**Washington State**
**House of Representatives**
**Office of Program Research**

# BILL ANALYSIS

# Early Learning & Children's Services Committee

# HB 1373

**Brief Description**: Concerning children's mental health services.

**Sponsors**: Representatives Dickerson, Kagi, Green, Cody, Darneille, Dunshee, Roberts, Goodman, Appleton, Kenney, Orwall, Hurst, Moeller, Takko, Chase, Rolfes, Carlyle, Simpson, Nelson, Conway and Ormsby.

**Brief Summary of Bill**

- Amends the definition of "severely emotionally disturbed" child to focus on the impact of the disorder on the child's functioning.
- Directs the Department of Social and Health Services to implement changes to the access to care standards for children.
- Requires changes to contracts with Regional Support Networks (RSNs) relating to mental health services to children.
- Eliminates the expiration date for increasing the annual number of office visits available to children needing outpatient mental health therapy in managed care programs and on a fee-for-service basis.

**Hearing Date**: 2/3/09

**Staff**: Sydney Forrester (786-7120)

**Background**:

*Overview of Children's Mental Health Services*

State-provided children's mental health services in Washington are delivered primarily through Regional Support Networks (RSNs) established to develop local systems of care. The RSNs consist of counties or groups of counties authorized to contract with licensed service providers

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and deliver services directly. In addition to RSN's, some children receive mental health services through managed care programs, such as Healthy Options, or from private providers on a fee-for-service basis. Access to mental health treatment can be achieved through minor-initiated, parent-initiated, or state-initiated options. Each option has a slightly different statutory framework and involves certain determinations made by professionals. Parent-initiated and state-initiated treatment options also involve petitions to the superior court.

*Second Substitute House Bill 1088 (2007)*

In 2007, the legislature enacted Second Substitute House Bill 1088 (2SHB 1088), declaring the intent to develop a system of children's mental health emphasizing early identification, intervention, and prevention with a greater reliance on evidence-based and promising practices, with the following elements:

1. a continuum of services from early identification and intervention through crisis intervention, including peer support and parent mentoring services;
2. equity in access to services;
3. developmentally appropriate, high-quality, and culturally competent services;
4. treatment of children within the context of their families and other supports;
5. a sufficient supply of qualified and culturally competent providers to respond to children from families whose primary language is not English;
6. use of developmentally appropriate evidence-based and research-based practices; and
7. integrated and flexible services to meet the needs of children at-risk.

*Access-to-Care Standards*

Access-to-care standards are intended to create standard criteria for accessing services across the RSNs. The standards utilize two levels of access, both of which depend on: a diagnosis of a mental illness; a specific score on a functioning assessment; and one or more functioning impairments, high-risk behaviors, escalating symptoms, or prior hospitalization or treatment within a specified time. In 2007, as part of 2SHB 1088, the Legislature directed the Department of Social and Health Services (DSHS) to revise the access-to-care standards to assess a child's need for services based on behaviors exhibited by the child and interference with a child's functioning in the family, school, or the community, as well as a child's diagnosis. The revised standards were to reflect the revised legislative intent and provide for:

1. a child's access to services not be conditioned solely on a determination the child is highly at-risk or in imminent need of hospitalization or an out-of-home placement; and
2. assessment and diagnoses for children under the age of five be determined using a nationally accepted age-appropriate assessment tool.

*Managed Care and Fee-for-Service Programs*

Under 2SHB 1088, the DSHS was directed to revise its Medicaid managed care and fee-for-service programs to improve access to children's mental health services by:

1. increasing from 12 to 20, the number of outpatient therapy visits allowed annually under the programs; and
2. allowing those services to be provided by any mental health professional licensed by the Department of Health.

These changes are set to expire July 1, 2010.

*Evidence-Based Practice Institute*

The Children's Mental Health Evidence-Based Practice Institute (EBP Institute) was established in 2007 as part of 2SHB 1088. The EBP Institute is located at the University of Washington Division of Public Behavioral Health and Justice Policy and serves as a statewide resource to the DSHS and other entities on child and adolescent evidence-based and promising practices. The EBP Institute also:

1. participates in the identification of outcome-based performance measures for monitoring quality improvement processes in children's mental health services;
2. partners with youth, families, and culturally competent providers to develop information and resources for families regarding evidence-based and promising practices;
3. consults with communities for the selection, implementation, and evaluation of evidence-based children's mental health practices relevant to the communities' needs;
4. provides sustained and effective training and consultation to licensed children's mental health providers implementing evidence-based or promising practices; and
5. collaborates with other public and private entities engaged in evaluating and promoting the use of evidence-based and promising practices in children's mental health treatment.

