants to support early providers in addressing challenging behaviors. These consultants are situated at the six regional affiliates of Child Care Aware Washington. As of September 15, 2020, there were 3,271 child care providers who are serving 107,678 children who can access one of these six consultants. That leaves 1,721 providers serving 54,883 children who do not have access to these consultants. Thus there is high unmet need and in order to someday address that unmet need, we must preserve what we have in order to build upon it in the future.

Additionally, the state investment leverages private funding for things the state investment does not cover. IECMH-C is one of the few evidence-based interventions that we have found that can have an impact on the disproportionate expulsion of boys of color.

Issue/Problem/Challenge:

A. What is the issue?

The state investment in IECMH-C is vulnerable. Given the fiscal realities the 2021 Legislature faces, the IECMH-C investment is vulnerable. The quarterly revenue forecast released on September 22, 2020 by the Economic and Revenue Forecast Council showed a $4.5 billion shortfall through June 2023. The state rainy day fund has a $3 billion balance which will not cover the projected shortfall, thus there is a high probability of cuts to services and programs. These cuts will come from areas in the budget that are not constitutionally protected (such as human services like IECMH-C).

The IECMH-C program has just begun and serves a critical need. In 2019, the Legislature passed SSSB 5903 which created an IECMH-C program at Child Care Aware of Washington (CCA WA). This builds on the work underway at the Department of Children, Youth, and Families. Examples include: the work in Early Achievers (our state’s quality rating and improvement system); mental health consultation with Washington Association for Infant Mental Health-endorsed consultants in the Birth to Three Quality Initiatives (funded through the infant toddler quality set aside in the Child Care and Development Fund - a state and federal partnership program); and, mental health consultation in Head Start (federal preschool program) and state preschool (called ECEAP).

Six consultants (one per CCA WA region) support 3,271 child care providers who are serving 107,678 children as of September 15, 2020. These numbers reflect the licensed child care providers participating in the Early Achievers who are open during the pandemic. The demand is immense due to the volume and acuity of behavioral health challenges. Thus, it is critical to preserve investment in IECMH-C.

The state investment leverages private funding. The state investment of $773,000 per year leverages this potential private funding. The potential private funding would supplement – not supplant – any state investment and provide support for things the state investment does not cover. A reduction of state investment and provide support for things the state investment does not cover. A reduction of state...
investments in IECMH-C can jeopardize future private investments. All assets are needed to continue development of this much needed system during this time of austerity so that our state’s most vulnerable children and families will continue to benefit from mental health consultation services.

The state investment must be preserved in order to continue progress. Preservation of this investment will also support the groundwork to implement the following systems infrastructure when additional funding becomes available at a future date: (1) setting standards for professional knowledge and skills competencies to ensure even levels of effectiveness; and (2) addressing barriers to access to mental health consultation services through intentional strategies to expand and diversify the mental health consultant workforce. Mental health consultation services have shown robust effects in reducing preschool suspension and expulsion in general and most effectively for preschool age Black boys.

B. What is the problem and how does it affect children, families, and communities?

More young children experience behavioral health disturbances than once thought.

- Approximately 9.5-14.2 percent of children birth to 5-years-old experience emotional, relational, or behavioral disturbance.9
- Young children who live in families dealing with parental loss, substance abuse, mental illness, or exposure to trauma are at heightened risk of developing infant/early childhood mental health disorders.9

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.10
- “Black children represent 19% of preschool enrollment, but 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.”11
- 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.12
- Infant and toddlers with mild developmental delays are at high risk of expulsion, exclusion from early learning programs, and lack of early screening and intervention services.13

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

The pandemic is leading to increases in mental health challenges. According to the Washington State Department of Health, the COVID-19 pandemic is having a significant impact on the mental health of families. It is predicted that three million Washingtonians will experience clinically significant behavioral health symptoms from September 2020 to January 2021. Symptoms of depression will likely be most common followed by acute stress and anxiety.14

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The early learning workforce needs supports — reopening the economy is closely tied to child care and early learning services and the mental health of these providers impacts children. In early May 2020, 3,355 members of New York’s early childhood workforce responded to a survey about the impacts of COVID-19. Ninety-one percent of respondents report their emotional well-being had been affected, of which 38 percent said it had been affected “greatly” or “a lot.” The pandemic has caused substantial stress and anxiety for early learning providers. Their mental health impacts their engagement with children and families.

D. How does this change address equity and health disparities?

Parents are workers who need jobs. Families need child care in order to work and support their families. Families want confidence their children are safe, loved, and learning in the care of teachers and caregivers who help manage trauma and transitions well.

Research shows IECMH-C to be an effective strategy in reducing preschool expulsion particularly among young children of color. Additionally, early childhood mental health consultation and the consultative alliance support the reduction of implicit bias which impacts expulsion rates among young children of color.

E. History in the Children & Youth Behavioral Health Work Group (CYBHWG):

This was a previous priority of the work group.

F. What options do we have to change this?

The PSRHS urges the Children and Youth Behavioral Health Work Group to include this preservation statement in their report so that we can protect the investments that are making a positive impact on children’s, families, and early learning providers’ behavioral health.

Children & Youth Behavioral Health Work Group: Prenatal through 5 Relational Health Sub Group
Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

**Service continuum (check all that apply):**
- X Prevention
- ☐ Early Interventions
- X Identification
- X Screening
- ☐ Assessment
- ☐ Treatment & Supports

**Age continuum (check all that apply):**
- X Prenatal – 5
- ☐ 6-12
- X 13-17 (teen parents)
- X 18 up to 25 (Parents)

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

**Type of Recommendation**
- ☐ Legislative-policy only ☐ Budget as ☐ Agency policy change ☐ Rule change X Support request

**Is this a previous priority of the work group or is it new?**
- ☐ Previous recommendation X New recommendation
Policy Brief: **Support Request 2:** Remove clinical barriers to postpartum mood and anxiety screening so that health disparities can be eliminated.

**Request:** Support the exploration of the Washington Chapter of the American Academy of Pediatrics’ “learning collaborative” (held September 2020-June 2021) so that we can identify and prepare to remove clinical barriers and eliminate racial disparities in routine postpartum mood and anxiety disorder screening and treatment.

**Issue/Problem/Challenge:**

**A. What is the issue?**

1. **Reduction in important screens.** During COVID-19, families are not being screened for postpartum mood and anxiety disorders (PMAD’s) due to missed well-child exams. This is a concern since a parent’s behavioral health is a key predictor of a child’s social-emotional development while an infant’s temperament and behaviors influence a parent’s behavioral health. There is currently no standard of practice for conducting telehealth PMAD screening to replace these in-person opportunities.

2. **Adult behavioral health is on the decline which impacts babies.** The DOH August Update of the *Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19*, the Department of Health projects that 30-60 percent of Washington’s general adult population may experience major depressive disorder and 5-30 percent may experience post-traumatic stress disorder.1

3. **Screening is inconsistent.** Due to lack of flexible physician time, billing, and other barriers, inconsistent screening is common across the nation. One study found “For example, less than one-half of a nationally representative sample of pediatricians regularly inquired or screened for maternal depression.”2 PMAD screening is now required for any caregiver/mother of a child (birth through age 6 months) participating in a well-child exam,3 but in Washington claims data do not show many screens have been billed. Given that the current reimbursement rate of $1.84 is less than the cost of submitting the bill for this reimbursement, it is unclear how many more are being done but not billed.4

4. **There are inadequate assessment services to which families can be referred when indicated.**

**B. What is the problem and how does it affect different groups of children, families, and communities?**

1. **Parents and infants develop together.** Just as children learn and develop capacities and skills when interacting with their environment, parents also are learning about parenting and how to respond to their child’s needs. Research shows that perinatal behavioral health issues affect the likelihood of secure infant-mother attachment.4 Research shows that perinatal behavioral health issues are associated with pre-term delivery5, low birthweight6 and increase chances of difficult infant temperament and sub-optimal breastfeeding practices.7 Babies who engage with responsive, nurturing caregivers and who live in safe and economically secure environments are more likely to have strong emotional health. As they mature, their strong emotional health fosters vigorous physical development and health, cognitive skills, language and literacy, social skills, and even their approach to learning and school readiness.8

2. **There are significant racial disparities in identification and treatment.** The leading cause of pregnancy-related deaths in Washington from 2014-2016 was behavioral health conditions 30%.9 The pandemic is highlighting the effects of stress and health access disparities on women of color for women of color post- and post-natal situations. Black women often receive poorer quality care than White women. The long-term psychological toll of racism puts Black women at higher risk for a range of medical conditions that threaten their lives and their infants’ lives, including mental health conditions.10 Exposure to stigma, bias, and differential treatment based on race or income level leads to poor health outcomes and impacts overall well-being.11

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9 *Adapted from ZERO TO THREE Infant Mental Health Task Force. 2007*.


