November 6, 2023

Governor Inslee and Members of the Legislature,

The Children and Youth Behavioral Health Work Group (CYBHWG) is pleased to share its prioritized list of recommendations for the 2024 legislative session. The CYBHWG is grateful for the critical investments you've put toward youth behavioral health. While investments have been made, there is still much to be done as Washington ranks 40th in the nation for youth mental health care.[1] We have seen added demand for intervention and crisis services, and lower capacity in service delivery due to workforce and facility shortages amplifying the problem.

The recommendations put forward reflect the work group's recognition that this is a supplemental budget year. In that context they take steps to address the two-fold need of meeting the current demand for services and determining what system changes are needed, through a strategic plan, to ensure a robust, equitable behavioral health system for our children with service across a full continuum of care from promotion of well-being, through crisis services, recovery and stabilization, and sustained well-being.

This year's recommendations:

- Address the workforce shortage, by increasing capacity to meet families' immediate needs in primary care, and bolstering supports for students and recent graduates entering the field.
- Improve services and supports for young people transitioning to adulthood and their families.
- Help schools and school districts provide school-based behavioral health services and supports.
- Expand programs to address behavioral health issues and trauma impacts in early childhood.
- Work to address wait lists, inequities, and other issues that hamper access to programs for infants and toddlers through young people transitioning to adulthood.
- Incorporate advisory group input, recent legislative action, current state agency and behavioral health context, and national best practices in behavioral health service delivery in our strategic plan effort to meet the needed and intended fidelity.

This year, the CYBHWG worked with a systems expert to evaluate the efficacy of the proposed recommendations. The prioritized recommendations were assessed by voting members on both achievability and potential improvements in equity, as well as system impact.

We are grateful to the over 400 stakeholders who participated in the development of these recommendations and the deep partnerships between providers, advocates, parents and young people with lived experience, and others that informed the proposals. We deeply appreciate the commitment you have made to improving access to and quality of behavioral health services for all Washingtonians.

We look forward to continuing this work with the 70th Legislature – you, our partners, and stakeholders, to address the crises and improve behavioral health and well- being for all our children, youth, and families.

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

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

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

Children & Youth Behavioral Health Work Group Annual Report, Part 1: 2024 Recommendations

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Children and Youth Behavioral Health Work Group
Recommendations for the 2024 legislative session

Overview

Each year, beginning in 2016, the Children and Youth Behavioral Health Work Group (CYBHWG) has developed recommendations for the Governor and the Legislature aimed at improving access to high-quality behavioral health services and supports for children, youth, and families. Over the past 8 years, the work of this group has expanded our shared awareness of the mental health crises and substance use issues our children, youth, young people transitioning to adulthood, and their families are experiencing. We've responded by increasing the voice of those impacted and expanding issue areas to address more barriers to care.

In recent years, holding this awareness – of both the immediate needs of children, youth and families in crisis and the underlying need for systemic change to effectively address the crisis – has made prioritization of the recommendations particularly challenging. We know all the recommendations will have an impact but also know we have limited resources of people, time, and money. We have worked to add tools to our prioritization process to identify and leverage those that will have the greatest impact.

This year's recommendations reflect the dual focus of the now and the long-term. Work group members unanimously agreed on an update to the legislation directing development of the Prenatal-25 Behavioral Health Strategic Plan to reflect learnings from the first year and ensure that these efforts are coordinated with other legislative initiatives aimed at addressing the capacity and access issues facing people of all ages with behavioral health needs. A detailed progress report on the P25 Strategic Plan work to date will be released, along with the CYBHWG's statements of support for other initiatives, in early December as Part 2 of this annual report.

Recommendations are developed in the CYBHWG's five subgroups:

- Behavioral Health Integration (BHI)
- Prenatal through Five Relational Health (P5RH)
- Youth & Young Adult Continuum of Care (YYACC)
- Workforce & Rates (W&R)
- School-based Behavioral Health & Suicide Prevention (SBBHSP)

Over the summer, the subgroups evaluated 37 possible recommendations, prioritizing 17 to put forward to the CYBHWG for consideration.

Through a voting process described in Appendix A, CYBHWG members[2] decided on the overarching strategic plan recommendation and 11 prioritized recommendations for inclusion in this year's report to the Governor and Legislature.

[2] 2 of the 38 members are alternates who were not called upon to vote and did not attend; another 5 members were in attendance but abstained from voting because they are affiliated with a state agency; another 13 members did not attend, of which three would have abstained; one additional member did not attend but submitted an absentee vote.

Recommendations

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

Each recommendation is identified as New, Legacy, or Previous (see definitions below). All subgroup recommendations include rough budget estimates, using the scale below. These were developed by the subgroups and not by agency staff. They should not be used in legislative proposals. Finally, each recommendation indicates whether it requires new funding, legislative action, and/or agency action.

Key definitions used in recommendation descriptions

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

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

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

Overarching recommendation

The Work Group aligned on one overarching recommendation. This recommendation is essential to achieving our statewide vision for the behavioral health system serving children and youth from Prenatal through age 25 (P-25) in Washington State.

Legacy **$-$$$** **Legislative Policy**	1. Update House Bill 1890 (2022) to reflect current work plan for the P-25 Behavioral Health Strategic Plan. Update legislation directing development of the P-25 Strategic Plan to: • Adjust delivery times, align advisory group membership, and update plan content to reflect learnings from the first year; and • Ensure this effort is included in the work of the Joint Select Committee on Health Care and Behavioral Health Oversight, the Joint Executive Legislative Committee on Behavioral Health - both established in 2023 - and the Substance Use Recovery Services Advisory Committee (SURSAC). *Current legislation directs coordination with the Crisis Response Improvement Strategy (CRIS) committee's work.*

Prioritized recommendations

The priority order of the rest of the recommendations in this list was determined through a ranking vote at the October 23 CYBHWG meeting (see Appendix A).

New **$$$** **Budget Ask** **Legislative Policy**	2. Finance behavioral health care coordination as performed by community health workers. Fund care coordination activities performed by Community Health Workers (CHWs) under the supervision of licensed providers to address the behavioral, emotional, social, and developmental needs of children on Apple Health (Medicaid). Approximately 43% of children with mental health conditions[3] require coordination beyond what occurs during their visits to ensure they successfully navigate from screening to services, carry out the care plan, and adjust the care plan as needs change. Almost half of these needs are currently going unmet. Primary care providers and behavioral health professionals are straining to coordinate care for the kids who need it, which compromises the care delivered. CHWs, who bring a wealth of community experience and for whom no professional degree is required, can do much of this work and be a tremendous help to overwhelmed primary care providers and behavioral health professionals. By providing a sustainable source of funding for CHWs, the state could increase capacity and ensure that children are receiving care that is culturally appropriate and responsive to their needs. *Recommended by the Behavioral Health Integration (BHI) Subgroup*
New **$$-$$$** **Budget Ask** **Legislative Policy**	3.1 Ensure equitable access to and realize the intended outcomes of intensive programs serving youth and young adults with the most complex behavioral health needs. Programs such as PACT (Program of Assertive Community Treatment), HOST (Homeless Outreach Stabilization Transition), WISe (Wraparound with Intensive Services), and New Journeys (for First Episode Psychosis) are intended to support individuals with complex behavioral health needs. These programs are not currently delivering the full continuum of care to all the youth and young adults they are intended to serve. We recommend that the Legislature: • Allocate funds and direct a task force to recommend concrete solutions to current challenges with access and implementation by December 31, 2024; • Remove the substance-use disorder (SUD) eligibility requirement of HOST to expand access; and • Increase funding to achieve parity across these programs while creating accountability for program effectiveness and accessibility. 3.2 Reduce administrative complexities in the Wrap-around with Intensive Services (WISe) program. Direct the Health Care Authority (HCA) to create parity in clinical auditing practices between physical health and behavioral health providers. Process auditing is particularly burdensome for the Wraparound with Intensive Services (WISe) program. This burden is leading to a shortage of individuals willing to provide WISe services and to instability for youth engaged in this service. Achieving parity requires HCA to transition from audits focused on process to tracking three industry-standard, age-appropriate, outcome-based measures and conducting an annual youth/family satisfaction survey designed to demonstrate the effectiveness of this program for youth and families in Washington State. These improvements will ensure state standards are met to support better life outcomes for youth and young adults at the more intensive needs end of the continuum of care. *Recommended jointly by the Youth and Young Adult Continuum of Care (YYACC) and Workforce & Rates (W&R) Subgroups*

