

Children and Youth Behavioral Health Work Group (CYBHWG)

**Friday, September 18
12:30 – 4:30 pm**

Zoom meeting: <https://zoom.us/j/96867334456?pwd=K09NYTRSOWZaenhNeUhZdWNoVHRqdz09>
(see last page for details)

Attendees					
<input type="checkbox"/>	Representative Lisa Callan, Co-Chair	<input type="checkbox"/>	Lacy Fehrenbach	<input type="checkbox"/>	Steve Kutz
<input type="checkbox"/>	MaryAnne Lindeblad, Co-Chair	<input type="checkbox"/>	Dr. Thatcher Felt	<input type="checkbox"/>	Amber Leaders
<input type="checkbox"/>	Randon Aea	<input type="checkbox"/>	Tory Gildred	<input type="checkbox"/>	Nickolaus Lewes
<input type="checkbox"/>	Dr. Avanti Bergquist	<input type="checkbox"/>	Camille Goldy	<input type="checkbox"/>	Laurie Lippold
<input type="checkbox"/>	Ruth Bush	<input type="checkbox"/>	Libby Hein	<input type="checkbox"/>	Rep. John Lovick
<input type="checkbox"/>	Representative Michelle Caldier	<input type="checkbox"/>	Dr. Robert Hilt	<input type="checkbox"/>	Joel Ryan
<input type="checkbox"/>	Diana Cockrell	<input type="checkbox"/>	Kristin Houser	<input type="checkbox"/>	Mary Stone-Smith
<input type="checkbox"/>	Senator Jeannie Darneille	<input type="checkbox"/>	Avreayl Jacobson	<input type="checkbox"/>	Jim Theofelis
<input type="checkbox"/>	Peggy Dolane	<input type="checkbox"/>	Lonnie Johns-Brown	<input type="checkbox"/>	Dr. Eric Trupin
<input type="checkbox"/>	Jamie Elzea	<input type="checkbox"/>	Kim Justice	<input type="checkbox"/>	Sen. Judy Warnick
<input type="checkbox"/>	Representative Carolyn Eslick	<input type="checkbox"/>	Judy King	<input type="checkbox"/>	Dr. Larry Wissow

No	Agenda Items	Time	Lead
Pre	Zoom Meeting Active for Early-Sign On & Technical Troubleshooting	12:15 – 12:30	Kimberly Harris/ Rachel Burke
1.	Introductions	12:30 – 12:35 pm	Rep. Lisa Callan/ MaryAnne Lindeblad
2.	Update: PAL Assessment (incl. Mental Health Referral Assist program)	12:35 – 12:45	Mary Fliss
3.	CYBHWG Member appointments	12:45 – 12:55	Amber Leaders (tentative) or Co-Chairs
4.	Legislative Session/Budget Outlook – Recommendation guidance	12:55 – 1:05	Rep. Lisa Callan/ MaryAnne Lindeblad
5.	Children with complex needs	1:05 – 1:10	MaryAnne Lindeblad
6.	Subgroup updates <i>25 minutes each – includes Q&A</i> <ul style="list-style-type: none"> Workforce and Rates (Laurie Lippold and Hugh Ewart) <i>Handout 1</i> Prenatal to Five Relational Health (Jamie Elzea) <i>Handout 2</i> 	1:10 – 2:00	Subgroup leads
	BREAK	2:00 – 2:10	

Note: The timeline for CYBHWG recommendations and the status of the work group's 2020 recommendations are included at the end of this packet, for reference purposes.

	Subgroup updates (cont'd.) <ul style="list-style-type: none"> School-based Behavioral Health and Suicide Prevention (Mark McKechnie) Youth and Young Adult Continuum of Care (Rep. Lauren Davis) 	2:10 – 3:00	Subgroup leads
7.	Cross-cutting Issues <ul style="list-style-type: none"> Centering equity/addressing systemic racism in our work Behavioral health integration Mental Health Referral Assist (PAL) 	3:00 – 3:30	Rep. Lisa Callan/ MaryAnne Lindeblad
8.	Wrap-up/Next Steps	3:30 – 3:40	Rep. Lisa Callan/ MaryAnne Lindeblad
9.	Public Comment	3:40 – 4:00	

Join Zoom Meeting

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**Workforce/Rates Subcommittee
Preliminary Recommendations
Sept. 18, 2020**

Decision Making Process: Over the past several months the subcommittee has met approx. 7 times and conducted several surveys to help determine which strategies, among many discussed, to advance to the full workgroup. The subcommittee has been very mindful of the state budget deficit and, therefore, is not recommending strategies that have significant fiscal implications for 2021.

Increasing access to quality behavioral health services is our primary goal and is in great part dependent upon a well-trained, diverse workforce. Unfortunately, a key factor associated with achieving this goal is the rate paid to providers and the cost of putting in place an appropriate rate would likely exceed what is realistic to obtain in the short term.

There are a number of other strategies that are believed to be closely associated with the workforce, particularly with respect to diversifying the workforce, and again, after conducting several surveys, the subcommittee has identified 5 top priorities.

Workforce Top Priorities:

Continuing Education: Require ongoing training and education regarding equity, diversity, anti-racism, and cultural humility for behavioral health and (potentially) other health care professionals. [Note: It is also acknowledged that it is important to identify ways to support professionals of color in the workforce.]

Behavioral Health Apprenticeship: Support funding (and other necessary strategies), in collaboration with the Training Fund, Behavioral Health Institute, SEIU, and others, to develop and launch a behavioral health apprenticeship for non-baccalaureate positions.

Incentives for the Supervision of Students and Those Seeking Their Certification/License: Develop a policy bill and/or budget proviso to establish a work group with representatives from HCA, DOH, higher ed, licensed behavioral health agencies, the Workforce Board, and the Washington Council for Behavioral Health to establish a teaching clinic enhancement rate for community behavioral health agencies supervising students and those seeking their certification/license. The work group will develop standards for classifying a BHA as a teaching clinic, a cost methodology to determine a teaching clinic enhancement rate, and a financing mechanism, including Medicaid/Medicare reimbursement.

Conditional Grants/Loan Repayment: Continue to support additional investments, public and private, into the Health Corps/ and in conjunction with the Washington Student Achievement Council (WSAC), address barriers that have existed related to Conditional Grants and Loan

Repayment. Additionally, develop a plan to transition from time-limited increases in private funding for conditional grants/loan repayment to an increased public investment.

Background Checks/Criminal History: Continue to participate in the ongoing Behavioral Health Workforce Assessment, led by the Workforce Board, to identify ways in which to address issues related to background checks/criminal history that preclude individuals from employment and or volunteering in the behavioral health workforce.

Workforce Support Items:

Additionally, the Workforce Subcommittee recommends that the Children and Youth Behavioral Health Workgroup develop strong statements of support related to the following:

Telehealth: 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 many clients can benefit from some of the tools in the telehealth toolkit. It is critical, though, to not jump to the conclusion too quickly that tactics can be broadly applied. Behavioral health stakeholders need the opportunity 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.