11 *Adapted from 2015 Center for Disease Control and Prevention report on key findings from the 2010 Behavioral Risk Factor Surveillance System (BRFSS), BRFSS, 2015*.

12 *Adapted from 2015 Center for Disease Control and Prevention report on key findings from the 2010 Behavioral Risk Factor Surveillance System (BRFSS), BRFSS, 2015*.
3. Birth mothers are not the only parents that experience postpartum mood and anxiety disorders. 1 in 7 new moms, 1 in 10 dads, and 1 in 8 adoptive mothers experience post-partum depression.\textsuperscript{12}

C. \textbf{What is the impact on the state budget and society?}

1. There is a human cost to undiagnosed and/or untreated conditions which can promote greater behavioral health challenges and increased health disparities.

2. Untreated perinatal mood and anxiety disorders had a total estimated six year (prenatal to age 5) societal cost of $304 million for mothers and children born in Washington in 2017\textsuperscript{13} even after accounting for children’s resilience.

3. Later behavioral health challenges are very costly. According to the National Research Council and Institute of Medicine in 2009: “Most mental, emotional, and behavioral (MEB) disorders have their roots in childhood and youth...In any given year, the percentage of young people with these disorders is estimated to be between 14 and 20 percent. MEB issues among young people—including both diagnosable disorders and other problem behaviors, such as early drug or alcohol use, antisocial or aggressive behavior, and violence—have enormous personal, family, and societal costs. The annual quantifiable cost of such disorders among young people was estimated in 2007 to be $247 billion.”\textsuperscript{14}

D. \textbf{How does this change address equity and health disparities?}

As noted in B2 and B3, there are substantial disparities in diagnosis and treatment for postpartum mood and anxiety disorders (PMADs). Further, most PMAD screening is focused on birthing mothers, though other parents also experience PMADs.

E. \textbf{History in the Children’s Behavioral Health Work Group:}

This is a new recommendation, intended to address historic barriers in screening that have worsened since the pandemic.

F. \textbf{What options do we have to change this?}

The P5RHS urges the Children and Youth Behavioral Health Work Group to include this support statement in their report so that we can ensure that we understand and are prepared to remove the clinical barriers and eliminate disparities in routine postpartum mood and anxiety disorder screening.

G. \textbf{Given current limitations, why is this something we should pay attention at this time?}

1. This is a key place to offer immediate relief to families.

2. This provides an opportunity to decrease racial health disparities.

3. Intervening now can save substantial later cost to the State.


Accessed 01-18-20
Children & Youth Behavioral Health Work Group: School-Based Behavioral Health and Suicide Prevention

Supporting the Implementation of Multi-Tiered System of Supports in Schools

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

**Service continuum (check all that apply):**
- ☒ Prevention
- ☒ Early Intervention
- ☒ Identification
- ☒ Screening
- ☒ Assessment
- ☐ Treatment & Supports

**Age continuum (check all that apply):**
- ☐ Prenatal - 5
- ☒ 6-12
- ☒ 13-17
- ☒ 18 up to 25

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

**Type of Recommendation**
- ☐ Legislative-policy only  ☒ Budget ask  ☐ Agency policy change  ☐ Rule change

**Is this a previous recommendation of the work group or is it new?**
- ☐ Previous recommendation  ☒ New recommendation
Policy Brief: The state should provide support for districts to implement equity-based Multi-tiered Systems of Support (MTSS), including the Interconnected Systems Framework (ISF) for behavioral health, through training, coaching, and technical assistance using a consistent, statewide framework. MTSS uses data-based decision making to support improved student outcomes and accountability at each level of the system (state, district, school, classroom, and student).

Request: A multi-tiered system of supports (MTSS) is a framework for enhancing the adoption and implementation of a continuum of evidence-based practices to improve important outcomes for all students and decrease adverse outcomes for student groups who experience opportunity gaps. MTSS integrates both academic and non-academic supports to meet the needs of the whole child. By integrating these supports, schools may also increase the efficiency, effectiveness, and sustainability of their services (McIntosh, K., & Goodman, S. 2016). As students (and adults) are experiencing the additional traumatic effects of a global pandemic, MTSS also provides a framework for more effectively integrating behavioral health supports into the school setting.

For the purposes of this recommendation, the School-Based Behavioral Health and Suicide Prevention Subcommittee recommends the CYBHWG support the MTSS Decision Package submitted to the 2021 Legislature by the Office of Superintendent of Public Instruction: Supporting Students through Multi-Tiered Systems of Support 2021–23 Biennial Operating Budget Decision Package (DP). Budget request: $4.47 Million for the biennium.

The package funds 12 regional implementation specialists to train, coach and support districts in order to align policies, personnel, and other resources so that their schools can implement and sustain MTSS with fidelity.

Issue/Problem/Challenge:

A. What is the issue?

While national prevalence data indicate that a significant percentage of children receive support and intervention for their behavioral health needs in school settings, Washington has not established a state-wide system for school-based behavioral health. There is no consistent framework, and funding is provided to schools and community-based organizations through a complex array of federal, state and local funding streams. MTSS is a tiered model with roots in public health in which universal social/emotional/behavioral supports are provided to all students, and targeted and individualized supports are provided to a smaller group of students identified to receive increased supports. MTSS helps schools align available resources and use them effectively by implementing evidence-based practices and using data-based team decision making. MTSS includes the active engagement of families and community partners in the process. MTSS implementation

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utilizes an Interconnected Systems Framework (ISF) to align behavioral health supports in the school setting by establishing consistent systems and approaches using a team structure that includes school staff and community-based service providers.

B. What is the problem and how does it affect children, youth, families, and communities?

Education has traditionally viewed its role as delivering content and instruction in reading, math and other academic subjects, but social/emotional well-being is a prerequisite for children to learn. While schools may understand that students have social/emotional needs that affect their learning, school systems haven’t sufficiently adapted to address these needs through systematic delivery and instruction of social/emotional/behavioral support.

In addition, students are at higher risk of contemplating and attempting suicide when they lack strong and healthy relationships with key adults and peers. MTSS also includes intentional relationship building as an evidence-based practice for supporting students emotionally and academically.

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

The social/emotional/behavioral supports provided by MTSS have commonly been known as School-Wide Positive Behavioral Interventions and Supports (SWPBIS). The Washington State Institute for Public Policy has estimated that the use of SWPBIS produces benefits for the students served, for taxpayers, for other groups and individuals, and indirect costs avoided. These include savings to the criminal justice and healthcare systems for adverse outcomes avoided, as well as benefits to the student and to the state in terms of higher lifetime earnings that result from improved academic attainment. The total average lifetime benefits minus costs per student were estimated to be $8,544, with a benefit-to-cost ratio of $14.12 for each dollar spent (in 2018 dollars).