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

New **$$-$$$$** **Budget Ask** **Legislative Policy**	4. Expand Early ECEAP (birth to three ECEAP) program. *ECEAP (pronounced "e-cap") = Early Childhood Education and Assistance Program* Budget request: Expand the Early ECEAP (also known as birth to three ECEAP) program, a comprehensive, childcare partnership model for high-need children 0-3 who need both classroom and family support services. Early ECEAP is modeled after the federal Early Head Start childcare partnership program that has been shown to reduce families' involvement with child protective services (CPS). It combines robust trauma-informed approaches with children and parents with high quality early learning. Policy request: Enact a policy change to allow continued eligibility for Working Connections Child Care (WCCC), our state's childcare subsidy program, for ECEAP/Early ECEAP, counting the intensive family partnership requirement as 'work activity.' *Recommended by the Prenatal through Five Relational Health (P5RH) Subgroup*
Legacy **$$$** **Budget Ask**	5. Provide school-based behavioral health funding for school districts. Provide funding directly to local education agencies (LEAs) to plan, coordinate, and/or provide school-based supports that address the emergent mental health crises in their student populations, specifically targeting funding for LEAs who have not been able to develop a plan for recognition, initial screening, and response to emotional or behavioral distress as required by RCW 28A.320.127. *Recommended by the School-based Behavioral Health and Suicide Prevention (SBBHSP) Subgroup*
New **$$$** **Budget Ask** **Legislative Policy**	6. Fund House Bill 1724 stipend program for recent graduates in the behavioral health field. Allocate funds to the Washington State Department of Health (DoH) for the stipend program they were directed to establish per HB 1724[4] and amend statute as necessary to activate other models if recommended. Other emerging models to enable individuals to complete the necessary hours to obtain their credential include expanding the school social worker proviso[5] that was included in the 2023-25 budget and contracting directly with behavioral health professionals to provide supervision so individuals seeking supervision don't have to pay out of pocket for this service. These alternative models may be lower cost and lower in administrative burden or could combine with the stipend program to broaden access to a wider pool of recent graduates. *Recommended by the Workforce & Rates (W&R) Subgroup*
Legacy **$-$$** **Budget Ask** **Legislative Policy**	7. Deliver and sustain approved funding for BH360 (formerly Parent Portal). *(tied with next recommendation)* Fund development of BH360, previously known as the Parent Portal, by amending the 2023 budget proviso to use state funds for this purpose instead of the federal Mental Health Block Grant (MHBG) funds currently specified in the budget. Federal regulations prevent the use of MBHG funds for early intervention services like BH360, which are essential for preventing behavioral health conditions from escalating. BH 360 is a one-stop resource for families and caregivers of youth with behavioral health challenges. The design and implementation of the website will deliver educational content and information to help families access programs and providers statewide. To remain relevant, BH360 will require sustained funding to update and expand content regularly. *Recommended by the Youth and Young Adult Continuum of Care (YYACC) Subgroup*

[4] "The Department shall establish a stipend program to defray the out-of-pocket expenses incurred by associates completing supervised experience requirements under RCW 18.225.090." *HB 1724 (2023-2024).*

[5] SB 5187 Sec.510 (17) https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20231012004441

New **n/a** **Legislative Policy**	7. Allow funding for the Washington Health Corps Behavioral Health Program. to be used for conditional scholarships. *(tied with previous recommendation)* Amend the current Revised Code of Washington (RCW) 28B.115 so that the Behavioral Health program funding language mirrors the language used for the general Washington Health Corps. This would enable Behavioral Health program funding to be used for conditional scholarships. The language is currently limited to loan repayment. *Recommended by the Workforce & Rates (W&R) Subgroup*
New **$** **Budget Ask**	8. Improve student access to mental health literacy education. Provide funding to a state agency (Office of Superintendent of Public Instruction or Department of Health) to fund an FTE staff position to serve as a mental health curriculum lead responsible for reviewing, disseminating, and cataloging high-quality, mental health literacy instructional curriculum for the P-12 education system. *Recommended by the School-based Behavioral Health and Suicide Prevention (SBBHSP) Subgroup*
Legacy **$$-$$$** **Budget Ask**	9. Provide bridge funding for Certified Community Behavioral Health Clinics (CCBHC). *(tied with next recommendation)* To ensure successful completion of implementation of a statewide CCBHC model, the state should support and sustain the current CCBHC expansion grant programs by providing bridge funding to current CCBHCs in Washington during the statewide planning process. *Recommended by the Workforce & Rates (W&R) Subgroup*
Legacy **$-$$$** **Budget Ask**	9. Increase investment in Infant and Early Childhood Mental Health consultation (IECMH-C). *(tied with previous recommendation)* Increase investment in Infant and early Childhood Mental Health consultants (IECMH-C) by $1.75 million annually to address unmet need and increase equitable access to IECMH-C for Washington's children, families, and adult caregivers in childcare. Funds would be used to: 1. Expand capacity to provide individualized mental health consultation services to more providers; 2. Provide IECMH-C services by linguistically and culturally matched consultants; and 3. Address ongoing program needs to maintain quality and increase access. *Recommended by the Prenatal through Five Relational Health (P5RH) Subgroup*
New **$$-$$$** **Budget Ask** **Legislative Policy**	10. Enable public access to behavioral health data. Create a centralized data repository using linked administrative data to create visualizations for a wide variety of non-technical end-users. Allocate funds and implement a potential legislative requirement for sharing administrative data with the public, within the confines of confidentiality rules. Creating the repository will require two FTE. Access to data for workforce planning is a major challenge in the field of behavioral health. Washington is one of the few states in the nation where administrative data from multiple sources is systematically collected, yet we lack a comprehensive view of the many factors affecting the stability and effectiveness of the behavioral health workforce. *Recommended by the Workforce & Rates (W&R) Subgroup*

Appendix A: Prioritization and Decision-Making Process

The process of reviewing and prioritizing this year's recommendations occurred over the course of four months from July through October. Each of the subgroups ran unique processes with their membership to identify issues of concern, develop recommendations to address them, and determine what recommendations to present to the CYBHWG. The CYBHWG considered the subgroups' recommendations over the course of three meetings.