Considerable work is underway by a number of groups related to telehealth. The Workforce/Rates Subcommittee does not recommend that the Workgroup develop recommendations outside of the context of these groups, at least at this time.

A strong statement of support will be developed as the priorities from the lead groups on this issue are identified.

Availability of Childcare/School Age Care: The pandemic has created a situation where many behavioral health clinicians are trying to juggle their work via telehealth, while taking care of their children, and now managing on-line school. The lack of childcare/school age care is creating a situation where, if at all possible, individuals are having to terminate their employment, leaving an even greater shortage in the workforce.

Strategies, including significant legislation, are being advanced related to childcare and it is recommended that the Workgroup develop a statement of support that links the childcare/school age care challenges with the BH workforce.

Workforce On Hold:

Advanced Peer Support Credential: Discussions are underway to determine if a bill related to establishing an Advanced Peer Support Credential will be introduced in 2021. If so, it is the

recommendation of the Workforce/Rates Subcommittee to develop a strong statement of support.

Rates Top Priorities:

Behavioral Health Rate Increase: Continue CYBHWG established support for the rate increase approved by the legislature in 2020 but then subsequently vetoed by the Governor.

Community Mental Health Referral Assistance Program: Continue CYBHWG established support for the Community Mental Health Referral Assistance Program by securing approximately \$800,000 GF-S to maintain the program. If funded, state costs will decline by approximately half as this program will be folded into the implementation framework for HB 2728 that requires commercial carriers to contribute funding for their clients who use the program.

Rates On Hold:

Network Adequacy: Continue to explore/investigate whether there is any public policy initiative to address Network Adequacy issues in the 2021 legislative session.

Prenatal through 5 Relational Health Sub Group
2021 Session Recommendations to the Children and Youth Behavioral Health Work Group
(09.15.20 Version)

The P5RHS has worked hard to engage diverse stakeholders, parents, and partners in the behavioral health system 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

Our Recommendations At-A-Glance:

- **Budget Request 1 (for CYBHWG legacy item): Apply findings from HCA Cost Analysis Study, fund developmentally appropriate assessment and treatment practices for infant and early childhood mental health**
 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, DC:0-5 rather than the DSM
- **Budget Request 2: Establish a complex needs fund to address the behavioral health challenges experienced by children ages 0-5 and their families. Funds would support:**
 1. Child care providers who need support and tools to address challenging behaviors so that: (a) children, their families, and child care providers can have a more positive, supportive experience; and (b) child care providers and families have the support they need to nurture a child's social and emotional learning and development.
 2. Mental health consultants who work with child care providers to address challenging behaviors may receive training and supports 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.
- **Policy Request 1: Promote responsive and appropriate telehealth access by:** (a) requiring state-funded programs to publicize the availability of Washington Lifeline, ask families about the need for digital access, and make appropriate referrals; and, (b) Creating a committee/study 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. The committee/study would:
 1. collect and analyze data about clinical efficacy of prenatal through five behavioral health services and supports through virtual mode;
 2. determine ways to maximize health benefit of different service modes (or mix of modes) to which families, in which situations, for which treatments;
 3. identify 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.
- **Policy Request 2: Clarify funding sources for targeted postpartum parent peer support** so that early intervention and perinatal parent peer counselors that meet specified standards of practice can support vulnerable families before behavioral health concerns become severe.
- **IECMH-C Preservation Statement Request (for CYBHWG legacy item):** The Prenatal-5 Relational Health Subcommittee 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 SGF.
- **Support Agenda Request:** Support the exploration of the Washington Chapter of the American Academy of Pediatrics' "learning collaborative" (held September 2020-June 2021) that will focus on identifying system strengths, barriers, and gaps in reliable screening and timely support for postpartum mood and anxiety disorders in pediatric settings.

Budget Request 1:

Provide Developmentally Appropriate Mental Health Services for Children 0-5

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

Recommendation: Change Medicaid policy to match best practices for mental health assessment and diagnosis of children birth through 5 years old:

Request:

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

A. The Issue: Research shows that even very young children can suffer from mental health conditions. Unfortunately the current assessment and diagnosis process in the behavioral health system does not meet the needs of young children. In light of the impending statewide increase in behavioral health impacts and expected increased in child abuse occurrences resulting from the Covid-19 pandemic [ii], 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. Problem and Impact on Children, Families, and Communities:

Even very young children – babies, toddlers, preschoolers -- can suffer from mental health conditions.

Very young children are especially at risk after experiencing trauma (e.g., abuse, neglect, or post-disaster settings such as the Covid-19 pandemic) or cumulative stress (e.g., child welfare system involvement) or when a parent is experiencing behavioral health challenges (e.g., birthing parent’s postpartum depression or anxiety). 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 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. Without appropriate and accurate diagnoses, there is no basis for accurate treatment planning. Brain science tells us how much more successful the right treatments are in getting young children back on developmentally normative trajectories, but many children in Washington are being deprived of effective, efficient treatment. This

creates risk for further complications in their care, including accumulating co-morbid conditions. It can also have long-term consequences for children in their social emotional development, relationship development, and learning. 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 [iv]. The nationally accepted [iii] 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. History in the Children’s Mental Health 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.

E. Models for this Change:

- 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.

Children & Youth Behavioral Health Work Group – 2020 Prenatal to Five Relational Health Sub Group

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

F. Why Urgent Now:

- 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 (ie 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

[i] The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood is found here: <https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training>. Additional information about the integration of the DC:0-5 into State Policy and Systems can be found here: <https://www.zerotothree.org/resources/2343-advancing-infant-and-early-childhood-mental-health-the-integration-of-dc-0-5-into-state-policy-and-systems#downloads>

[ii] Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19. August 2022 Drawn from the web

9/20: <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19StatewideSummaryForecastofBHImpacts-Aug2020Update.pdf>

[iii] Minnesota overview of the DC:0-5: <https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/diagnostic-assessment-young-children/>

[iv] 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

[v] How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: RESULTS OF A 50-STATE SURVEY (2018 UPDATE) http://www.nccp.org/wp-content/uploads/2018/11/text_1211.pdf

Budget Request 2:

Establish a complex needs fund to address the behavioral health challenges experienced by children ages 0-5 and their families

This account would help address the behavioral health challenges children 0-5 experience. 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. This complex needs fund would support the following:

- 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, 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.

Policy Request 1:

Promote Responsive & Appropriate Telehealth Access

G. What is the issue?

1. 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 is useful to address changing needs. Access to telehealth and audio options allows families more choice about how to receive services.
2. 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 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. 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.
3. Families of color already experience disparities that affect 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%.¹

Exposure to stigma, bias, and differential treatment based on race or income level leads to poor health outcomes and impacts overall well-being.² Additionally, chronic stress caused by racism and bias can compound socioeconomic issues that also lead to poor health outcomes.³ From 2014-2016 in Washington, American Indian and Alaska Native women had higher maternal mortality ratios than any other race/ethnic group.⁴

4. Standards of practice are unclear regarding when in-person, audio-video, or audio only modes are most effective. Due to telehealth being a newer practice, the research on effectiveness is unclear. Early data shows a mixed review of when in-person, audio-video, or audio only modes are most effective for what types of care. Thus, this has implications on which telehealth services should be temporarily allowed during the pandemic, which should be allowed permanently, which are more optimal for in-person services, and which can be offered either in-person or via telehealth on a permanent basis.