The investment of approximately $2.2 million per year would help to ensure that state basic education funding is used more efficiently and effectively, as instruction, supports and services are aligned to evidence-based practices and data-based decision making. Further, the Interconnected Systems Framework assists schools and community partners to coordinate and align behavioral health supports and services more effectively and efficiently.

McIntosh and colleagues (2013) found that district capacity building is a statistically significant predictor of sustained implementation. Sustainability of implementation has been found to be dependent on having standardized and centralized training curricula and systems at the state level, in order to support good district coaching systems (Hume & McIntosh 2013, McIntosh et al 2013), as this graphic shows:

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In addition, McIntosh and colleagues (2016) found that states where 50% or more of schools had sustained implementation of PBIS over five years were likely to be in states with “an existing state SWPBIS leadership team [and]… centralized SWPBIS trainings, with state-level trainers and standardized training curricula,” among other factors.4

**D. How does this change address equity and health disparities?**

MTSS can and should be implemented with a focus on equity. MTSS promotes equity by providing universal supports to all students, by using standardized methods for assessing the needs of all students, and by scaffolding and delivering evidence-based supports based upon individual student needs. MTSS helps reduce disparities by focusing on changing the behavior of adults to neutralize the effects of implicit bias, for example. Conversely, traditional systems have defaulted to a “wait to fail” approach, in which student needs have to become more acute and outcomes have to be poor enough to qualify for additional services.

Experience in other states, such as Wisconsin, has found that implementation of MTSS with fidelity closes gaps related to student’s social/emotional/behavioral functioning, as measured by, for example, reducing the incidents of suspension and expulsion for over-represented groups, including Black and Hispanic students and students with disabilities. MTSS also closes gaps in academic performance and achievement for these groups.

**E. History:**

This is a new recommendation, however, discussions about the need for schools to implement MTSS to provide timelier and more consistent support to students with social/emotional/behavioral needs have been on-going.

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F. What options do we have to change this?

PBIS (the social/emotional/behavioral component of MTSS) has been extensively studied internationally through multiple random-control trials and meta analyses. It is used in tens of thousands of schools in the United States and endorsed as an evidence-based practice by the Department of Education, which funds technical assistance centers to assist states, districts and schools. The national center is housed jointly by the University of Oregon, University of Connecticut and University of South Florida. PBIS has been found to reduce student behavior problems and concentration problems, improve social-emotional functioning, and increase prosocial behavior. Because research and practice experience consistently point to the interrelationship between academic and social/emotional learning, tiered approaches to behavior (PBIS) and academics (Response to Intervention, or RTI) have merged into a single approach, multi-tiered system of supports (MTSS). The literature on the efficacy of PBIS includes these studies cited by the WSIPP (2019) in its cost-benefit analysis of PBIS:


Research in the state of Wisconsin found that when Tier I MTSS supports for behavior, reading, or both, were implemented with fidelity, all students made gains in reading and social/emotional learning, and that the gains made by Black students and students with disabilities were accelerated so that gaps were significantly narrowed or closed. See:


G. Given current limitations, why is this something we should pay attention at this time?

Briefly and persuasively describe the recommended solution/risk, what existing capacity can be leveraged, and how this could sustain or transform Washington’s ability to quickly and effectively make a difference? [Use affirmative talking points as well as opportunity costs. Given the budget climate we are in, also highlight any opportunity costs if cuts were made is also important. Particularly for CBH, is there anything we see manifested down the line which increases costs to the state, strains program bandwidth, and is tough on kids and families?]

Add footnotes

a. Example affirmative talking point focused on future costs savings – Schools across Washington need to utilize a consistent framework for implementing evidence-based practices that support the social and emotional well-being of all students and which also provide increased support to a smaller group of students when and where they need it. A statewide system for implementation helps to support fidelity of evidence-based practices and sustainability over time.
b. *Example talking point about opportunity costs if cuts are made* This investment is long overdue and is modest compared to investments made by most other states over the last decade or more. MTSS helps to ensure that K-12 and other resources are used effectively and efficiently, which is even more important at times when resources are stretched thin.

c. *Example talking point for return on investment (ROI)* – MTSS benefits educators by providing clear and consistent structures, tools and methods to support students. Students benefit academically, socially, emotionally, and behaviorally, and they experience better short-term and life-long outcomes as a result, including life-long improvements in their health and earning potentials.
Increase K-12 Staffing Levels to Support Student Behavioral Health and Wellbeing

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

**Service continuum (check all that apply):**
- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

**Age continuum (check all that apply):**
- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

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

**Type of Recommendation**
- Legislative-policy only
- Budget ask
- Agency policy change
- Rule change

Is this a previous recommendation of the work group or is it new?
- Previous recommendation
- New recommendation
Policy Brief: Increase staffing levels in schools to support the social/emotional/behavioral health of students. Increasing staffing will improve tier 1 universal supports for students, as well as provide increased staffing to provide individual and targeted supports to students with more significant behavioral health needs.

Request: The subcommittee recommends that the Work Group endorse the staffing enhancements proposed by the Office of Superintendent of Public Instruction (OSPI) to support the social/emotional/behavioral well-being of students. The OSPI decision package, “Building Staffing Capacity to Support Student Well-Being,” requests increased staff allocations in the prototypical school funding model for school counselors, school nurses, social workers, psychologists, family engagement coordinators, and student, and staff safety personnel no later than the 2024-25 school year.

The subcommittee recommends support for Components 1 and 2:

Component 1 of the Decision Package includes more appropriate staffing allocations to help ensure students are in healthy, safe, and productive learning environments.

Component 2 includes additional days of professional development for certificated and classified staff. This increase phases in over three years, with the end result of six days for certificated instructional staff and classified staff, and three days for certificated administrative staff. The professional development would include, in part, mandatory learning focused on racial literacy and cultural responsiveness. This focus is necessary to accelerate the closure of persistent opportunity gaps. Training on these topics is critical for serving all students, regardless of race. Professional development for racial literacy will be expected of all district personnel statewide on an ongoing basis. Request for the 2022-2023 School and Fiscal Year: $194,831,000

The subcommittee did not discuss and did not make a recommendation on components three or four of the decision package.

Issue/Problem/Challenge:
The American School Counselor Association has established an appropriate school counselor to student ratio of one counselor for 250 students (1:250). The prototypical funding model currently provides for 1:811 (elementary), 1:355 (middle), and 1:236 (high school). These initial values were based on research and analysis from the mid-1970s.

It currently takes 5,263 elementary students, 7,200 middle school students, or 6,250 high school students to generate funding for a full-time equivalent (FTE) school nurse. Schools across Washington are left without even part-time school nurses, or nurses who are available one day a week, at this level of funding.
School psychologists serve many roles in school districts, including identifying and/or serving students with disabilities. Under the prototypical model currently, it takes 216,000 middle school students to generate funding for a single school psychologist. That is roughly the number of middle school students in the entire state of Washington. (Please note that most existing school psychology positions are funded with special education funding, versus basic education funding.)

School social workers “are an integral link between school, home, and community in helping students achieve academic success” (School Social Work Association of America). They are provided for in the prototypical funding model at ratios of 1:9,524 (elementary), 1:72,000 (middle), and 1:40,000 (high school).

A. **What is the issue?**

Washington’s K–12 education system is working well for some, but not all, of Washington’s children. Opportunity gaps experienced by children across the state are evident in the academic, social, and economic outcomes of our education system. The needs of students have changed significantly over the past several years and the model for supporting school districts has not kept up. The prototypical funding model, established in statute, is inadequate to meet the social emotional and safety needs of our students (including providing for high-quality ongoing professional development for educators) and is impacting educators’ ability to eliminate the opportunity gaps they see every day.