September 22nd CYBHWG meeting

24 of 38 members attended this meeting.

Subgroups provided the CYBHWG with a first look at their proposed recommendations on September 22nd. Each subgroup had 12 minutes to present their recommendations and 8 minutes for Q&A. In addition to these presentations, a systems expert introduced a framework to help the work group members make sense of the 20+ recommendations put forward and think more critically about the impact each recommendation will have on children and youth and on the broader system – both immediately and over the longer term. The framework introduced work group and subgroup members to using systems thinking as a tool to help improve the impact of the work group's recommendations over time.

As a next step, subgroups further refined their recommendations by:

1. Considering the questions and feedback provided during the meeting,
2. Considering how their recommendation acts on the levers presented in the systems framework, and
3. Collaborating with other subgroups whose recommendations intersect with theirs.

October 20th CYBHWG meeting

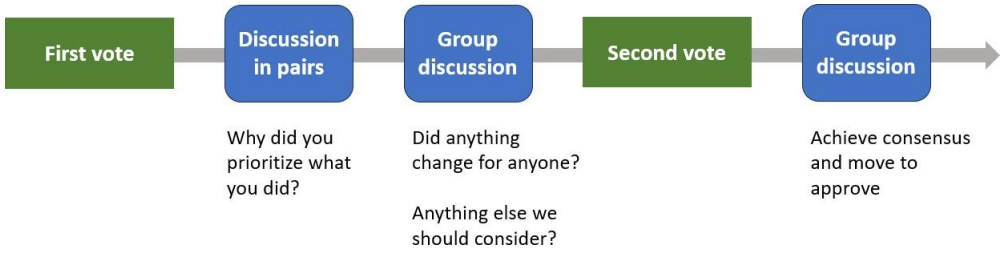
This meeting was dedicated to presentation and discussion of the final proposed recommendations, as input to the subsequent voting meeting held on October 23rd. Each subgroup presented their recommendations. Rep. Lisa Callan presented the overarching recommendation related to the Prenatal through 25 Behavioral Health Strategic Plan.

19 of 38 members attended this meeting. The co-chairs asked members in attendance to indicate their support for the overarching recommendation by a show of hands. A majority of members present (15 of 19) indicated their support. Four members abstained because of their affiliation with a state agency.

Chris Soderquist reviewed the systems framework introduced during the September 22nd meeting, and work group members were prompted to consider three characteristics of each recommendation in advance of voting on October 23rd: 1) potential impact, 2) achievability, and 3) potential contribution to equity.

October 23rd CYBHWG meeting

Approach to voting. The group conducted two votes, with discussion in between. Each member was instructed to identify the top three recommendations in order of priority. Limiting the number of votes per member helped identify a manageable set of top priorities out of the 17 put forward by the subgroups. The structure of the vote was designed to help build a shared understanding of the recommendations and move the group toward consensus. The first vote was meant to inform discussion and the second was the basis for how the group determined which recommendations to submit in which order of priority.



22 of 38 members attended this meeting. 17 members in attendance voted, and one member not in attendance voted absentee before the meeting. 5 members in attendance abstained from voting.

Results of first vote. 18 members participated. This included one absentee vote.

The first vote was held to guide group conversation on prioritizing the recommendations through the lens of impact, achievability, and contribution to equity. Following the first vote, pairs (dyads) of members broke out to discuss their immediate reactions to the results of the vote and share their reasoning. After these dyad discussions, members came back together in the full group to raise any thoughts and/or concerns before entering the second voting period. The discussion between voting periods proved beneficial to reaching consensus. Members expressed appreciation for the ability to discuss with other members their shared and differing perspectives in prioritizing the recommendations.

Results of second vote. 18 members participated. This included one absentee vote.

To ensure all work group members had the opportunity to vote, the Behavioral Health Catalyst provided members who could not attend the October 23rd meeting with a form after the October 20th meeting. Absentee votes had to be submitted before the October 23rd meeting began. One absentee vote was counted in both rounds of voting, with no revisions.

Prioritization. The group looked at unweighted and weighted voting results. The weighted results take into account members' ranked prioritization of each recommendation.

11 of the 17 recommendations put forward by subgroup members received at least one vote. The CYBHWG agreed to prioritize these 11 recommendations for the 2024 legislative session and to rank them in order of their weighted votes. This is in addition to the overarching recommendation that was approved by a majority on October 20th.

The prioritized recommendations are presented in order in Figure 1 on the next page. The weighted voting results and the raw vote count are presented in Figures 2 and 3 on the pages that follow.

Figure 1

Ranked recommendations

The CYBHWG will put forward a total of 12 recommendations for the 2024 legislative session