Research shows that cognitive behavioral therapy delivered through audio-video reduces attrition (20.9% for audio-video vs. 32.7% for face-to-face), while achieving similar results to face-to-face therapy.⁵ Research on Parent-Child Interaction Therapy shows similar higher participation/lower attrition for telehealth services vs. face-to-face and comparable outcomes.⁶ 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.⁷ However, some studies show that effects are less long-lasting for some clients.

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

¹ Report to the Legislature Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016, Department of Health, (October 2019), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-010-MMRPMaternalDeathReport2014-2016.pdf>.

² Smedley, B.D., Stith, A.Y., Nelson, A.R. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academy of Sciences. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK220358/pdf/Bookshelf_NBK220358.pdf

³ Kim, S., Im, E., Liu, J., Jiangong, & Ulrich, C. (2018). Factor Structure for Chronic Stress before and During Pregnancy by Racial/Ethnic Group. *Western Journal of Nursing Research*. Retrieved at: https://www.researchgate.net/profile/Sangmi_Kim5/publication/326463782_Factor_Structure_for_Chronic_Stress_Before_and_During_Pregnancy_by_RacialEthnic_Group/links/5b4f429aaca27217f9f8562/Factor-Structure-for-Chronic-Stress-Before-and-During-Pregnancy-by-Racial-Ethnic-Group.pdf

⁴ Report to the Legislature Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016, Department of Health, (October 2019), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-010-MMRPMaternalDeathReport2014-2016.pdf>.

⁵ David C. Mohr, PhD; Joyce Ho, PhD; Jenna Duffecy, PhD; et al, "Effect of Telephone-Administered vs Face-to-face Cognitive Behavioral Therapy on Adherence to Therapy and Depression Outcomes Among Primary Care Patients" in *Journal of the American Medical Association* (June 6, 2012) [307,21] [2278-2285] retrieved on 09-11-20, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3697075/>, doi: 10.1001/jama.2012.5588.

⁶ Jonathan S. Comer, PhD, "Broadening the reach of parenting intervention through technology" in the American Psychological Association CYF News (May 2019), retrieved on September 14, 2020, <https://www.apa.org/pi/families/resources/newsletter/2019/05/parenting-intervention-technology>

⁷ Nai-Ching Chi, George Demiris, "A Systematic Review of Telehealth Tools and Interventions to Support Family Caregivers" in the *Journal of Telemedicine and Telecare* (January 1, 2015 - Article first published online in PubMed: December 4, 2014) Volume: 21 issue: 1, page(s): 37-44, retrieved September 14, 2020, <https://journals.sagepub.com/doi/abs/10.1177/1357633x14562734>, <https://doi.org/10.1177/1357633x14562734>.

Children & Youth Behavioral Health Work Group – 2020 Prenatal to Five Relational Health Sub Group

1. Limited Access to Telehealth Options – Many low-income families have never had reliable access to high-speed Internet, new hardware, or software modules that are used in telehealth. 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 be based more on the presence of potential paying consumers than on those places with the most families in need. Additionally, schools are handling distribution of hardware and software through their relationships with children in their catchment area. Routine mechanisms to reach parents prenatally through the child’s 5th year are more difficult and rely on a patchwork of programs that have flexible funding (like ECEAP or ESIT) to address this. Since healthcare providers are saying that many families are not getting well-child exams, this primary place to connect with families (and orient them) is also now less available.
2. Time to Bill for Preparing Families to Benefit from Telehealth Treatment Is Temporary – Current flexibility during the pandemic allows behavioral health providers to bill for the variety of care coordination activities families need to truly have access (scheduling, initial telehealth access configuration, and training in telehealth tools).
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. Research shows that services delivered over the phone increase participation and reduce attrition, while offering similar benefits. State Medicaid is committed to allowing clinically appropriate billing of “audio only” services after the 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.

I. 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 2017⁸ even accounting for children’s resilience.⁹
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 2021.¹⁰ 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.

J. What options do we have to change this?

Legislative Request

1. **Create a committee/study** 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.

⁸ <https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-washington>

⁹ Luca, D.L., Garlow, N., Staatz, C., Margiotta, C., Zivin, K. (April 19, 2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in Washington. Cambridge, MA: Mathematica Policy Research.

<https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-washington>

¹⁰ Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19, Department of Health website, retrieved on September 14, 2020, <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19StatewideSummaryForecastofBHImpacts-Aug2020Update.pdf>.

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.

Ongoing P5RHS Work (non-legislative purview)

1. **Administrative advocacy/Work with Accountable Communities of Health** to have the Office of Broadband and Office of Equity prioritize expansion of land-based broadband in locations where there are large numbers of low-income families. This includes administrative advocacy to maximize federal Universal Service and private funds to expand in these areas.
2. **Administrative advocacy** to have the option of providing specified early intervention services as needed (typically, one in-person needs to be provided and others can be virtual)
3. **Prepare for future policy** to pay clinically appropriate and financially sustainable “audio only” payment to policy enabled by [SB 5385](#).

K. Given current limitations, why is taking the recommended action a smart move?

1. During the pandemic, many families will not access services any other way.
2. Some families will only use services that have a telehealth option.
3. Without building these capacities, we cannot effectively reach underserved communities.
4. Facilitating telehealth services now can save money long-term by preventing and/or intervening in anticipated increased pandemic-related behavioral health challenges.
5. Telehealth services contribute to efforts to reduce our carbon footprint by reducing car/bus travel.
6. Understanding effectiveness has long-term implications that can help families. Understanding effectiveness and access are two key components to improving health equities for families through telehealth.

Policy Request 2:

Clarify Funding Sources for Targeted Postpartum Parent Peer Support

1. What is the issue?

1. Lack of support can increase risks. Lack of social support is a major risk factor for developing postpartum depression before COVID-19 started and now poses an even greater risk to the health of parents and infants.¹¹
2. Peer support can help. Parent peer support provides opportunities for reflective parenting, problem solving, information sharing, and socioemotional support during stressful times. Families find it useful to have support from racially reflective peers with children of similar ages, development, and family considerations.
3. Targeted peer support programs can leverage behavioral health system investments. Our behavioral health system is overtaxed, and there are not enough mental health providers to provide care. Peer support services provide both preventative and important treatment components. Peer support can help reduce severity and acuity of mental health disorders¹², thereby:
 - o augmenting the overall capacity of the mental health system;
 - o increasing access to services by reducing stigma;
 - o reducing barriers and supporting parents in finding appropriate care; and,
 - o helping parents stay in services and increase treatment retention/engagement by providing education about mental health system navigation and supporting self/family advocacy.