B. **What is the problem and how does it affect children, youth, families, and communities?**

*Briefly and persuasively describe the problem or issue and the current impact on different groups and current inequitable outcomes. Use data graphics, and images to describe the scope of the problem. Add footnotes*

Districts across the country are rethinking how they increase the number of skilled and caring adults in school buildings in ways that will enhance the safety for all students and for all staff members.

The Office of Superintendent of Public Instruction (OSPI) requests increasing staff allocations in the prototypical school funding model for school counselors, school nurses, social workers, psychologists, family engagement coordinators, and student and staff safety personnel. In order to provide more appropriate allocations that can ensure students are in healthy, safe, and productive learning environments, OSPI proposes increasing staffing values to those approved by voters in Initiative 1351.

The world our students are living in is rapidly changing, and educators must shift their own practices in order to truly support each and every student as they prepare for postsecondary pathways. If we do not resource school districts to provide high-quality professional development, educators will not be given the tools and supports to continually improve their practice.

C. **What is the impact on the state budget and society?**

*Briefly and persuasively describe the current cost or impact of not seizing the opportunity to change. Use data graphics, and images to describe the current cost (higher cost care later, reduced well-being/productivity, etc.). Add footnotes*
This request phases-in enhanced staffing levels that prioritizes research- or evidence-based strategies to reduce opportunity gaps between student groups and strengthen support for all school and district staff. School districts will be able to hire additional school counselors, school nurses, social workers, psychologists, family engagement coordinators, and student and staff safety personnel. In addition, this request adds professional development for all staff with a specific focus on racial literacy and cultural responsiveness.

The investments are specifically chosen as the right mix of increased capacity that will result in improved social-emotional well-being and academic outcomes for all students, shrinking opportunity gaps. Building-level leadership (principals) work in tandem with school counselors, school nurses, school social workers, school psychologists, family engagement coordinators, and with student and staff safety to provide the necessary support. Additional professional learning days will benefit students through changes in practices.

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<td>$582,306,000</td>
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D. How does this change address equity and health disparities?

This proposal addresses student equity by increasing the allocation for staff specifically targeted for assessing and addressing the social emotional needs of students. The intended outcome is ensuring all students have access to essential supports to reduce the persistent opportunity gap.

At the proposed staffing levels, school districts will be better positioned to meet the needs of all students by: increasing staffing ratios related to the safety and social emotional needs of students, funding additional professional development for school staff to the prototypical model no later than the 2024–25 school year.

E. History:

When the Workgroup was setting priorities for the 2020 Legislative Session, they agreed to support initiatives that aligned with the mission of the Workgroup. The School-Based Behavioral Health Subcommittee proposed that the Workgroup support any recommendations that came from the report from the Staffing Enrichment Workgroup, which was delivered to the Legislature in Dec 2019. SB 6615 was introduced in January 2020 and the workgroup supported the recommendations of this bill, which did not make it out of the committee of origin in the 2020 session. Funding to increase
school counselor positions was approved by the 2020 Legislature, however, the additional funds were unfortunately vetoed by the Governor due to the emerging financial crisis created by the COVID-19 pandemic.

F. What options do we have to change this?

This request phases-in enhanced staffing levels that prioritizes research- or evidence-based strategies to reduce opportunity gaps between student groups and strengthen support for all school and district staff. School districts will be able to hire additional school counselors, school nurses, social workers, psychologists, family engagement coordinators, and student and staff safety personnel. In addition, this request adds professional development for all staff with a specific focus on racial literacy and cultural responsiveness. The investments are specifically chosen as the right mix of increased capacity that will result in improved social-emotional well-being and academic outcomes for all students, shrinking opportunity gaps. Additional professional learning days will benefit students through changes in practices.

G. Given current limitations, why is this something we should pay attention at this time?

Now, more than ever, schools need increased resources to support the emotional well-being of students generally and to address the increased stress and trauma that will result from the COVID-19 pandemic for years to come.
Assessment of the Current Resources and Approaches used to Support Student Behavioral Health by the Subcommittee

Please note: This recommendation is not a request for legislative action at this time. It is a request that OSPI, HCA and other relevant agencies support the subcommittee in mapping and assessing the ways in which behavioral supports are delivered in schools.

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

Service continuum (check all that apply):
Whole Continuum of school-based supports and services

Age continuum (check all that apply):
All school age, 6-21

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

- Capacity and access to services (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)
- Equity/Disparities (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others)
- Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Network adequacy (Medicaid and private insurers)
- Payment and funding (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates)
- Quality of services and supports (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination (e.g., improve/address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
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Type of Recommendation

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

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

- Previous recommendation
- New recommendation
Policy Brief: With the support of the Healthcare Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and other relevant agencies and organizations, the subcommittee would like to examine funding streams (including Medicaid, private insurance benefits, K-12 funding, and other federal, state and local funds) which contribute or could contribute to supporting the emotional well-being and behavioral health care of students in K-12 schools. Using this information, the committee would examine available resources, systems of support and service delivery, and the prevalence of behavioral health needs, including needs exacerbated by the COVID-19 pandemic, among children and youth in K-12 schools in Washington. The committee would also access existing and previous reports which contain the information necessary to conduct this assessment in an efficient manner.

Request: The committee would like to receive presentations, reports and other relevant information from HCA staff who are specialists in Medicaid funding, including covered services for children and youth, and from specialists familiar with coverage requirements for commercially available insurance plans, including individual and employer-based coverage. The committee would also receive presentations from OSPI staff who are specialists in state and federal funds provided to schools by OSPI. The committee would also invite experts to discuss the prevalence of mild, moderate and severe behavioral health disorders and symptoms among children and youth between the ages of 6-21.

Issue/Problem/Challenge: Washington does not have a coherent state-wide system to deliver tiered supports for student emotional wellbeing, including suicide prevention, or to deliver services to address student behavioral health disorders. Washington’s school district enrollments range in size from less than 100 students to more than 55,000. Resources are impacted by population, demographics, geography, and proximity to population centers, interstate freeways, institutions of higher education, military bases, and other assets.

A. What is the issue?
School-age children spend much of their time in school. There is a great potential to locate services and supports in schools in order to reach more students, and to serve them efficiently and in a timely manner in order to avoid more expensive adverse outcomes should their needs go unaddressed.

B. What is the problem and how does it affect children, youth, families, and communities?
The sense of the committee is that the available supports for students are insufficient and difficult to access, and they want to have the opportunity to better quantify the gaps.

C. What is the impact on the state budget and society?
To be determined

D. How does this change address equity and health disparities?
It is also the sense of the committee that inadequacies in behavioral health supports include the lack of culturally-responsive services for students of color, students who speak languages other than English, and other groups. Additionally, neither the behavioral health workforce nor the current K-12 workforce involved in supporting student wellbeing and behavioral health reflect the racial, cultural, and linguistic demographics of the current K-12 student population. Without intervention, this gap may only widen. The committee would like to examine this problem in greater detail, as well, in order to provide targeted recommendations in the future.
Children & Youth Behavioral Health Work Group: YYACC

Youth and family peer access and workforce

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

**Service continuum (check all that apply):**
- ☐ Prevention
- ☐ Early Intervention
- ☐ Identification
- ☐ Screening
- ☐ Assessment
- ☒ Treatment & Supports

**Age continuum (check all that apply):**
- ☐ Prenatal - 5
- ☐ 6-12
- ☒ 13-17
- ☒ 18 up to 25

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

**Type of Recommendation**
- ☐ Legislative-policy only
- ☒ Budget ask
- ☐ Agency policy change
- ☐ Rule change

**Is this a previous priority of the work group or is it new?**
- ☐ Previous recommendation
- ☒ New recommendation
Policy Brief: Youth and family peer access and workforce

Request: Expand the availability of youth and family peer services across the continuum of care, remove barriers to entry and improve retention of peers in the workforce, enhance diversity in the peer workforce, and ensure peers are supported in their own recovery and the secondary trauma they experience on the job.