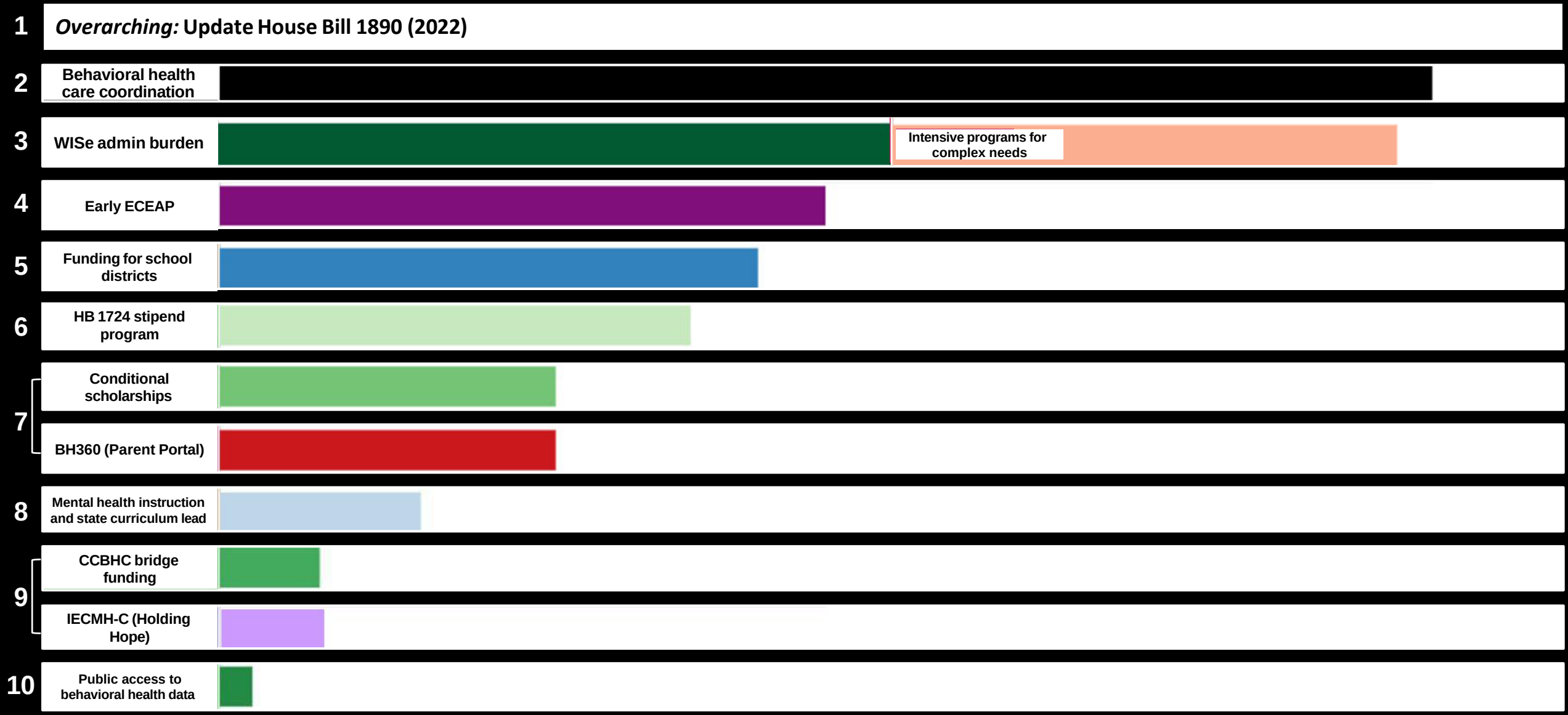


Figure 2

Weighted by priority

Vote counts for 1st, 2nd, 3rd

Individuals voting: 18

Weights: 1st priority = 5
2nd priority = 3
3rd priority = 1

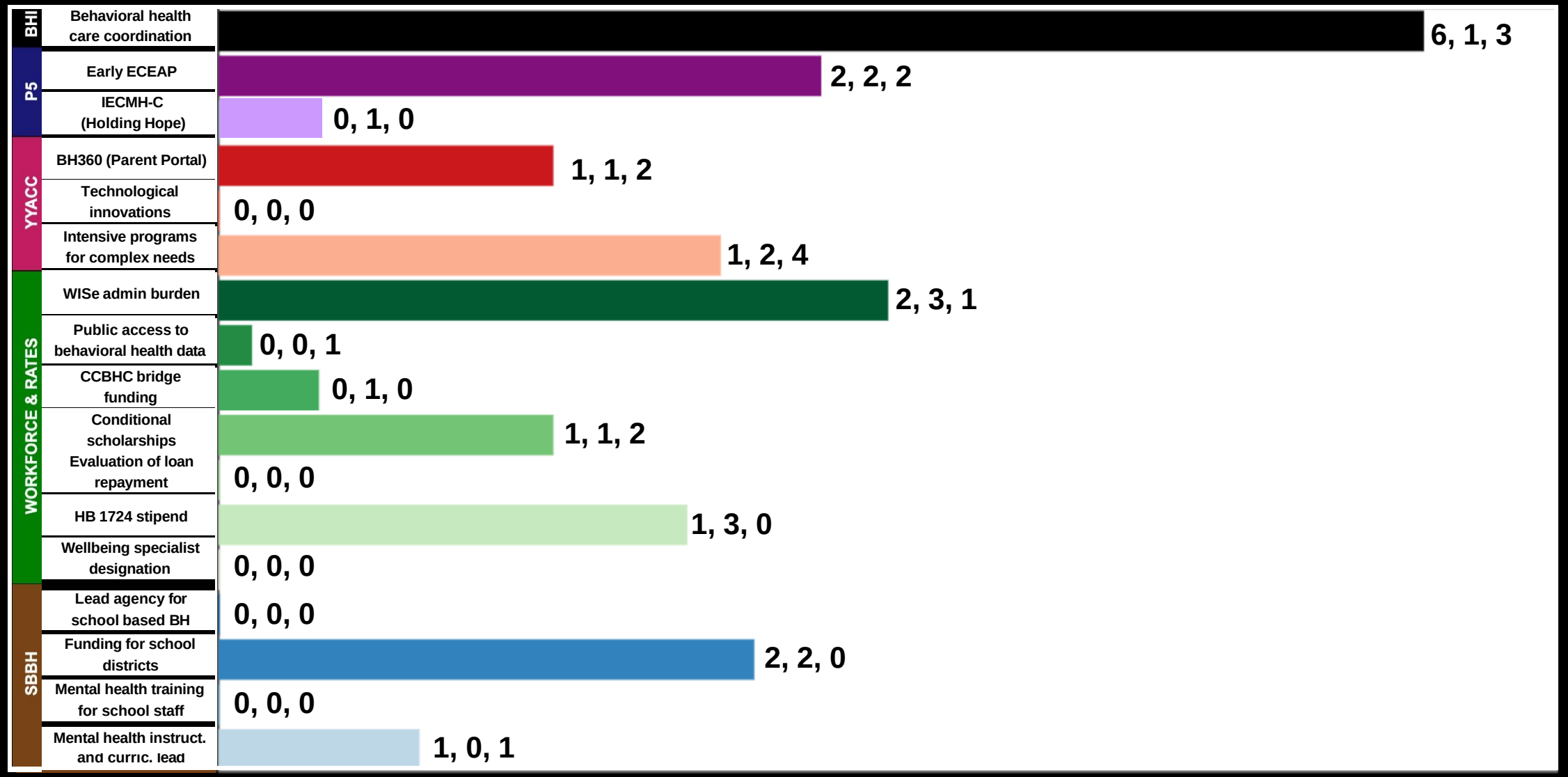
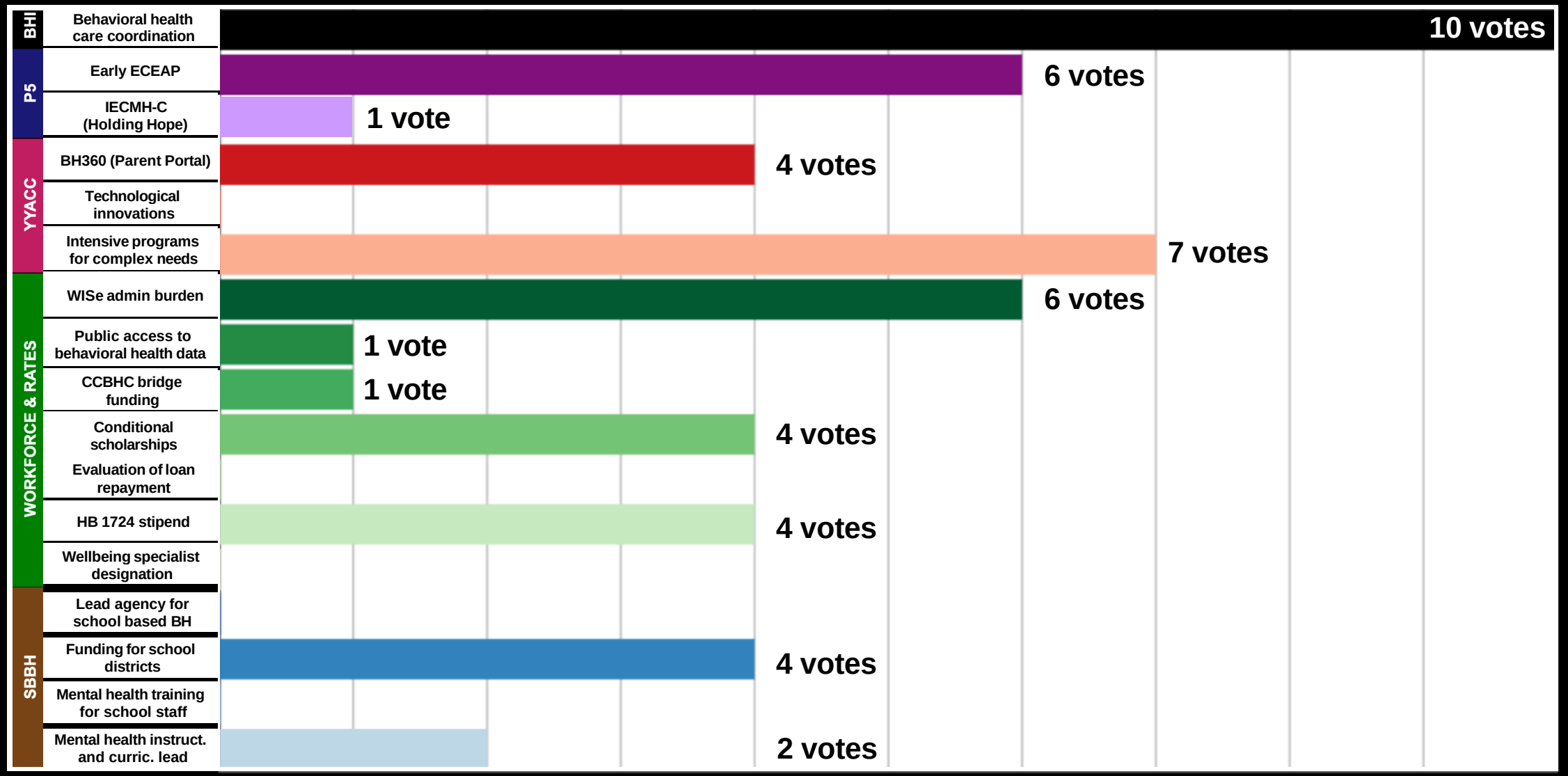