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

1. Risks to Families with Young Children. Social isolation during the postpartum period (in the first year) is the highest risk linked to child abuse and neglect.¹³ The pandemic has increased these risks due to economic disruption. The disproportionate impacts of the pandemic and current racial tension also may be increasing stress for families of color. During the pandemic, reported case of child abuse and neglect have dropped presumably because of the lack of opportunities for children to be seen by mandatory reporters.
2. Racial Disparities. 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. 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. The leading cause of pregnancy-related deaths in Washington from 2014-2016 was behavioral health conditions 30%.¹⁴

Exposure to stigma, bias, and differential treatment based on race or income level leads to poor health outcomes and impacts overall well-being.¹⁵ Additionally, chronic stress caused by racism and bias can compound socioeconomic issues that also lead to poor health outcomes.¹⁶ From 2014-2016 in Washington, American Indian and Alaska Native women had higher maternal mortality ratios than any other race/ethnic group.¹⁷

3. Peer Support Programs Can Prevent or Mitigate Some Behavioral Health Concerns. By addressing this period, we can address the parent and the child's needs. Many programs are designed to enhance parents' peer social support to address social isolation and stress and prevent or intervene in significant behavioral health challenges early. Programs shown to be effective include "new parent" support groups delivered in-person and via virtual connection. Perinatal support programs and neurodevelopmental centers currently provide parent peer support with peers matched by race, child age, and child developmental needs. Facilitators of these support groups either are licensed mental health professionals or directly supervised by them, and all follow mandatory reporting guidelines. Because peer support services are more accessible

¹¹ Pao, C., Guintivano, J., Santos, H., & Meltzer-Brody, S. (2019). Postpartum depression and social support in a racially and ethnically diverse population of women. *Archives of women's mental health*, 22(1), 105-114.

¹² Pfeiffer, P. N., Heisler, M., Piette, J. D., Rogers, M. A., & Valenstein, M. (2011). Efficacy of peer support interventions for depression: a meta-analysis. *General hospital psychiatry*, 33(1), 29-36.

¹³ Child Abuse and Neglect Risk and Protective Factors, *Centers for Disease Control & Prevention*. Retrieved September 14, 2020, <https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>

¹⁴ Report to the Legislature Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016, Department of Health, (October 2019), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-010-MMRPMaternalDeathReport2014-2016.pdf>.

¹⁵ Smedley, B.D., Stith, A.Y., Nelson, A.R. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academy of Sciences. Retrieved from:

https://www.ncbi.nlm.nih.gov/books/NBK220358/pdf/Bookshelf_NBK220358.pdf

¹⁶ Kim, S., Im, E., Liu, J., Jiahong, & Ulrich, C. (2018). Factor Structure for Chronic Stress before and During Pregnancy by Racial/Ethnic Group. *Western Journal of Nursing Research*. Retrieved at:

https://www.researchgate.net/profile/Sangmi_Kim5/publication/326463782_Factor_Structure_for_Chronic_Stress_Before_and_During_Pregnancy_by_RacialEthnic_Group/links/5b4f429aaca27217f9f8562/Factor-Structure-for-Chronic-Stress-Before-and-During-Pregnancy-by-Racial-Ethnic-Group.pdf

¹⁷ Report to the Legislature Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016, Department of Health, (October 2019), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-010-MMRPMaternalDeathReport2014-2016.pdf>.

even during a pandemic and focus on development of trusting, safe (and de-stigmatized) relationships, they can elicit what is happening for the family early and increase parent interest in seeking support and/or services earlier.

4. Digital Divide Makes These Supports Unavailable to Some Families. During the pandemic, these groups are virtual only, exacerbating inequities for those on the other side of the digital divide.

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

1. 1 in 7 new moms¹⁸, 1 in 10 dads¹⁹, and 1 in 8 adoptive mothers experience postpartum depression.²⁰
2. Women of color experience post-partum depression at a rate of close to 38 percent²¹
3. Up to 48% of low-income mothers report elevated postpartum depression symptoms.²²
4. 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 2017²³ even after accounting for children's resilience.²⁴
5. 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 2021.²⁵

N. What options do we have to change this?

Legislative Request

1. **Clarify policy** to articulate how early intervention and targeted postpartum parent peer counselors that meet specified standards of practice (e.g., peer counselor directly supervised by a mental health professional)²⁶ can be funded for peer support prevention services.

Ongoing P5RHS Work (Non-legislative purview)

- **Administrative advocacy** to create public service announcements and social media promoting and destigmatizing parent peer support.
- **Explore** other ways to support informal and formal peer support.
- **Explore** payment parity for these services when provided through virtual services (if as indicated by recommendation 1 future standards of practice).

O. Given current limitations, why is taking the recommended action a smart move?

1. With the increase in population behavioral health forecasts (Moderate to high anxiety was identified in 72% of women [from pregnancy to 1 year postpartum] 3 months into the pandemic up from 29% before)²⁷ – this is a way to prevent more mental health challenges and provide immediate treatment/relief to vulnerable families and children at the same time.
2. This can leverage other parts of the mental health and child welfare systems by increasing participation in needed mental health supports and retention in treatment.
3. This approach could prevent more costly later mental health needs.
4. Research shows that such trusted peer interactions can promote beneficial behaviors during a pandemic.²⁸

¹⁸ Wisner, K.L., Sit, D.K.Y., McShea, M.C., et al. (May 2013). Onset Timing, Thoughts of Self-harm, and Diagnoses in Postpartum Women with Screen-Positive Depression Findings. *JAMA Psychiatry*. 2013;70(5):490-498.

<https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1666651>

¹⁹ Paulson, J.F., Bazemore, S.D. (May 19, 2010). Prenatal and Postpartum Depression in Fathers and Its Association with Maternal Depression: A Meta-analysis. *Journal of the American Medical Association*. 2010;303(19):1961-1969.

<https://jamanetwork.com/journals/jama/article-abstract/185905?redirect=true>

²⁰ Mott, S.L., Schiller, C.E., Richards, J.G., O'Hara, M.W., Stuart, S. (August 2011). Depression and anxiety among postpartum and adoptive mothers. *Archives of Women's Mental Health*. 2011 Aug; 14(4): 335–343.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433270/>

²¹ Keefe, R., Brownstein-Evans, C., Rouland, R. (2016). Having Our Say: African American and Latina Mothers Provide Recommendations to Health and Mental Health Providers Working with New Mothers Living with Postpartum Depression. Social Work in Mental Health.

²² Lindsay Garfield, PhD., et al, "Risk factors for Postpartum Depressive Symptoms in Low-Income Women with Very Low Birth Weight Infants" in *Advances in Neonatal Care*, 2015 Feb; 15(1): E3-E8. Retrieved September 14, 2020 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4313576/>; doi: 10.1097/ANC.0000000000000131.

²³ <https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-washington>

²⁴ Luca, D.L., Garlow, N., Staats, C., Margiotta, C., Zivin, K. (April 19, 2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in Washington. Cambridge, MA: Mathematica Policy Research.

<https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-washington>

²⁵ Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19, Department of Health website, retrieved on September 14, 2020, <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19StatewideSummaryForecastofBHImpacts-Aug2020Update.pdf>.