Note: The items enumerated below are all needed system changes, but not all require statutory change and/or funding. What is presented below is a reflection of as far as our group was able to get given the time constraints. Further discussion is needed to distill which elements would be incorporated into a bill or budget proviso and what those precise asks would be.

Expand youth and family peer services across the continuum of care
In some regions of the state, access to youth and family peers has largely been limited to WISE teams. The demand for youth and family peers transcends families engaged in WISE. Some WISE families cite the youth/family peer as one of the most beneficial component of the program. Access to peer services improves engagement in treatment and ensures continuity of care across levels of care.

- Provide access to youth and family peers for all interested families in traditional outpatient behavioral health settings
- Provide access to youth and family peer bridgers for all interested families in inpatient behavioral health settings
- Allow WISE families to access both a parent and a youth peer, not either/or

Remove barriers to entry and improve retention of youth and family peers in the workforce

- Amend background check procedures for youth peers who wish to enter the peer workforce and have a history of criminal legal system involvement
- Shorten and streamline the peer application process
- Improve wages of youth and family peers to reflect their value, allowing them to earn a livable wage
- Provide training to help agencies:
  - Shift their culture such that peers are recognized as an equal and exceptionally valuable part of the care team. This includes creating a culture wherein other staff do not patronize peers or disclose a peer’s personal narrative on their behalf.
  - Ensure everyone in the agency understands what is within and outside of a peer’s scope of practice and how to collaborate with youth and family peers within the agency
  - Offer peers adequate, supportive coaching/supervision that is not “one size fits all.” This coaching should include support from highly trained, seasoned peers.
  - Help peers feel supported in their roles, and that their agency “has their back”
  - Support peers in being a part of macro-level systems change, in addition to direct service
  - Support peers in taking paid time off for self-care when needed and have clear policies to support this aspect of employee support and retention
  - Note: These elements could be incorporated into the Operationalizing Peer Support training, if they are not already included
- Enhance opportunities for peer professional development, continuing education and educational pathways
- Create a career ladder for peer advancement
Enhance diversity in the peer workforce

- Support agencies in the structural and cultural change processes necessary to create a work environment that welcomes and supports employee diversity and is actively anti-racist
- Require regular trainings in anti-racism, cultural humility and implicit bias to all staff, including examples of how implicit bias shows up in the behavioral health field
- Ensure agency leadership, management and board of directors includes people of color and reflects the communities being served

Ensure peers are supported in their own recovery and the secondary trauma they experience on the job

- Create a statewide mechanism to provide peer support groups for employed peers, led by highly trained, seasoned peers
- Create a mechanism for newly hired peers to complete an optional confidential crisis trigger plan to have a coping plan and be aware of times when they might need extra support
- Create a mentorship program for youth and family peers
Children & Youth Behavioral Health Work Group: YYACC

Youth mobile crisis services

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

Service continuum (check all that apply):
- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):
- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

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

Type of Recommendation
- Legislative-policy only
- Budget ask
- Agency policy change
- Rule change

Is this a previous priority of the work group or is it new?
- Previous recommendation
- New recommendation
Policy Brief: Youth mobile crisis services

Request: Expand youth mobile crisis services statewide and ensure existing teams can meet the significant increase in demand exacerbated by the pandemic

In regions that have youth mobile crisis services, the services work well and can divert youth from both emergency departments as well as the juvenile legal system. However, not all regions have youth mobile crisis services. Even in the regions that do have it, the capacity of the service is being pushed to its limits due to the significant increase in volume and acuity due to the pandemic, including in youth with no previous behavioral health history. Also, if our system moves toward a third 911 portal beyond police/fire, we will need to ensure that youth mobile crisis teams can respond quickly in order to avert law enforcement engagement.

Behavioral health administrative service organizations (BHASOs) are tasked with administering crisis services within their region. Designated crisis responder (DCR) services are required, but youth mobile crisis services are not. Due to an array of issues, including BHASOs having to spend more on local E&T beds due to the state hospital backlog and crisis response not necessarily matching the 70/30 Medicaid/private insurance split (particularly in children where the payer mix is 50/50), BHASOs have less discretionary funds available.

Needs:

- Expand youth mobile crisis services statewide and ensure existing teams can meet the significant uptick in demand exacerbated by the pandemic
- Provide ant-racism, implicit bias and cultural humility training to mobile crisis teams
- Track and publish data based by race on which youth are diverted vs referred to hospitals and law enforcement
- Create and implement a coordinated communications plan to ensure all parents, caregivers, primary care providers and schools are aware of youth mobile crisis services so that unnecessary ED visits and law enforcement interaction are avoided
- Ensure sufficient mobile crisis team staffing such that teams can debrief a previous call and have a moment to recover before heading to the next one
- Promote widespread inclusion of youth and parent peers on youth mobile crisis teams
- Come up with a solution to address the issue of many youth with private insurance presenting for mobile crisis services and the BHASOs picking up the tab. Partner with commercial carriers to devise a solution.
- Allow and encourage the use of youth mobile crisis teams that do not require an MHP. For example, the recently popular CAHOOTS model in Eugene does not require MHPs, but rather highly trained crisis workers with varying educational backgrounds. The MHP workforce crisis presents limitations on scalability if the MHP requirement is maintained.
- Create regional youth mobile crisis teams within counties with a vast geography and/or traffic congestion that causes delays in response times
- Partner with youth-serving behavioral health agencies to determine a mechanism other than an ED visit to generate a crisis care from the agency
- Explore the possibility of requiring a youth mobile crisis visit in the ED before youth admission to a psychiatric inpatient unit, as a means of promoting less restrictive alternatives and diverting unnecessary hospitalizations (this used to be a requirement prior to fully integrated managed care)
Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

**Service continuum (check all that apply):**
- [ ] Prevention
- [x] Early Intervention
- [ ] Identification
- [ ] Screening
- [ ] Assessment
- [x] Treatment & Supports

**Age continuum (check all that apply):**
- [ ] Prenatal - 5
- [x] 6-12
- [x] 13-17
- [ ] 18 up to 25

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

**Type of Recommendation**
- [ ] Legislative-policy only
- [x] Budget ask
- [ ] Agency policy change
- [ ] Rule change

Is this a previous priority of the work group or is it new?
- [ ] Previous recommendation
- [x] New recommendation
Policy Brief: Respite care for youth with behavioral health challenges

Request: Direct HCA to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the DDA and DCYF respite waivers

The Statewide FYSPRT initially moved the need for youth behavioral health respite forward in 2017 after identifying this as a need statewide for youth and families. In 2017, only one region had behavioral health respite for youth ages 10-18, paid for by regional sales tax dollars. The remaining nine regions identified no access to respite through behavioral health services. Up to July 1, 2012, respite services were provided through Medicaid as part of the 1915(b) waiver. When this waiver was terminated due to Legislative action and proposed budget cuts, funding for respite became dependent on other funding available in the regions. For example, Regional Service Networks could identify state or block grant funds to be utilized for respite services if outlined in their expenditure plans for state or block grant funding.

Since 2017, youth behavioral health respite services continues to come up as a need/theme in many dialogues at the Statewide FYSPRT. One area of need is around community resources to support youth and families in the home to prevent hospitalization or placement in a Children’s Long Term Inpatient Program (CLIP) or juvenile detention facility. It has also come up as a need to support long term success for youth who are discharging from CLIP or other institutional placements. In addition, youth behavioral health respite was identified as a recommendation from the Substitute Senate Bill (SSB) 6560 workgroups. These workgroups were formed to develop recommendations to make sure that no youth is discharged into homelessness from a system of care (such as behavioral health, juvenile rehabilitation, foster care). Currently, there is an active Cross-Agency Coordination of Children in Complex Situations workgroup that has identified respite (with ABA trained providers) as a potential service to meet the needs of youth and families.