Figure 3

Raw vote count

Individuals voting: 18



Appendix B: Contributors to Recommendation Development

Representatives from the following organizations contributed to the 2024 recommendations

Advocates and Community Organizations

A Common Voice
Building Changes
Behavior Analyst Certification Board
Catholic Community Services of Western Washington
Café Collaborative
Center for Children and Youth Justice
Chad's Legacy Project
Child Care Aware of Washington
ChildStrive
Children's Alliance
Committee for Children
Communities in Schools of Washington State Network
CSA Pathways
Equity in Education Coalition
Family, Youth & System Partner Round Tables (FYSPRTs)
Foundation for Healthy Generations
Foundation for Youth Resiliency and Engagement
Friends of Youth
Guided Pathways Support for Youth and Families
HealthierHere
Health System Transformation
Justice for Girls Coalition
King County Best Starts for Kids
Mockingbird Society
Mothers of the Mentally Ill
North Central Washington Peer Connection
North Sound Behavioral Health Administrative Services Organization
North Sound Youth and Family Coalition
National Council for Mental Well-being
Navos
NorthStar Advocates
Partners for Our Children
Pathwaves Washington
Prenatal Support Washington
Program for Early Parent Support
Ryther
Start Early
TeamChild
The American Indian Health Commission
The Learning Project Training Center
Treehouse
Thriving Together
Tubman Center for Health & Freedom
Voices of Pacific Island Nations
Washington Association for Community Health
Washington Association for Infant Mental Health
Washington Association of School Social Workers
Washington Chapter of the American Academy of Pediatrics
Washington Council for Behavioral Health
Washington Disability Rights
Washington Frontiers of Innovation
Washington Head Start and ECEAP
Washington Mental Health Counselors Association
Washington National Alliance on Mental Illness
Washington Occupational Therapy Association
Washington PAVE
Washington Psychiatric Association
Washington School-Based Health Alliance
Washington School Counselor Association
Washington State Alliance of Boys and Girls Clubs
Washington State Association of School Psychologists
Washington State Community Connectors
Washington State Council of Child and Adolescent Psychiatry
Washington State Hospital Association
Washington State Medical Association
Washington State Parent Teachers Association
Washington State Psychiatric Association

Education and Research

Behavioral Health Institute
Burlington-Edison School District
Educational Service District 101
Educational Service District 105
Educational Service District 113
Educational Service District 189
Forefront in the Schools
Highland School District
Monroe School District
North Central Educational Service District
Puget Sound Educational Service District
Richland School District
Seattle Public Schools
South Kitsap School District
Spokane Public Schools
Sumner-Bonney Lake School District
UW Barnard Center
UW Department of Psychiatry
UW Evidence-based Practice Institute

UW School of Social Work
UW SMART Center
University of San Francisco
Vancouver Public Schools
Washington Association of Educational Service Districts
Washington Association of School Principals
Washington Education Association
Washington State School Directors Association

Philanthropic Organizations

Ballmer Group
Health Career Fund
Perigee Fund

Managed Care Organizations & Commercial Insurers

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

Providers

Carelon Behavioral Health of Washington
Center for Human Services
Childhaven
Children's Village in Yakima
Columbia River Mental Health Services
Community Youth Services
Excelsior Wellness Center
Greater Lakes Mental Healthcare
Harborview Medical Center
Hope Sparks Family Services
Kids Mental Health Pierce County
Council of Child and Adolescent Psychiatrists
Kitsap Children's Clinic
Kitsap Mental Health Services
Mary Bridge Children's Hospital
Mercer Island Youth and Family Services
Northwest Neighborhood Clinics
Northwest Pediatric Center
Pearl Youth Residence
Pediatrics Associates of Whidbey Island
Providence Health Services
Seattle Children's Hospital
Seneca Family of Agencies
Stilly Valley Health Connections
Sundown M Ranch Rehab Center
The Learning Project Training Center
The Practice NW
UW Neighborhood Clinic
Yakima Valley Farmworkers Clinic

State and County Agencies

Clark County Juvenile Justice
Department of Children, Youth and Families
Department of Health
Department of Justice
Department of Social and Health Services
Governor's Office
Health Care Authority
Health Resources and Services Administration
Jamestown Tribe
King County Behavioral Health and Recovery
Office of Developmental Disabilities Ombuds
Office of Homeless Youth
Office of the Attorney General
Office of the Insurance Commissioner
Office of the State Auditor
Office of Superintendent of Public Instruction
Tacoma-Pierce County Health Department
Tulalip Tribes
Workforce Training and Education Coordinating Board

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

Since 2016, this work group has brought together legislators, providers, agencies, managed care organizations, tribes, advocates, and family members and youth who have received mental health and substance use services to identify and address barriers to access to these services for children, youth, and families, and make recommendations to the Legislature. Recommendations for the 2024 legislative session were developed by five subgroups, described below.

Behavioral Health Integration

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

The Behavioral Health Integration subgroup was formed in 2021 to respond to the large unmet need for behavioral health services early on when children and teens first present with needs. Primary care clinics can identify behavioral health issues early in a child's life and provide effective treatment before problems become more severe.

There is a growing consensus that behavioral health integration, which embeds behavioral health counselors in primary care clinics and provides a team-based approach to care actively involving the primary care provider, is an effective means of leveraging scarce behavioral health resources to provide such early identification and treatment.