²⁶ <https://app.leg.wa.gov/WAC/default.aspx?cite=182-502-0002>

²⁷ Margie H. Davenport, et al, "Moms Are Not OK: COVID-19 and Maternal Mental" in *Frontiers of Global Women's Health*, 19 June 2020, retrieved on September 14, 2020,

https://www.frontiersin.org/articles/10.3389/fgwh.2020.00001/full?utm_campaign=ba-cov-sci-fgwh-mental-health&utm_medium=vcj&utm_source=fweb; <https://doi.org/10.3389/fgwh.2020.00001>

²⁸ Bavel, J.J.V., Baicker, K., Boggio, P.S. et al. Using social and behavioural science to support COVID-19 pandemic response. *Nat Hum Behav* 4, 460–471 (2020). <https://doi.org/10.1038/s41562-020-0884-z>

Preservation Statement Request:

Support existing investments in infant and early childhood mental health consultation

The Prenatal-5 Relational Health Subcommittee 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 SGF.

In 2019, the legislature passed [2SSB 5903](#) which created an IECMH-C program at Child Care Aware of Washington (CCA WA). This was a start to building an urgently needed IECMH-C system of support for child care providers. A total of six consultants (one per CCA WA region) support 3,271 child care providers who are serving 107,678 children.²⁹ These numbers reflect the licensed child care providers participating in the Early Achievers program 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 the investment in IECMH-C.

Starting in 2019, a \$773,000 per year investment began to support the program at CCA WA. This funding is only for the six consultants. It does not include funding for a leadership/management position to coordinate the six consultants, infrastructure for the program, or professional development. There is currently a proposal to a private funder to support a leadership/management position, professional development for the six consultants and other mental health consultants who work with child care providers, and scholarships for credential attainment to diversify the mental health consultant workforce.

The state investment of \$773,000 per year leverages this potential private funding. 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.

Preservation of this investment will also support the ground work 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. A review of research findings is included below to provide background for the potential impacts of mental health consultation services on implicit racial and gender bias.

BACKGROUND INFO / RESEARCH FINDINGS

Expulsion data

- Black children's preschool expulsion rate is nearly two times as high compared to Latino and white children. (<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/understanding-eliminating-expulsion-early-childhood-factsheet.pdf>)
- "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." (p2, <https://www2.ed.gov/about/offices/list/ocr/docs/2013-14-first-look.pdf>)
- 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

²⁹ Child Care Aware Washington, 9/15/20

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benefit from daily attendance in preschool programs. (p1, <https://www.instituteforchildsuccess.org/wp-content/uploads/2018/12/ICS-2018-PreschoolSuspensionBrief-WEB.pdf>)

- Research shows early childhood mental health consultation to be an effective strategy in reducing preschool expulsion particularly among young children of color (Meek & Gilliam, 2016) and Shivers ([Smart Support Evaluation](#), 2015)
- Early childhood mental health consultation and the consultative alliance support the reduction of implicit bias which impacts expulsion rates among young children of color ([Davis, Shivers & Perry, 2018](#))

Authorizing legislation is [2SSB 5903](#) passed in 2019. See Sec. 7, p.7

NEW SECTION. **Sec. 7.** A new section is added to chapter 43.21615RCW to read as follows:

The department of children, youth, and families must enter into a contractual agreement with an organization providing coaching services to early achievers program participants to hire one qualified mental health consultant for each of the six department-designated regions. The consultants must support early achievers program coaches and child care providers by providing resources, information, and guidance regarding challenging behavior and expulsions and may travel to assist providers in serving families and children with severe behavioral needs. In coordination with the contractor, the department of children, youth, and families must report on the services provided and the outcomes of the consultant activities to the governor and the appropriate policy and fiscal committees of the legislature by June 30, 2021.

The funding source is in the 2019 operating budget, [ESHB 1109](#). See p.213 starting line 9 (Sec. 225, DCYF)

(x) \$773,000 of the general fund—state appropriation for fiscal year 2020 and \$773,000 of the general fund—state appropriation for fiscal year 2021 are provided solely for implementation of Second Substitute Senate Bill No. 5903 (children's mental health). If the bill is not enacted by June 30, 2019, the amounts provided in this subsection shall lapse.

Regarding funding, 20% of the \$773,000 GFS annual investment was included in DCYF's cost reduction

Support Agenda Request:

Remove Barriers to PMAD Screening of All Parenting Adults

1. What is the issue?

1. Reduction in important screens. During COVID19, families are not being screened for postpartum mood and anxiety disorders (PMAD's) due to skipped 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.³⁰
3. Screening is inconsistent. Due to lack of flexibility time available to most, 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".³¹ PMAD screening is now required for any caregiver/mother of a child (birth through age 6 months) participating in a well-child exam,³² 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. There are inadequate assessment services to which families can be referred when indicated.

2. 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.³³
2. Parental behavioral health affects the child and parent. Research shows that perinatal behavioral health issues are associated with pre-term delivery³⁴, low birthweight³⁵ and increase chances of difficult infant temperament and sub-optimal breastfeeding practices.³⁶
3. The time right after children are born is pivotal. Difficulties in managing the stress of the transition to parenting is a risk factor for severe mood regulation problems, such as postpartum depression, marital problems, and harsh parenting (a term that can include a range of parenting behaviors, from corporal punishment and verbal aggression to child maltreatment), in both men and women.³⁷
4. Racial Disparities. The leading cause of pregnancy-related deaths in Washington from 2014-2016 was behavioral health conditions 30%.³⁸ 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.⁴² Exposure to stigma, bias, and differential treatment based on race or income level leads to poor health outcomes and impacts overall well-being.³⁹

³⁰Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19. August 2020 Drawn from the web 9/20: <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19StatewideSummaryForecastofBHImpacts-Aug2020Update.pdf>

³¹ Kerker, B. D., Storfer-Isser, A., Stein, R. E., Garner, A., Szilagyi, M., O'Connor, K. G., ... & Horwitz, S. M. (2016). Identifying maternal depression in pediatric primary care: changes over a decade. *Journal of developmental and behavioral pediatrics: JDBP*, 37(2), 113.

³² EPSDT Billing Guide (page 20)

³³ Atkinson, L., Paglia, A., Coolbear, J., Niccols, K., Parker, K.C., Guger, S. Clinical (November 2000). Attachment security: A meta-analysis of maternal mental health correlates. *Clinical Psychology Review*. Volume 20, Issue 8, November 2000, Pages 1019-1040. <https://www.sciencedirect.com/science/article/pii/S0272735899000239>

³⁴ Yaari, M., Treyvaud, K., Lee, K.J., Doyle, L.W., Anderson, P.J. (July 2019). Preterm Birth and Maternal Mental Health: Longitudinal Trajectories and Predictors. *Journal of Pediatric Psychology*. Volume 44, Issue 6, July 2019, Pages 736-747. <https://doi.org/10.1093/jpepsy/jsz019>

³⁵ Grote, N.K., Bridge, J.A., Gavin, A.R., Melville, J.L., Iyengar, S., Katon, W.J. (October 4, 2010). A Meta-analysis of Depression During Pregnancy and the Risk of Preterm Birth, Low Birth Weight, and Intrauterine Growth Restriction *Archives of General Psychiatry*. 2010;67(10):1012-1024. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/210887>

³⁶ Wouk, K., Stuebe, A. M., & Meltzer-Brody, S. (2017). Postpartum Mental Health and Breastfeeding Practices: An Analysis Using the 2010-2011 Pregnancy Risk Assessment Monitoring System. *Maternal and child health journal*, 21(3), 636-647. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5253344/>

³⁷ Perren, S., von Wyl, A., Bürgin D., Simoni H., von Klitzing K. (2005). Depressive symptoms and psychosocial stress across the transition to parenthood: associations with parental psychopathology and child difficulty. *Journal of Psychosomatic Obstetrics & Gynecology*. 2005 Sep;26(3):173-83. <https://www.ncbi.nlm.nih.gov/pubmed/16295515>

³⁸ Report to the Legislature Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016, Department of Health, (October 2019), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-010-MMRPMaternalDeathReport2014-2016.pdf>.