*Definition of "Mental Disorder"*

A mental disorder is defined as an organic, mental, or emotional impairment with substantial adverse effects on a person's cognitive or volitional function. Alone, substance abuse, juvenile criminal history, antisocial behavior, or mental retardation are not sufficient to justify a finding of a mental disorder.

*Definition of "Severely Emotionally Disturbed" Child*

A severely emotionally disturbed child is one who has been determined by the RSN to have a mental disorder and who meets one of the following criteria:

1. has received inpatient treatment or has been in an out-of-home placement because of a mental disorder within the past two years;
2. has received involuntary treatment within the past two years;
3. is being served by the child welfare system or the juvenile justice system, or is receiving special education or services for children with developmental disabilities; or
4. is at risk for escalating maladjustment due to family dysfunction; changes in a custodial adult; entering or being discharged from an out-of-home placement or inpatient treatment facility; repeated physical abuse or neglect; drug or alcohol abuse; or homelessness.

**Summary of Bill**:

*Definition of "Severely Emotionally Disturbed" Child*

The definition is amended to remove the requirement for a determination by the RSN, and the requirement that the child meet at least one additional criteria. The amended definition requires the child have a mental disorder that clearly and significantly interferes with the child's functioning, in the family, at school, in the community, or with peers.

*Acces- to-Care Standards*

The DSHS is directed to implement revised access-to-care standards beginning July 1, 2012. Implementation must be done in consultation with the RSNs, mental health service providers, consumers, and other stakeholders. The revised standards must reflect the change in the definition for "severely emotionally disturbed" child and the corresponding analysis of whether the child's emotional disorder clearly and significantly interferes with the child's functioning in the family, at school, in the community, or with peers.

For children under age five, the standards must:

1. accommodate use of a nationally accepted assessment tool specifically for use with infants and young children;
2. recognize there may be significant assessment and behavioral differences between the five and under age group and school-age children; and
3. acknowledge the vital importance of the parent-child dyad, including the impact of parental emotional difficulties on the child and the need to provide family inclusive therapy to effectively treat the child.

*Managed Care and Fee-for-Service Programs*

The July 1, 2010, expiration date for the increase in the annual number of office visits and the provision allowing services to be provided by all licensed mental health professionals is eliminated. The annual number of office visits for children receiving outpatient mental health therapy under the managed care and fee-for-service programs is 20 visits per year, and those services can be provided by all licensed mental health professionals.

*RSN Contract Changes*

To assure the special mental health needs of children are met, contracts with RSNs must establish minimum thresholds for the number of children served in the RSN, both as a percentage of all persons served and as a percentage of total outpatient service hours. Minimum thresholds for serving children are defined as follows:

1. for the biennium beginning July 1, 2009, children must comprise 30 percent of persons served and 25 percent of outpatient service hours; and
2. for the biennium beginning July 1, 2011, children must comprise 36 percent of both the persons served and percent of outpatient service hours in each RSN.

Contracts with RSNs also must set minimum standards for collaboration between the RSNs and various divisions with the DSHS, local school districts, and local juvenile courts.

*Evidence-Based Practice Institute*

The DSHS and the EBP Institute must collaborate to encourage and create incentives for the use of prescribing practices and evidence-based and research-based practices by licensed mental health professionals serving children.

*Unspecified Appropriations*

Undetermined amounts are to be appropriated to continue the following activities relating to 2SHB 1088 enacted in 2007:

1. the wrap around pilot program;
2. expedited Medicaid enrollment for youth leaving juvenile detention programs;
3. psychiatric consultation services for primary care providers;
4. the work of the EBP Institute;
5. expanded Medicaid and children's outpatient mental health services; and
6. improvements to the Medicaid prescribing practices for children mental health medications.

**Appropriation**: None.

**Fiscal Note**: Requested on January 30, 2009.

**Effective Date**: The bill takes effect 90 days after adjournment of the session in which the bill is passed.