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

Prenatal through Five Relational Health

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

In 2023, the Prenatal through Five Relational Health Subgroup did robust and intentional outreach to engage stakeholders of different racial, ethnic, and cultural backgrounds, incomes, and family structures as well as professionals who work directly with children and families to have a community-informed policy development approach. Parents of children with behavioral health needs participated in subgroup meetings to share about the barriers that prevent families from accessing support and potential solutions. Stipends were available to parents through the Health Care Authority to participate in subgroup meetings to compensate them for their time and respect and appreciate their expertise.

Additionally, the group reached out to parents, providers, and community leaders who are not able to attend the subgroup meetings to listen and learn. There was a particular focus on outreach to parents who have experience with infant and early childhood mental health issues and perinatal mood and anxiety disorders themselves as well as parent leaders who are knowledgeable about the experiences of others in their communities. Kristin attended four different evening parent group meetings involving almost 60 unique parents. Kristin talked with family home childcare providers during an in-person meeting, including Somali- and Spanish-speaking providers and childcare providers across the state. In addition to parents, the subgroup has nearly 160 diverse stakeholders on their email distribution list, including parents, behavioral and mental health professionals and clinicians, policymakers, advocates, physicians, and those familiar with Medicaid and private insurance.

School-based Behavioral Health and Suicide Prevention (SBBHSP)

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

The School-based Behavioral Health and Suicide Prevention subgroup advises the full work group on creating and maintaining an integrated system of care through a tiered support framework for kindergarten through 12th grade school systems. The 37 appointed members on this subgroup represent parents, guardians, and families; behavioral health providers and agency representatives; school district and educational service district staff and administrators; and stakeholders from health care organizations, higher education, philanthropy, and advocacy groups. The subgroup is also advised by a 12-member Youth Advisory Committee (YAC), made up of students or recent students in Washington aged 15-23. Non-members are encouraged to join the mailing list and attend the group's meetings and share their perspectives during the public comment period. In 2023, the subcommittee developed recommendations across five Zoom workshops and 2 YAC meetings. Staff encouraged members to propose recommendation ideas and evaluation criteria, which members prioritized through a survey. 21 of the group's 37 members voted in the survey, along with votes on behalf of the Office of Superintendent of Public Instruction (OSPI) and the Health Care Authority (HCA), respectively. In addition, YAC members provided feedback on the recommendation priorities.

Workforce and Rates

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

The Workforce and Rates subgroup is open to anyone who wants to participate. With a mailing list of over 100 people and 30 or more people attending each meeting, the work group benefits from the participation of many individuals with considerable expertise who draw on their professional and personal experience. As it develops its recommendations, the group coordinates with others, including the Workforce Training and Education Board, the Washington Behavioral Health Council, the Behavioral Health Institute, the philanthropic community, and the other subgroups of the CYBHWG.

Youth and Young Adult Continuum of Care (YYACC)

Co-leads*: Representative Lauren Davis (32nd district), Representative Carolyn Eslick (39th district), Michelle Karnath (parent), Lillian Williamson (young adult/Jan.-Aug. 2023), and Taanvi Arekapudi (youth/begin. Oct.2023)*

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

This year, Lillian Williamson, the previous youth/young adult co-lead, started a group for young people who have received behavioral health services. This group met outside of the regularly scheduled YYACC meetings to share their perspectives and responses to the issues and solutions raised by the subgroup.

2023-24 Children and Youth Behavioral Health Work Group Members

Represents	Member
Co-Chairs	Representative Lisa Callan (D) Dr. Keri Waterland
Washington State House of Representatives	Representative Carolyn Eslick (R) Representative My-Linh Thai (D) (alternate) Representative Michelle Caldier (R) (alternate)
Washington State Senate	Senator Claire Wilson (D) Senator Judy Warnick (R)
Health Care Authority	Diana Cockrell
Department of Children, Youth and Families	Judy King
Department of Social and Health Services - Developmental Disabilities Administration	Shelley Bogart
Department of Health	Michele Roberts
Office of Homeless Youth Prevention and Protection Programs	Kim Justice
Office of the Governor	Amber Leaders
Behavioral Health Administrative Services Organization (BH-ASO)	Avreayl Jacobson, King County Behavioral Health and Recovery
Community Mental Health Agency	Mary Stone-Smith, Catholic Community Services of Western Washington
Medicaid Managed Care Organization (MCO)	Libby Hein, Molina
Medicaid MCO serving child welfare	Maureen Sorenson, Coordinated Care
Regional provider of co-occurring disorder services	Jim Theofelis, NorthStar Advocates
Pediatrician	Dr. Larry Wissow, Seattle Children's
Pediatrician or primary care provider located east of the Cascade Mountains	Dr. Thatcher Felt, Yakima Valley Farm Workers Clinic
Provider specializing in infant or early childhood mental health	Kelli Bohanon, Washington Association for Infant Mental Health *(beginning April 2023)* Bridget Lecheile, Washington Association for Infant Mental Health *(served through March 2023)*
Advocate for children and youth behavioral health issues	Laurie Lippold, Partners for Our Children
Evidence-based Practice Institute	Dr. Eric Trupin, UW
Parent or caregiver of child under the age of 6 who has received behavioral health services	Elizabeth de la luz (*served through September 2023)*
Parent or caregiver whose child or youth has received behavioral health services	Kristin Houser
Education or teaching institution that provides training for mental health professionals	Dr. Bob Hilt, UW Department of Psychiatry
Tribal governments	Summer Hammons, Tulalip Tribes Andrew Joseph, Jr., Confederated Tribes of the Colville Reservation

Foster parent	Mary McGauhey
Provider of culturally and linguistically appropriate health services to traditionally underserved communities	Cindy Myers, Yakima Valley Farmworkers Clinic
Child psychiatrist	Dr. Avanti Bergquist, Child and Adolescent Psychiatry
Organization representing the interests of individuals with developmental disabilities	Noah Seidel, Developmental Disabilities Ombuds
Youth representatives (2)	Javiera Barria-Opitz Hannah Adira
Private insurance organization	Preet Kaur, Regence Blue Shield
Statewide Family, Youth and System Partner Roundtable	Michelle Karnath
Substance use disorder professional	Jackie Yee, Educational Service District 113
Superintendent of Public Instruction	Lee Collyer
Office of the Insurance Commissioner	Delika Steele *(beginning May 2023)* Jane Beyer *(served through April 2023)*
Early learning and childcare providers	Joel Ryan, Washington State Association of Head Start and Early Childhood Education and Assistance Program (WSA)

Appendix D: Children and Youth Behavioral Health Work Group Recommendation Detail

Overarching recommendation

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

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

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

1. What is the issue?

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

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

A strategic plan lays the foundation for all other behavioral health improvements. Ranked 40th of 50[6], Washington is one of the worst states in the nation for youth mental health care. Yet we can have a system where care is equitably accessible, where services are culturally and linguistically responsive, where the workforce is diverse and representative – but we must design that system. Now is the time to make this plan for our children, youth, and families. The impacts of the COVID-19 pandemic on mental health will likely be felt for at least a decade; we need a behavioral health system that is ready to support this generation of youth and the next.