³⁹ Smedley, B.D., Stith, A.Y., Nelson, A.R. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academy of Sciences. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK220358/pdf/Bookshelf_NBK220358.pdf

3. **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 2017⁴⁰ 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."*⁴¹

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

Legislative Ask

- **Support the exploration** of the Washington Chapter of the American Academy of Pediatrics' "learning collaborative" (held September 2020-June 2021) that will focus on identifying clinical barriers to routine postpartum mood and anxiety disorder screening.

Ongoing P5RHS Work (Non-legislative purview)

- **Explore ways to fund/support** additional behavioral health assessment and treatment capacity.
- **Explore a change to policy** to provide adequate billable reimbursement amount and time to allow a more searching PMAD screening conversation (as informed by the WCAAP Learning Collaborative clinical pilots)
- **Explore options** for immediate e-consult for physicians whose time/schedule does not allow deeper screening/assessment.

5. **Given current limitations, why is taking the recommended action a smart move?**

1. This is a key place to offer immediate relief to families.
2. This provide an opportunity to decrease health disparities.
3. Intervening now can save substantial later cost to the State

⁴⁰ Luca, D.L., Garlow, N., Staatz, C., Margiotta, C., Zivin, K. (April 19, 2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in Washington. Cambridge, MA: Mathematica Policy Research. <https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-washington>

⁴¹ National Research Council and Institute of Medicine. Preventing Mental, Emotional, and Behavioral Disorders among Young People. (2009). https://www.integration.samhsa.gov/integrated-care-models/IOM_Report_on_Prevention.pdf. Accessed 01-18-20

CYBHWG 2020 Timeline

Mar
Apr
May
Jun
Jul
Aug
Sept
Oct

CMHWG meetings

March 27, 2020
Session debrief
Discuss priorities/process
Determine 2020 subgroups

June 5, 2020
1st subgroup report—
Work to date

September 18, 2020
2nd subgroup report—
Draft recommendations

October 21, 2020
3rd subgroup report—
Final recommendations

Subgroups

Subgroups identified
Leads identified
Targets and scope defined
Members invited/solicited

Recommendation: 1st meeting held/
meeting schedule determined and publicized
**June 2: Materials for June CMHWG meeting
submitted to HCA staff**

Recommendation development

Recommendations drafted
**New date September 15: Draft recommenda-
tions submitted to HCA staff**

Final recommendations drafted
Subgroup review and consensus on recs
**New date October 16: Recommendations
finalized and submitted to HCA staff.**

HCA Staff

Support subgroup leads:
*Meeting notices
Conference calls
Note taking
Help draft recommendations*

Prepare and post meeting materials, including
subgroup recommendations

Prepare and post meeting materials, including
subgroup recommendations

Children’s Mental Health Work Group Recommendations for 2020 Session – Post-Session Status (draft)

Legend: Vetoed Passed by Legislature No legislative action taken Non-legislative action needed

Topic/Recommendations	Priority	Action needed			Notes/Status
		Policy	Budget	Other	
<p>Prenatal to Five Relational Health</p> <p>1. Require HCA to analyze the fiscal impact of changing Medicaid policy to match best practices for mental health assessment and diagnosis of children birth through 5 years old, including:</p> <ul style="list-style-type: none"> • Allowing 3-5 sessions for intake and assessment. • Allowing assessments to occur in home or community settings, and reimbursing clinicians for travel. • Requiring use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). 	#1 of 7 budget priorities	Yes	\$100,000 <i>Appropriated:</i> \$31,000 GF-State FY20 \$94,000 GF-State FY21 \$125,000 GF-Fed		<p>ESSB 6168 budget proviso Sec. 215 (62)</p> <p>HCA to conduct an analysis on the impact of changing Medicaid policy to match best practices for 0-5 mental health assessment and diagnosis.</p> <ul style="list-style-type: none"> • Analysis to include cost estimates. • Report due 12/1/2020.
<p>2. Extend Medicaid coverage to 365 days postpartum.</p>			\$ 2.5 million		<p>E2SSB 6128-Postpartum period/Medicaid</p> <p><i>Vetoed.</i></p> <ul style="list-style-type: none"> • Takes effect when HCA becomes eligible to receive federal financial participation for persons with income \geq193% of FPL. • HCA to submit a waiver request to CMS by 1/1/2021. • HCA to report on waiver status by 1/1/2021.
<p>3. Provide scholarships and training for Perinatal and Infant Mental Health for Maternity Support Service and Infant Case Management providers.</p>	#6 of 7 budget priorities		\$200,000 - \$400,000 <i>Appropriated:</i> \$300,000 GF-State FY21 (Prenatal to 5 and Workforce proposals combined)		<p>ESSB 6168 budget proviso Sec. 215 (56)</p> <p><i>Vetoed</i></p> <ul style="list-style-type: none"> • Grants to provide flexible funding for training and mentoring of clinicians serving children and youth (birth through adolescence). • HCA to implement in partnership with Accountable Communities of Health (ACHs) or UW Behavioral Health Institute. • HCA to consult with stakeholders (behavioral health experts, providers, and consumers) to develop guidelines for how funding can be used, with a focus on evidence- based and promising practices, continuing education requirements, and quality-monitoring infrastructure.