Per information gathered by the Statewide FYSPRT in 2020, respite services as part of behavioral health are not available and when respite services are available [through Developmental Disabilities Administration (DDA) and the Department of Children, Youth, & Families (DCYF)], they are very limited and difficult to access.

Additional information gathered by the Statewide FYSPRT in 2020 is below identifying who has the most critical need for respite:

- Families and youth that experience complex behavioral/medical health needs (or other complex diagnosis – for example developmental disabilities and mental health).
- Single parent families or families with multiple children in services.

The Statewide FYSPRT also gathered information about what situations or circumstances behavioral health respite would be helpful to keep youth with their families and in their communities:

- To prevent use of emergency departments or higher level of care (such as CLIP, juvenile justice, or behavioral rehabilitation services) or prevent escalation (police involvement).
- To assist with transitions from inpatient or CLIP back home to increase long term success.
- Assist children/youth having a difficult time with family dynamics/environment.
  - Respite provides a break from volatile home situations that allows for time to learn and practice skills in safe environments (for both children and parents), to improve family functioning, avoid family conflict, stabilize the household, and support safety in the household.
  - Prevent running away and youth becoming homeless.
• To manage or prevent crisis through planned, routine breaks while knowing your child is safe.
  o Avoid burnout and help caregivers stay healthy and able to better meet the needs of their child/youth.
  o Opportunity for learning and practicing skills when not in crisis.

Potential cost savings from supporting youth and families in the community and avoiding the cost of hospitalization or being placed in an institutional setting such as CLIP or juvenile rehabilitation facility.
Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

**Service continuum (check all that apply):**
- ☐ Prevention
- ☐ Early Intervention
- ☐ Identification
- ☐ Screening
- ☐ Assessment
- ☒ Treatment & Supports

**Age continuum (check all that apply):**
- ☐ Prenatal - 5
- ☐ 6-12
- ☒ 13-17
- ☒ 18 up to 25

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

**Type of Recommendation**
- ☐ Legislative-policy only
- ☒ Budget ask
- ☐ Agency policy change
- ☐ Rule change

**Is this a previous priority of the work group or is it new?**
- ☐ Previous recommendation
- ☒ New recommendation
Policy Brief: Care transitions from inpatient behavioral health and juvenile justice settings

Request: Improve transitional care for youth discharging from inpatient behavioral health and juvenile justice settings

The YYACC is highly interested in supporting the work of the SB 6560 work group in improving care transitions for youth, including ensuring that young people do not end up experiencing homelessness post-discharge. Many of the recommendations that will arise from the 6560 work are not yet ready for legislative consideration, but the YYACC stands ready to support these forthcoming recommendations in future legislative sessions.

Two recommendations to better serve young people discharging from these settings are contained in other YYACC recommendations:

- Offer youth and family peer bridgers for discharges from inpatient behavioral health settings
- Direct the HCA to explore Medicaid waiver options for behavioral health respite care

Two care transition recommendations not currently captured elsewhere are:

- Expand access to app-based recovery support services that leverage evidence-based practices (e.g. contingency management) for youth exiting these systems
- Select and support a mobile application and a website to show available resources for youth and young adults exiting these systems. This could be a public-private partnership, as there has been work done to solicit private funding.
Children & Youth Behavioral Health Work Group: Workforce/Rates

Child Mental Health Referral Service

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

Service continuum (check all that apply):

☐ Prevention
☐ Early Intervention
☒ Identification
☐ Screening
☐ Assessment
☒ Treatment & Supports

Age continuum (check all that apply):

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

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

☒ Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)

☒ Network adequacy (Medicaid and private insurers)

☐ Payment and funding (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.

☒ Quality of services and supports (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)

☒ Cross-system navigation and coordination (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)

☐ Trauma-informed care (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others
Workforce/Rates Subgroup Recommendation Brief

Child Mental Health Referral Service

Policy Brief: Continue the state’s child mental health referral service.

Request: Continuation funds for the “Washington State Mental Health Referral Service for Children and Teens,” to prevent program shut-down in July 2021. Request is for $850,000 annual total service budget, though only $425,000 annual general fund would be requested because HB 2728 enacts a covered-lives based sustainable funding model that includes financial contributions from commercial carriers beginning July 2021.

Issue/Problem/Challenge:

A. What is the issue?

The process of looking for a child mental health care provider who is: A) covered by the family’s insurance plan, B) has the evidence based treatment skills which match their child’s needs, and C) is available for seeing new patients and in their area has remained a daunting task for families across the state. Prior to the pilot program’s initiation families in our state would often give up in this process, unable to make a therapy connection in a timely way, which significantly delays treatment for children. The challenge with connecting into care is even more significant for families with commercial insurance than with Apple Health coverage. In fact, nearly 75% of the past year’s referral assistance calls were made by families whose children have private insurance coverage.

B. What is the problem and how does it affect children, youth, families, and communities?

Children identified by their schools, their families, or their primary care providers as having mental health problems in need of intervention often do not receive timely care because families typically struggle to connect into care. Therapists listed on private insurance panels are typically not accepting new patients, leading families into a weeks and months long process of unanswered calls before they can find a connection, if they do not give up in that process. Parents who call the referral assistance service have typically already been looking for treatment services for a long time, while their children have continued to suffer and go untreated.

Before initiating this program, receipt of child mental health services was inequitable. Children with parents both able and willing to invest significant time in securing a mental health treatment provider received services.

Now that our state has a fully functional mental health referral assistance service, any parent, school or primary care office in the state can relatively easily connect children into care. Since the service’s initiation in April 2019, over 3000 families have reached out to the service, and demands for assistance are not diminishing.

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

Washington’s Mental Health Referral Service for Children and Teens is a 2-year pilot initiative, due to sunset on July 1 2021. Program staff have learned what the steady statewide community demand is and what the staffing needs are to continue locating and matching families with treating providers. This requires a fiscal investment of $850,000 annually. Importantly per last session’s law HB 2728 about one half of these total costs will be reimbursed by the state’s private insurers going forward, resulting in a general funds need of about $425,000 annually to continue the service.
D. **How does this change address equity and health disparities?**

This service is available to everyone, anywhere in the state, regardless of their insurance type. Its design is to get every child desired by their caregivers into mental health care to be able to access this in a far more timely and individual needs-matching way. Family feedback regarding the services received has been highly positive (see the above graphic). Further program information is available at [www.seattlechildrens.org/wa-mental-health](http://www.seattlechildrens.org/wa-mental-health).

E. **History:**

This service was previously promoted by the Child Mental Health Workgroup, and recommended as a legislative initiative.

This year we are requesting that it be continued rather than stopped.

F. **What options do we have to change this?**

Our state is now a national leader in this area, in that we have built a child mental health referral assistance service as a statewide and insurance blind initiative to help all families. We have a unique opportunity during the 2021 legislative session for this to be continued as a lasting system support, taking advantage of last session’s law for costs of this program to be shared equally between the state and private health insurers.
G. Given current limitations, why is this something we should pay attention at this time?

If this referral assistance service is not continued during the current legislative session, we will revert to the state’s children taking longer to enter mental health care, or not receiving care at all due to their parents giving up in the process of seeking care. At current rates of utilization, this would mean well over 2000 families a year will face prolonged mental health suffering.
Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

**Service continuum (check all that apply):**
- Prevention
- Early Intervention
- Identification
- Screening
- Assessment
- Treatment & Supports

**Age continuum (check all that apply):**
- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

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

**Type of Recommendation**
- Legislative-policy only
- Budget ask
- Agency policy change
- Rule change

Is this a previous priority of the work group or is it new?
- Previous recommendation
- New recommendation
**Policy Brief:** Advance timely and equitable access to behavioral health services grounded in best practices by ensuring that Medicaid rates are sufficient to increase access and support competitive salaries.