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

2. What do you recommend?

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

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

3. Why is this a smart move now?

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

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

4. What outreach has informed this recommendation?

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

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

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

Prioritized recommendations

2. Finance behavioral health care coordination as performed by community health workers

New	$$$	Budget Ask, Legislative Policy

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

1. What is the issue?

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

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

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

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

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

2. What do you recommend?

The Behavioral Health Integration Subgroup recommends the Legislature:

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

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

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

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

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

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

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

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

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

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

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

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

3. Why is this a smart move now?

Care coordination acts and improves on multiple levers of the behavioral health system,[7] including:

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

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

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

Reducing workforce burnout – There is greater recruitment, retention, and job satisfaction[8] by primary care providers and behavioral health professionals when they can work in integrated teams and are supported by care coordination resources.

Reducing workforce and overall care costs – Lower cost workers providing care coordination improves outcomes at low cost to the system. Additionally, every $1 spent on integrated care, saves $6.50 in health care costs.[9]

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

Improving outcomes for kids with developmental delays – Care coordinators connecting with a family when the child is in infancy increases the chances that kids with developmental needs will receive care early, when it can do the most good, thus improving outcomes.[10]

Increasing patient satisfaction and improving behavioral health outcomes – Research has shown that patient experience is significantly improved by engagement with a CHW, which in turn improves patient engagement with, and the effectiveness of, care.[11] Research also shows that using lay care coordinators improves behavioral health outcomes in low-income children and youth with ADHD.[12]

Improving physical health – Recent research also found that incorporating CHWs in primary care improved children's receipt of preventive care services, further demonstrating the importance of the CHW role for closing healthcare access gaps and achieving health equity.[13]

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

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

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

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

[10] Ibid Clinical Trial. JAMA, 329(20), 1757–1767. https://doi.org/10.1001/jama.2023.7197

[11] Ibid.

[12] Ibid.

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

4. What outreach has informed this recommendation?

The BHI subgroup has collaborated with the P5RH, W&R and SBBHSP subgroups of the CYBHWG in the development of this recommendation, in addition to numerous community outreach efforts, including a major Managed Care Organization (MCO); staff from Childhaven, Harborview, Kent Des Moines Clinic, Hope Sparks, and WCAAP. All are extremely supportive of this proposal and believe it would greatly enhance the services they provide, ensure better connections with the communities they serve, and expand their capacity to meet the behavioral and other health needs of the children and families they work with.

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

New	$$$	Budget Ask, Legislative Policy

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

1. What is the issue?

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

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

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

- **Crisis response**: People who are receiving care under the programs do not always get the help they need quickly enough when they are in crisis. For this population, delays in care can lead to devasting consequences, including death.

2. What do you recommend?

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

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

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

3. Why is this a smart move now?

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

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

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

4. What outreach has informed this recommendation?

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

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

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

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

New	n/a	Legislative Policy

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

1. What is the issue?

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

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

2. What do you recommend?

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

- Revise Washington Administrative Code (WAC) 182-501-0215 to ensure WISe Quality Plan and oversight cannot create significant administrative burden on provider agencies or staff and are consistent with industry standards for oversight and parity with physical health outcomes.
- Eliminate current auditing practices that focus on process – Quality Improvement Review Tool (QIRT) and individual chart review – and do not align with industry standards of methodology for outcomes-based data collection consistent with physical healthcare.
- Identify three quality-focused, industry-standard measures such as those used for value-based contracting and to demonstrate physical health outcomes.[14] Data collection methodology must use available claims or encounter-based information that is readily available.
- Direct HCA (or a designee) to conduct an open and transparent process to identify performance data and outcomes to be monitored. This review should involve stakeholders such as WISe provider agencies, other behavioral health providers, Managed Care

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

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

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

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

3. Why is this a smart move now?

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

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

4. What outreach has informed this recommendation?

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

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

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

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

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

1. What is the issue?

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

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

Loss of childcare subsidy leads to instability of care.

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

2. What do you recommend?

Expansion of Early ECEAP slots in high-need areas.

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

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

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

3. Why is this a smart move now?

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

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

4. What outreach has informed this recommendation?

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

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

5. School-based behavioral health funding for school districts

Legacy	$$$	Budget Ask

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

1. What is the issue?

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

The Office of the Superintendent of Public Instruction (OSPI) conducted a survey of all 321 Local Education Agencies (LEAs) in the state between March 2022 and February 2023 to gauge compliance with the RCW 28A.320.127.[15] Data collected from the survey found that only 172 LEAs (54%) reported that they had an EBD plan in place. **149 LEAs reported they did not have an EBD plan in place**. The survey asked LEAs about barriers they encountered in developing an EBD plan. Lack of time or adequate staff was the most mentioned barrier, cited by 84 LEAs in the survey. Lack of funding and/or resources was the second most commonly cited barrier. Many LEAs mentioned that they needed more funding to ensure proper training and professional development, both to create the plan and train their staff to support the plan once it was created. Several LEAs also mentioned that they would need funding for an additional staff member to create the plan, since they felt their current staff didn't have the time or the proper expertise. Similarly, some LEAs said that they would need money to hire behavioral health staff to support the plan once it was created. Other LEAs pointed to a lack of behavioral health resources in their community as a barrier to putting this plan in place and/or emphasized, in general, that the EBD RCW, as it stands, is "another unfunded mandate."

2. What do you recommend?

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

[15] This data collection effort was legislatively mandated via \screening, and response to emotional or behavioral distress in students

- Technical assistance, training, resources and/or staff support to adequately meet the behavioral health needs of all students, including creating and/or strengthening a plan for recognition, and
- Creating a tiered approach to suicide prevention inclusive of prevention, intervention, and postvention.

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

3. Why is this a smart move now?

OSPI survey data from the last 19 months shows a clear picture of where LEAs need support with planning and coordinating for effective screening, recognition, and response to emotional and behavioral distress in students. **149 LEAs (46% of those across the state) self-reported that they did not have an EBD plan in place.** Within that context, we know that WA students are experiencing a mental health crisis. 19% of 8th graders, 20% of 10th graders, and 20% of 12th graders said they **considered** suicide in the past year. 9% of 8th graders, 8% of 10th graders, and 7% of 12th graders said they **attempted** suicide in the past year.

Among 12th grade students, 74% said they felt nervous or anxious in the past two weeks, 63% said they were unable to stop or control their worrying in the past two weeks, 48% reported feeling sad or hopeless in the past year, and 15% felt they had no adult to turn to for support when feeling sad or hopeless.[30] The data on these mental health indicators show significant disproportionality by race, sexuality, and disability status. In one tragic example, the 2022 COVID-19 Student Survey found that 20% of students that – when asked their gender – identify as transgender, 10% of students that identify as "questioning or unsure of their gender," and 12% of students that marked "Something else fits better," said they **attempted** suicide in the past year, compared to 3% and 5% of their peers that identified as male or female, respectively. It is imperative that we address the mental health crisis that WA students are facing by providing crucial funding support for LEAs to use to create and strengthen their EBD plans and mental health support systems. We acknowledge that the Legislature made a significant investment in the funding allocations for physical, social, and emotional (PSES) support staff through House Bill 1664 (2022). This funding will move our system towards a longer-term "righting" of the school staff capacity we need for prevention/education. However, schools need dedicated funding right now to address the mental health crisis WA students are facing.