Children’s Mental Health Work Group Recommendations for 2020 Session – Post-Session Status (draft)

Topic/Recommendations	Priority	Action needed			Notes/Status
		Policy	Budget	Other	
<p>Behavioral Health Rates</p> <p>1. Require that proposals related to increasing Medicaid rates must be grounded within the rate-setting process for the provider type or practice setting, incentivize preventive care, and recognize the shift toward value-based purchasing. Any increase in Medicaid rates for behavioral health services must include a proportional increase to services with a care rate, with a priority on WISE.</p>	#1 of 3 policy priorities	Yes	Potential		<p>EHB 2584-Behavioral health rates</p> <ul style="list-style-type: none"> Requires HCA to work with actuaries in implementing funded behavioral health rate increases, including those provided through MCOs, to assure they are appropriate adjustments are made to services paid through a case rate.
<p>2. Require the HCA, with respect to funds appropriated by the legislature with the intent of increasing Medicaid rates paid to providers, to establish mechanisms that ensure these funds are passed on by MCOs directly to behavioral health providers as intended.</p>	#2 of 3 policy priorities			Yes	<p>EHB 2584-Behavioral health rates</p> <ul style="list-style-type: none"> Requires HCA to establish a process for verifying that funding appropriated for behavioral health provider increases, including rate increases provided through MCOs, is used for the objectives stated in the appropriation.
<p>3. Enhance transparency and accountability mechanisms utilized by HCA and MCOs to ensure that appropriated community behavioral health funds are used by HCA and MCOs for their intended purpose.</p>				Yes	<p>EHB 2584-Behavioral health rates</p> <ul style="list-style-type: none"> Requires HCA to provide annual reports to the Legislature regarding the implementation processes and results of targeted behavioral health provider rate increases.
<p>4. Increase children’s Medicaid behavioral counseling and psychotherapy rates by 8% or to the Medicare reimbursement rate, whichever is higher. Prioritize the following treatment codes (these will have the greatest impact to increase access for children and youth and address significant rate disparities: (\$\$\$)</p> <ul style="list-style-type: none"> Behavioral Health Counseling and Psychotherapy – H0004, 90832, 90834, 90838, 99354, 99355, 90833, H0036 Care coordination – H2015, H2021 Family Therapy with or without youth present – 90847; 90846 Group treatment – 90853, 90849 	#3 & #5 of 7 budget priorities		<p><i>Appropriated:\$1,857,000 GF-State FY21</i> <i>\$3,146,000 GF-Federal</i></p>		<p>ESSB 6168 budget proviso Sec. 215 (78) Vetoed</p> <ul style="list-style-type: none"> Increases state fee-for-service (FFS) provider rates by 15% or to Medicare rate (or an equivalent relative value, if there is no Medicare rate), whichever is lower, for children <i>and</i> adults for these codes: 90832, 90833, 90834, 90837, H0004, H0036, H2015, H2021, H0023, 90836, 90838, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 90845, 90846, 90847, 90849, 90853, 90785, and 90791. Require in MCO contracts, beginning in CY 2021, that MCOs pay no lower than the FFS rate for these codes, and adjust managed care capitation rates accordingly.

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Topic/Recommendations	Priority	Action needed			Notes/Status
		Policy	Budget	Other	
5. Additional children’s Medicaid behavioral counseling and psychotherapy rates to increase by 8% or to the Medicaid reimbursement rate: <ul style="list-style-type: none"> • Intake, Assessment, Treatment Planning – H0031, H0032 • Medication management – 99211, 99212, 99213, 99214, 99215 					
6. Work with stakeholders to study the underlying salary assumptions and compare them to other market standards, including Medicare.	#1 of 2 HCA priorities		<i>Appropriated: \$50,000 GF-State FY21 \$50,000 GF-Federal FY21</i>	Yes	ESSB 6168 budget proviso Sec. 215 (57) <ul style="list-style-type: none"> • HCA to work with actuaries, UW behavioral health institute, MCOs, and community mental health and SUD providers to develop strategies for enhancing behavioral health provider reimbursement to promote workforce development. • HCA to submit report to OFM and Legislature by 12/1/2020.
7. Appropriate funding for partial hospitalization and intensive outpatient as an alternative to inpatient hospitalization and require reimbursement for these services. [PH and IOP allow children and adolescents to have their behavioral health needs met through intensive therapies up to 3-8 hours/day without requiring inpatient hospitalization.]			<i>Appropriated: \$1,801,000 GF-State FY21</i>		ESSB 6168 budget proviso Sec. 215 (76) <ul style="list-style-type: none"> • HCA to implement two pilot programs for intensive outpatient services and partial hospitalization services for certain children and adolescents, contracting with one hospital in western Washington and one hospital in eastern Washington, effective 1/1/2021. • Eligible patients: children and adolescents discharged from an inpatient hospital treatment program who require the level of services offered by the pilot programs in lieu of continued inpatient treatment, and children and adolescents who require this level of services to avoid inpatient hospitalization. • Services may not be offered if there are less costly alternative community based services that can effectively meet an individual’s needs.
Topic/Recommendations	Priority	Action needed			

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		Policy	Budget	Other	Notes/Status
8. Direct HCA to build payment models that adequately reimburse for multi-disciplinary team-based services, such as shared appointments, care conferences, and team meetings.	#2 of 2 HCA priorities			Yes	
Workforce					
1. Expand capacity in the WA Student Achievement Council’s Behavioral Health Loan Repayment Program and initiate a Conditional Scholarship Program targeted towards those serving the highest needs populations, those who increase opportunities for the provision of culturally-responsive care, and individuals going into behavioral health fields.			\$2 million Ongoing		
2. Direct the WSAC and/or the Board of Community and Technical Colleges to develop (or expand) apprenticeships within the field of behavioral health that would begin in 2021.		Yes			
3. Request that HCA work with DOH as they are re-writing the rules related to paperwork reduction – as well as legal, business process, and accreditation standards for children’s BH professional credentialing - and that they identify barriers associated with reducing paperwork requirements, and report to CYBHWG.				Yes	
4. Review the 2019 Behavioral Health Workforce Report and Recommendations following submission to the Legislature and Office of the Governor. Participate and designate representatives in Phase 2 of the Workforce Board’s proviso work, including the Background Check Subcommittee and subcommittee focused on incentives for supervision of interns and trainees. Advance specific recommendations to the CBHWG for consideration in 2021.				Yes	

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Topic/Recommendations	Priority	Action needed			Notes/Status
		Policy	Budget	Other	
5. Develop and fund clear, transparent, and flexible payment models for adequate training (including training for those working with children 0-5), supervision (including Reflective Supervision), and coaching within children’s behavioral health programs.		Yes	Less than \$2M – developing funding model and training (includes 0-5 \$400K) <i>Appropriated: \$300,000 GF-State FY21 (Prenatal to 5 and Workforce proposals combined)</i>		ESSB 6168 budget proviso <i>Vetoed</i> <ul style="list-style-type: none"> Grants to provide flexible funding for training and mentoring of clinicians serving children and youth (birth through adolescence). HCA to implement in partnership with Accountable Communities of Health (ACHs) or UW Behavioral Health Institute. HCA to consult with stakeholders (behavioral health experts, providers, and consumers) to develop guidelines for how funding can be used, with a focus on evidence- based and promising practices, continuing education requirements, and quality-monitoring infrastructure.
6. Require diversity, equity, and inclusion training for licensed/certified behavioral health professionals.		Yes			
Student Well-Being and School-based Connections to BH/IDD Services and Supports 1. Establish in statute (as a subcommittee of the CMHWG) the School-based Behavioral Health and Suicide Prevention subcommittee. <ul style="list-style-type: none"> Establish staff support at HCA and OSPI. Additional details in proposal. 	#4 of 7 budget priorities	Yes	\$200,000 (staffing and travel for community members) <i>Appropriated: \$107,000 FY21</i>		2SHB 2737-Children’s Mental Health Work Group <ul style="list-style-type: none"> Establishes School-based Health and Suicide Prevention advisory group.