**Request:** Support inclusion of the following budget proviso that was passed by the Legislature last year but subsequently vetoed by the Governor due to the financial implications of the COVID-19 global pandemic (dates would need to be updated accordingly):

**SB 6168, Section 211 (78)** $1,857,000 of the general fund—state appropriation for fiscal year 2021 and $3,146,000 of the general fund—federal appropriation are provided solely to maintain and increase access for behavioral health services through increased provider rates. The rate increases are effective in January 2021 and must be applied to the following codes for children and adults enrolled in the medicaid program: 90832, 90833, 90834, 90837, H0004, H0036, H2015, H2021, H0023, 90836, 90838, 96156, 96158, 96159, 96164, 96165, 96166, 96167, 96168, 96170, 96171, 90845, 90846, 90847, 90849, 90853, 90785, and 90791. The authority may use a substitute code in the event that any of the codes identified in this subsection are discontinued and replaced with an updated code covering the same service. Within the amounts provided in this subsection the authority must:

(a) Implement this rate increase in accordance with the process established in Engrossed House Bill No. 2584 (behavioral health rates);
(b) Raise the state fee-for-service rates for these codes by up to fifteen percent, except that the state medicaid rate may not exceed the published medicare rate or an equivalent relative value unit rate if a published medicare rate is not available;
(c) Require in contracts with managed care organizations that, beginning in calendar year 2021, managed care organizations pay no lower than the fee-for-service rate for these codes, and adjust managed care capitation rates accordingly; and
(d) Not duplicate rate increases provided in subsection (79) of this section.

**Issue/Problem/Challenge:**

**A. What is the issue?**

Low reimbursement rates for behavioral health services have been repeatedly identified as a major barrier to healthcare integration. They are the root cause for challenges to paying competitive salaries, and for recruiting, educating, training, and retaining a skilled behavioral healthcare workforce, especially in settings with large numbers of Medicaid-insured patients, such as behavioral health agencies.

The codes listed in the request above will have the greatest impact to increase access for children and youth and address significant rate disparities.

Primary care settings also struggle with low reimbursement rates as Medicare often pays higher rates than Medicaid. Accordingly, Medicare rates for comparable behavioral health codes are one key benchmark to be considered. The following table highlights just a few of the discrepancies between Medicare rates for adults and Medicaid rates for children for the same services delivered by physicians:

<table>
<thead>
<tr>
<th>Treatment and code</th>
<th>Medicaid Rate (children)</th>
<th>Medicare Rate (adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Rate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy for 60 minutes (90837)</td>
<td>70.88</td>
<td>136.83</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation (90791)</td>
<td>72.54</td>
<td>140.11</td>
</tr>
<tr>
<td>Family therapy for 50 minutes (90847)</td>
<td>59.29</td>
<td>114.52</td>
</tr>
<tr>
<td>E&amp;M 30 minute medication management (99214)</td>
<td>86.94</td>
<td>110.51</td>
</tr>
</tbody>
</table>

B. **What is the problem and how does it affect children, youth, families, and communities?**

In 2016, the Legislature’s Children’s Mental Health Work Group reported that Medicaid rates reflect current system capacity (i.e., historical use), not service need or demand, or the desire to actively engage people in treatment further upstream. This is even more apparent in rural areas. Qualified providers choose to opt out of serving Medicaid clients, and many are taking private pay only. Medicaid rates are only about two-thirds of Medicare rates for the same units of service, highlighting care inequities between children and adults within our system.²

C. **What is the impact on the state budget and society?**

Lack of action to remedy low behavioral health reimbursement rates puts transformation to behavioral and physical health integration at risk. In order for integration to work, the portion of the healthcare system that provides behavioral health services in community-based settings needs to be strong and robust. Additionally, by better reimbursing outpatient providers, we will increase access to care, and prevent expensive and traumatic hospitalizations and/or contact with the justice system.

D. **How does this change address equity and health disparities?**

The Legislature has found that children and their families face systemic barriers to accessing necessary mental health services. These barriers include a workforce shortage of mental health providers throughout the system of care. Of particular concern are shortages of providers in underserved rural areas of our state and a shortage of providers statewide who can deliver culturally and linguistically appropriate services. The Legislature has also found that children with mental health service needs have higher rates of emergency room use, criminal justice system involvement, and an increased risk of homelessness.³ By increasing Medicaid reimbursement rates for both behavioral health and primary care settings, we can increase the recruitment and retention of a qualified behavioral health providers, and also help incentivize them to accept Medicaid enrollees.

E. **History:**

- *Is this a previous priority of the work group, or is it new?*
- *Was this recommendation previously presented as a priority to the work group but not selected?*
- *Any idea why this was the case?*

This recommendation was previously selected in 2019 by the CYBHWG, and it was included in the budget bill, ESSB 6168, Sec. 211, (78): $1,857,000 of the general fund—state appropriation for fiscal year 2021 and $3,146,000 of the general fund—federal appropriation are provided solely to maintain and increase access for behavioral health services through increased provider rates. Unfortunately, due to the financial implications of dealing with the COVID-19 pandemic, Governor Inslee vetoed this subsection of the budget bill.

F. **Given current limitations, why is this something we should pay attention at this time?**

The Children & Youth Behavioral Health Work Group has been recommending increasing Medicaid rates since 2016. As the COVID-19 pandemic continues and children attend school remotely, there are dire predictions that we will see a significant increase of individuals and families needing behavioral health treatment. Now more than ever, we need to ensure that community-based providers are adequately funded to meet this demand.

Support Telehealth for Behavioral Health Services

Support and advocate for the use of telehealth for behavioral health services, including audio only, for children and youth 0-24 that are appropriately compensated, consistent with standards of practice, maximize the effectiveness of the tool, ensure accessibility for individuals of varying income levels, abilities and available bandwidth, and build on lessons learned.

2020 has been an unplanned and at-scale pilot of the telehealth models that have been long-discussed. While there has not been a chance to systematically review the experience, one immediately promising finding has been that our clients can benefit from some tools in the telehealth toolkit. It is critical, though, to not jump too soon or assume that tactics can be broadly applied. Behavioral health stakeholders need the chance to struggle through the pandemic demands and then evaluate the lessons learned. This will likely result in findings that some telehealth tools are appropriate and should be secured and expanded, and other things cannot be digitized but depend on in-person, contemporaneous interaction.
Children & Youth Behavioral Health Work Group: Prenatal through 5 Relational Health Sub Group

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

**Service continuum (check all that apply):**
- X Prevention
- X Early Interventions
- X Identification
- X Screening
- X Assessment
- X Treatment & Supports

**Age continuum (check all that apply):**
- X Prenatal – 5 (NOTE: All ages will benefit from standards of practice)
- □ 6-12
- □ 13-17
- □ 18 up to 25

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

**Type of Recommendation**
- X Legislative-policy only
- □ Budget ask
- □ Agency policy change
- □ Rule change

Is this a previous priority of the work group or is it new?
- □ Previous recommendation
- □ New recommendation
[Note: The following information was created as part of the recommendation development process prior to the CYBHW subgroup leads identifying responsive and effective telehealth as an overarching priority. This content may be useful for setting context for the prenatal through 5 elements of this recommendation.]