4. What outreach has informed this recommendation?

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

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

New	$$$	Budget Ask, Legislative Policy

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

1. What is the issue?

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

Meanwhile, experts are exploring other models besides stipends to support individuals in completing the necessary hours to obtain their credential, including: 1) expanding the school social worker proviso that was included in the 2023-25 budget and 2) contracting with behavioral health professionals to provide supervision so individuals seeking supervision don't have to pay out of pocket for this service. These alternative models may be lower cost and lower in administrative burden or could combine with the stipend program to broaden access to a wider pool of recent graduates. If either of these are projected to reduce cost or increase access, and if the current language in HB 1724 does not allow for such models to be employed by the DOH, the Legislature could amend the statute to broaden the tools available to DOH as they seek to help recent graduates achieve certification.

2. What do you recommend?

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

3. Why is this a smart move now?

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

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

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

4. What outreach has informed this recommendation?

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

7. Deliver and sustain approved funding for BH360 (formally Parent Portal) *(tied with next recommendation)*

Legacy	$-$$	Budget Ask, Legislative Policy

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

1. What is the issue?

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

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

2. What do you recommend?

The YYACC Subgroup recommends that the Legislature fund BH360 by:

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

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

3. Why is this a smart move now?

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

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

4. What outreach has informed this recommendation?

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

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

7. Allow funding for the Washington Health Corps Behavioral Health Program to be used for conditional scholarships *(tied with previous recommendation)*

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

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

1. What is the issue?

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

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

2. What do you recommend?

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

3. Why is this a smart move now?

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

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

4. What outreach has informed this recommendation?

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

8. Improving student access to mental health literacy education

New	$	Budget Ask

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

1. What is the issue?

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

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

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

2. What do you recommend?

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

3. Why is this a smart move now?

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

Studies show including Mental Health Literacy (MHL) in an education program leads to decreased stigma and a stronger mental health knowledge base. In turn, that leads to robust peer support amongst youth, decreased delays to care, improved student productivity and more effective interventions for students at risk of suicide (Kutcher et. al, 2016).

Regardless of the availability of SEL (Social-Emotional Learning) programs, MHL is likely a key support for addressing today's youth mental health crisis and eliminating mental illness stigma for a generation.

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

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

4. What outreach has informed this recommendation?

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

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

9. Certified community behavioral health clinic (CCBHC) bridge funding. *(tied with next recommendation)*

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

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

1. What is the issue?

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

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

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

2. What do you recommend?

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

3. Why is this a smart move now?

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

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

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

4. What outreach has informed this recommendation?

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

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

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

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

9. Increase investment in infant and early childhood mental health consultation (IECMH-C) *(tied with previous recommendation)*

Legacy	$-$$$	Budget Ask

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

1. What is the issue?

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

Child Care Aware of Washington's (CCA of WA) Holding Hope IECMH-C program currently employs a diverse and talented team of Mental Health Consultants (MHCs) statewide, with 9 of 15 consultants representing various communities of color and 6 fluent in languages other than English, including Spanish and Somali. As of June 2023, there are 5,542 licensed childcare providers statewide with a capacity to serve 194,052 children.[16] At current funding levels, this means that we have one MHC for every 370 licensed childcare providers, or one MHC for every 12,937 children in care. With full caseloads, the team of MHCs can typically serve around 110-130 providers at a time, roughly 2% of licensed providers. Most childcare sites served have multiple child/family concerns and classroom/ programmatic needs which consultants are supporting in partnership with Early Achievers Coaches.

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

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

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

Per the 2022 survey of all licensed childcare providers statewide:[17]

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

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

[16] Child Care Aware of Washington (August 2023).

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

Black children's preschool expulsion rate is nearly two times as high as Latino and white children.[18] And while Black children represent 19% of preschool enrollment, they account for 47% of preschool children receiving one or more out-of-school suspensions. In comparison, white children represent 41% of preschool enrollment, but 28% of preschool children receiving one or more out-of-school suspensions.[19] 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.[20] Because Holding Hope IECMH-C is built on a national evidence-based model that is proven to reduce suspension and expulsion, we are asking for expansion funds to serve underserved communities, assure fidelity to the national model, and disrupt expulsion practices and trends here in Washington.

Loss of childcare subsidy leads to instability of care.

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

2. What do you recommend?

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

IECMH-C is an evidence-based prevention-oriented, multilevel intervention that results in improved caregiver social-emotional support for young children and improved children's social-emotional well- being.[21] It is also an effective practice to interrupt bias and disproportionate expulsions and suspensions of young children of color in childcare and early learning, providing more equitable opportunities for children to participate in high-quality childcare and early learning experiences.[22] IECMH-C leads to many positive results for children and families including: increased social-emotional skills and self-regulation, reductions in challenging behavior, and reduced expulsion rates.[23] For caregivers, it increases positive interactions with children, reduces stress and turnover, and improves caregiver self- efficacy and knowledge, among other positive results.[24]

3. Why is this a smart move now?

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

14% percent of parents report that their children have developed more serious mental health and behavioral challenges since the start of the pandemic.[25] During the pandemic, verbal, motor and social-emotional development for the youngest children was negatively impacted - the number of

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

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

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

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

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

[23] Ibid.

[24] Ibid.

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

words spoken by parents to children was lower than in the past two years; opportunities for physical play and interaction with peers was reduced; and parents experienced high levels of stress, depression, anxiety, social isolation and a reduction in personal and family interaction.[26] Additionally, rates of social-emotional and behavioral challenges were one to four times higher among racial and ethnic minorities.[27]

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

A recent national study revealed that 55% of Washington childcare providers screened positive for symptoms of clinical depression.[28] These symptoms among caregivers result in less responsive and attuned interactions with young children and indicate a need for increased caregiver support. This same study also revealed an alarming increase in young children's challenging behaviors. 65% of early childhood education professionals in Washington reported that they had children with increased externalizing and internalizing behaviors in their classrooms or programs since the pandemic.[29] Further, there was significant staff turnover of childcare providers during the pandemic, resulting in a less experienced, newer workforce that needs training, professional development and ongoing support to offer quality social emotional learning experiences and environments for young children.[26] As the Holding Hope IECMH-C model is built on the national model with evidence of reduced staff stress and turnover and reductions in children's challenging behaviors, we believe that increased investment will have a positive impact on these trends in Washington.

The need for mental health support for Washington's caregivers, children and families is significant, and IECMH-C is an evidence-based prevention-oriented, multilevel intervention that results in improved caregiver social-emotional support for young children and improved children's social-emotional well- being.[30]

4. What outreach has informed this recommendation?

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

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

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

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

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

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

[29] Ibid.

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

10. Public access to behavioral health data

New	$$-$$$	Budget Ask, Legislative Policy

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

1. What is the issue?

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

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

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

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

2. What do you recommend?

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

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

3. Why is this a smart move now?

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

4. What outreach has informed this recommendation?

The School of Social Work at the University of Washington-Seattle has been working with researchers, graduate students, practitioners, data scientists, public agencies, law enforcement, crisis responders, legislators, and all the higher education programs in the state of Washington who confer clinical degrees. The School of Social Work works closely with private philanthropy and is a participant in several behavioral health policy reform efforts. Several behavioral health advisory councils are maintained, as is a network of over 100 community behavioral health agencies who participate in the Workforce Development Initiative funded by the Ballmer Group. While there are several opinions about what data are needed, there is general agreement that improving our information about the behavioral workforce should be a part of any effort to improve the behavioral health system.