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Topic/Recommendations	Priority	Action needed			Notes/Status
		Policy	Budget	Other	
2. Build upon previous Suicide Prevention work in the broader work on school-based recognition and response to emotional and behavioral distress (HB 1336) – address the urgency of need across the K-12 system and foundational strength; include student voice.	#3 of 3 policy priorities	Yes	<i>Appropriated: \$2,549,000 FY21</i>		<p>ESSB 6168 budget proviso</p> <ul style="list-style-type: none"> To provide statewide support and coordination for the regional network of behavioral health, school safety, and threat assessment established in chapter 333, Laws of 2019 (school safety and well-being). Within the amounts appropriated in this subsection (4)(f)(iv), \$200,000 of the general fund—state appropriation for fiscal year 2021 is provided solely for grants to schools or school districts for planning and integrating tiered suicide prevention and behavioral health supports. Grants must be awarded first to districts demonstrating the greatest need and readiness. Grants may be used for intensive technical assistance and training, professional development, and evidence-based suicide prevention training. <i>(4)(f)(iv)</i>
3. Fund ESD navigators from HB 1216 and further specify their role (see recommendation proposal for details).	#2 of 7 budget priorities		<p><i>Appropriated: \$570,000 FY21</i></p> <p>See OSPI 2020 decision package</p>		<p>ESSB 6168 budget proviso</p> <ul style="list-style-type: none"> Funding is provided to OSPI for the student mental health and safety network established in Chapter 333, Laws of 2019 (2SHB 1216). Activities funded include statewide coordination and oversight of the regional network at the Educational Service Districts, implementation grants to school districts, and a contract with the University of Washington-Forefront Suicide Prevention program. <i>(Found in agency detail but not in bill)</i>
4. Support state initiatives to integrate physical and behavioral health in the school setting.		Yes	\$1.408M (for 2020)	Yes	
5. Fund a Community Care Coordination System for integrated behavioral health for the 1 percent of youth with the most costly, complex, chronic behavioral health problems.		Yes	Yes		

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Topic/Recommendations	Priority	Action needed			Notes/Status
		Policy	Budget	Other	
<p>Partnership Access Line</p> <p>1. Develop a funding model that builds upon HCA’s previous funding model efforts and:</p> <ul style="list-style-type: none"> • Determines the annual cost of operating the PAL and its various components. • Collects a proportional share of program cost from each health insurance carrier. • Differentiates between activities that are eligible for Medicaid funding and those that are not. 	#7 of 7 budget priorities (2021-2023)	Yes	\$5m/biennium (existing \$ + carriers) <i>Appropriations: \$98,000 (JLARC; HCA funding begins in next biennium)</i>		<p>SHB 2728-Funding model/telehealth</p> <ul style="list-style-type: none"> • Establishes a funding model for the PAL program. • Establishes same funding model for Telehealth Access Line (PAL for Kids) and PAL for Moms if they are continued beyond pilots. • Modifies data and reporting requirements for PAL programs. • Directs Joint Legislative Audit and Review Committee to conduct a review of PAL programs by 12/1/2022.
<p>2. Pursue an appropriation for PAL for Kids for Jan. 1, 2021 – June 30, 2021 to bring the program’s funding on to the state’s fiscal year cycle and avoid interrupting the service. (Seattle Children’s proposal – Oct. 1 meeting)</p>	Essential	Yes	\$493,650 <i>Appropriations: \$586,000 FY21</i>		<p>ESSB 6168 budget proviso Sec. 215</p> <ul style="list-style-type: none"> • One-time funding to extend the PAL for Moms and PAL for Kids Referral Assist Service until 6/30/2021.
<p>HB 1874 Follow-up/Family Initiated Treatment</p> <p>1. Include adolescent residential treatment as a service that a parent can consent for under the Family Initiated Treatment section of RCW 71.34.600-670. Residential treatment facilities must be licensed under 246-337 WAC. Use the same monitoring and reporting guidelines and provider/facility safeguards for residential treatment that were established for Intensive Outpatient Program and Partial Hospitalization Program under HB 1874.</p>		Yes			<p>SHB 2883-Adolescent behavioral health</p> <ul style="list-style-type: none"> • Adds residential treatment facilities (RTFs) to FIT. • Requires additional medical necessity review every 30 days. • HCA to communicate review findings to MCO. • MCOs can also conduct medical necessity reviews. • If adolescent is not released as a result of petition, may remain in RTF as long as it continues to be a medical necessity.
<p>2. Explore whether to create a licensing category for Wilderness Therapy and Therapeutic Boarding Schools that would be considered residential treatment under Family Initiated Treatment.</p>		Yes		Yes	<p>SB 6637-Wilderness therapy license</p> <p><i>Not passed</i></p>

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Topic/Recommendations	Priority?	Action needed			Notes/Status
		Policy	Budget	Other	
3. Task HCA to develop a data collection and tracking system for youth served under FIT to identify opportunities to fill gaps in care, expand services, and better understand the needs of our adolescent population (details, including recommended data to collect, in recommendation proposal.		Yes	\$200,000s		SHB 2883-Adolescent behavioral health <i>Delivered to Governor (3/9)</i> <ul style="list-style-type: none"> • Adds specific requirements for HCA data collection. • <i>Additional funding not required.</i>
4. Identify Wraparound with Intensive Services (WISe) in the definition section of 71.34 as Intensive Outpatient Treatment for admission under Family Initiated Treatment. Exempt WISe from the monitoring and reporting guidelines and data tracking system, since there are already processes in place to gather and track youth in WISe.		Yes			
<p>CMHWG Reauthorizing Legislation</p> <p>1. Reauthorizing legislation to include:</p> <ul style="list-style-type: none"> • Changing the title to “Children, Youth and Young Adults Behavioral Health Work Group. • Consider alternatives to “work group” designation (e.g. task force, joint legislative committee, etc.). • Broaden scope to include addressing the needs of young adults (to age 25). • Review/revise membership categories to foster cross-system coordination and ensure all who need to be at the table are represented, including youth and young adults. • Create two standing sub-committees: <ul style="list-style-type: none"> • School-based Behavioral Health and Suicide Prevention • Family Youth and System Providers Round Table (FYSPRT) Executive Leadership Team 	Essential (2020)		<i>Appropriations: \$139,000</i>		<p>2SHB 2737-Child. Mental health wk grp</p> <p><i>Delivered to Governor (3/12)</i></p> <ul style="list-style-type: none"> • Extends work group until 2026 and renames it the “Children and Youth Behavioral Health Work Group.” • Expands membership to include 2 youth representatives with lived experience; representatives from a developmental disabilities organization, a private insurer, and the statewide Family Youth System Partner Round Table (FYSPRT); and an SUD professional. • One of the two family representatives must have a child under 6 years old. • All Governor-appointed positions must be re-appointed. • Establishes a permanent School-based Behavioral Health and Suicide Prevention advisory group. • CYBHWG will consider issues and recommendations put forward by the statewide FYSPR established in the <i>T.R. v. Strange and McDermott</i> settlement agreement. • Requires an annual report and recommendations submitted to the Governor and Legislature by November 1 of each year.