Original PSRHS Policy Request

Policy Request 1: Ensure responsive and effective access to telehealth services so that immediate relief can be provided to families and behavioral health disparities eliminated

Request: A) Charge a current or new committee to develop standards of practice for audio and video telehealth services so that racial and income disparities in behavioral health service access are eliminated and virtual services provided clinically effective relief for children and families. B) Require state-funded programs to publicize the availability of Washington Lifeline, ask families about the need for digital access, and make appropriate referrals so that low income families can effectively access appropriate virtual behavioral health services.

Issue/Problem/Challenge:

A. What is the issue?

1. There is an income-based digital divide. Families experience different situations of income, work flexibility, trust, comfort, and cultural considerations regarding how they access behavioral health services during the pandemic and after it. Many families lack access to high-speed Internet, Internet-enabled devices, and access to digital literacy and technical support to effectively participate in behavioral health services delivered through audio-video mode. Homeless families experience even more barriers to having access to safe and confidential behavioral health services delivered virtually.

2. Families of color already experience disparities that affect their behavioral health. The pandemic is highlighting the effects of stress and health access disparities on behavioral health for women of color, especially during pre- and post-natal situations; Black women often receive poorer quality care than White women. The long-term psychological toll of racism puts Black women at higher risk for a range of medical conditions that threaten their lives and their infants’ lives, including mental health conditions. So much so that the leading cause of pregnancy-related deaths in Washington from 2014-2016 was behavioral health conditions 30%. Exposure to stigma, bias, and differential treatment based on race or income level leads to poor health outcomes and impacts overall well-being. Additionally, chronic stress caused by racism and bias can compound socioeconomic issues that also lead to poor health outcomes. Due to the historically traumatic relationship that African Americans have had with large institutions and healthcare systems in the U.S., in addition to existing community stigma, those who struggle with mental health difficulties often fail to get support when needed. Stigma and judgment prevent many Black and African American people from seeking treatment for their mental illnesses.

3. Telehealth is the only way to access services during the pandemic. This is a life and death situation for a lot of people - telehealth reduces their exposure. The pandemic illustrates that having a range of treatment modes allows families more choice about how to receive services.

4. Some families will only use services that have a telehealth option. This is because in-person services may be threatening. For example, a family that has been involved in the child welfare system may be reluctant to have home visits for fear of children being removed. Starting with a telehealth visit provides time to build a trusting relationship with the behavioral health provider and the safety of being in their own home.

5. It is unclear when in-person, audio-video, or audio only modes are most effective. Research shows that audio-video mode cognitive behavioral therapy might reduce attrition (20.9% for audio-video vs. 32.7% for

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face-to-face), while achieving similar results to face-to-face therapy. Further, a review of 65 peer-reviewed research articles found that more than 95% of the studies (using audio-video, or audio only modes) reported significant improvements in the caregivers’ outcomes and that caregivers were satisfied and comfortable with audio-video mode of services. However, some anecdotal information suggests benefits for some and access issues for others. Standards of practice to address missed visualization and physical or behavioral cues have not yet been developed.

6. No group is charged with engaging varied partners and developing telehealth standards of practice for the full range of services families need. The Washington State Telehealth Collaborative is working with health care industry partners to implement telemedicine. The Behavioral Health Institute is studying what is happening among providers during the pandemic. Agencies like the Health Care Authority and Department of Health are working on agency policies. The Office of Broadband Services and collaborations like the Internet Access Crisis Team are tackling important gaps in our technology infrastructure (I-ACT). None of these entities is specifically charged with engaging a diverse array of stakeholders (e.g., prenatal through age 5 and other ages, consumers, providers, and institutions, etc.) to address the range of services (e.g., behavioral health, health, early learning, etc.) by reviewing current and emerging evidence to develop standards of practice for services that can deliver results for children and families.

B. What is the problem and how does it affect different groups of children, families, and communities?

1. Access to Broadband Service - The Washington Lifeline service provides free or nominal cost cellular service, but it is not well-known and underfunded. The State Broadband Office is prioritizing “shovel ready” projects, which may not be focused on those places with the most families in need.

2. Access to Telehealth Options – Routine mechanisms to reach families with young children to provide access to high-speed Internet, new hardware, or software modules that are used in telehealth are more difficult and rely on a patchwork of programs that have flexible funding (like ECEAP or ESIT) to address this.

3. Continued “Audio Only” Service Billability after COVID-Related Temporary Orders Are Rescinded. “Audio only” provides easier access for some families. As a practical matter, sometimes video throughput is not possible in addition to audio. Privacy concerns, fear of agency reach, and other issues may cause some families to prefer to begin with audio only until trust is built with the provider. Services delivered in this way will not billable after temporary orders are rescinded. It is unclear whether this will be true for health plans.

4. Equitably Available and Appropriately-Used Telehealth Treatment, SB 5385 ensures payment parity for clinical health care services funded through health plans, and health carriers provided via audio-video mode (starting January 1, 2021) to add to our Medicaid Plan which already allowed parity of payment. However, Early Support for Infants and Toddlers (ESIT) may not have the same flexibility to respond to family needs.

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

1. There is a human cost to undiagnosed and/or untreated conditions which can promote greater behavioral health challenges and increased health disparities. There is a dollar cost too. For example, untreated perinatal mood and anxiety disorders had a total estimated six-year (prenatal to age 5) societal cost of $304 million for mothers and children born in Washington in 2017 even accounting for children’s resilience.

2. According to the Washington State Department of Health, by March 2021 “in the general Washington population, major depressive disorder (30-60%) and PTSD (5-30%) are (projected to be) common” by March or 2021. Failure to address this will be costly.

3. There is a risk of providing services that do not provide the benefits families need if we do not know when, how and for whom in-person, audio-video, or audio modes are best.


D. **How does this change address equity and health disparities?**

As detailed in sections A2-A4 above, families of color experience disparities in access that affect their behavioral health. Low-income families face many barriers to effective access to audio and audio-video behavioral health services.

E. **History in the Children & Youth Behavioral Health Work Group (CYBHWG):**

This is a new priority since the pandemic. Some aspects of telemedicine have been addressed in past sessions and some administrative actions have been taken since the pandemic. The prenatal through 5 period, behavioral health services, and behavioral health services not funded through health care have not been included in some past/current actions.

F. **What options do we have to change this?**

The P5RHS urges the Children & Youth Behavioral Health Work Group to include these policies in their report:

1. **Create a committee/study** to access the insights of a range of professions and consumers to review research literature and develop standards of practice for appropriate situations and safeguards for “in-person”, “audio-video”, and “audio only” modes of prenatal through 5 behavioral health services and supports. Exploration to include: 1) collect and analyze data about clinical efficacy of prenatal through five behavioral health services and supports through virtual mode; 2) how to determine (and maximize health benefit) of different modes (or mix of modes – like accessing services at primary care provider office for specialized treatment for those without reliable Internet access) to which families, in which situations, for which treatments; and, 3) what parts of care coordination (i.e., intake, scheduling, initial system navigation, and setting up/training in telehealth access) could be billable [and how] after pandemic-related provisions are lifted.

2. **Adopt policy** to require state-funded programs to publicize the availability of Washington Lifeline, ask families about the need for digital access, and make appropriate referrals to facilitate technology access and training.

G. **Given current limitations, why is this something we should attend to at this time?**

1. During the pandemic, many families will not access services any other way. This is a life and death situation for a lot of people - telehealth reduces their exposure. The pandemic illustrates that having a range of treatment modes is useful to address changing needs. Facilitating telehealth services now can save money long-term by preventing and/or intervening in anticipated increased pandemic-related behavioral health challenges.

2. Some families may avoid services without a telehealth option. For example, a family that has been involved in the child welfare system may be reluctant to have visits in the home or in an institutional setting for fear of children being removed. Starting with a telehealth visit provides time to build a trusting relationship with the behavioral health provider and the safety of being in their own home.