Children and Youth Behavioral Health Work Group

Recommendations for the 2022 legislative session *Updated 10/24/22*

Budget proposals: $ < $500,000 $$ = $500,000 -$999,000 $$$ = $1 million - $10 million $$$$ > $10 million

Overarching recommendations (page 4)

Legacy **$$$$**	Medicaid rate increase Building upon investments made by the 2022 Legislature, provide necessary stabilization and support to the behavioral health safety-net by appropriating and implementing a substantial Medicaid rate increase for all providers of pediatric behavioral health services, as well as a 15% rate bump for the Children's Long-Term Inpatient Program. The CLIP rate increase shall be implemented on July 1, 2023 to address the workforce crisis that is affecting inpatient capacity. The overall rate increase, effective January 1, 2024, shall be implemented for all behavioral health inpatient, residential, partial hospitalization, intensive outpatient, and outpatient providers receiving payment for services through Medicaid managed care organizations and fee-for-service. The rate increase should apply to both parts of the budget and both parts of the state plan that cover behavioral health provider reimbursement. *Workforce & Rates*
New **$ TBD**	Expand services and codify a consistent approach to support the needs of youth who are effectively "stuck" in hospitals This package of recommendations includes four budget proposals and one policy proposal: • Expand the capacity in DDA in-home and out-of-home services. • Expand the capacity and capability of WISe to support high-needs youth – potential promising pilots include exploring how to concurrently offer ABA and WISe, piloting a Wraparound with Intensive Behavioral Supports (WIBS) model, and continuing educational opportunities such as RUBI and the ECHO for WISe teams. • Expand access to ABA supports. • Explore a therapeutic educational residential placement in Washington State through an evaluation/study. • Codify a new approach to creating a service and placement plan for children. *Youth & Young Adult Continuum of Care*

Subgroup recommendations

Workforce and Rates (page 10)	
New **$$$$**	Reduce the educational debt burden for clinicians In order to address education debt burden and increase the behavioral health workforce, we recommend a three-pronged strategy: 1. Allocate $25 million to recruit and support 325 master-level students with $75,000 conditional grants to diversify the behavioral health workforce by 2028; 2. Create a loan repayment fund specifically targeted to individuals employed in community behavioral health agencies; and 3. Allocate funds to support behavioral health loan repayment awards to address retention challenges within a variety of settings and conduct an evaluation of program outcomes.

New **$**	Reduce behavioral health workforce barriers To address barriers to retaining and expanding the Behavioral Health workforce: 1. Amend the Revised Code of Washington (RCW) to allow inclusion of Washington in the national Counseling Compact; and 2. Reduce or eliminate identified administrative burdens.
Legacy **$ TBD**	Certified Community Behavioral Health Clinics (CCBHCs) Build on foundational work from FY2022 to develop a sustainable, prospective payment system for comprehensive community behavioral health services by refining the CCBHC model, pursuing federal demonstration state status, conducting related actuarial analysis, obtaining continued technical assistance from the National Council for Mental Wellbeing, and proposing a pathway for statewide implementation of CCHBCs.
Legacy **$**	Teaching clinic enhancement rate Allocate funds for a .5 FTE at the HCA to participate in a public/private partnership to implement the behavioral health teaching clinic demonstration project led by the WA council for Behavioral Health.
New **$-$$$**	Scale up culturally affirming mental health care for children and families (CARE project) Fund continued support the next phase (two years) of the CARE project (culturally affirming mental health care for children and families) by bringing together diverse communities and sectors to collaboratively develop a three-pronged effort to: 1. Expand a culturally diverse, child mental health workforce; 2. Train licensed child mental health providers in culturally affirming care; and 3. Support specialty child mental health leaders to lead organizational change efforts to support these workforce shifts.
Behavioral Health Integration (page 22)	
New **$ TBD**	Finance kids' behavioral health care coordination in primary care Direct HCA to adopt Medicaid billing codes that would reimburse primary care clinics for care coordination activities on behalf of children and teens with behavioral health problems.
New **$-$$** $ for 1 year	Continue and expand behavioral health integration in primary care (through PAL, Mental Health Referral Service for Children and Teens, and First Approach Skills Training (FAST) • Continue and expand televideo case-based trainings beyond June 2023 to be offered for all state primary care-based therapists and, potentially, for primary care providers. • Initiate televideo case-based trainings for interested mental health center-based therapists to learn the First Approach Skills Training (FAST) model. • Develop new materials and improve FAST materials for language access and cultural sensitivity.
Prenatal through Five Relational Health (page 31)	
Legacy **$$$$**	Increase the Early Childhood Education and Assistance Program (ECEAP) and Child Care Complex Need Funds (CNFs) to meet need Providers and programs report an overwhelming and unmet demand for ECEAP and Child Care CNFs. CNFs provide the ECEAP, and Child Care providers vital state funding to support children with developmental delays, differing abilities, or challenging behaviors. Early learning providers submit requests for CNF supports; to date, providers have submitted far more requests than the available budgets.
Legacy **$-$$$**	Expand Infant Early Childhood Mental Health Consultation (IECMH) to meet need These funds would be used to (1) provide IECMH-C services by linguistically and culturally matched consultants; (2) attend to the wait list by offering "one to many" types of supports for childcare providers needing support; (3) expand capacity to provide individualized mental health consultation services to more providers, and (4) address on-going program needs to maintain quality and access to a variety of intensity of services. These funds will be used to hire 13 additional mental health consultants. There are currently 110 early learning providers on the waitlist.

New **$**	Improve awareness and navigation support for parents and caregivers for families in the perinatal stage and children through age 5 HCA should direct a comprehensive analysis of relationally based awareness and navigation supports that is directly informed by parents/caregivers with lived experience seeking support for medical issues, developmental delays, and/or mental health. This analysis will be used to develop trainings and education resources that center the empowerment of parents and caregivers and potentially inform practices with existing services.
Student Behavioral Health and Suicide Prevention (in prioritized order) (page 40)	
New **$ TBD**	Designate a lead agency for students' behavioral health Designate a lead agency responsible for ensuring student access to the continuum of behavioral health and wellness services in school settings. In Year One, allocate funding for the designated lead agency to develop a work and project plan. In Year Two, include flexible funding to education service districts (ESDs) and school districts for development of comprehensive behavioral health services, support in becoming a licensed behavioral health provider, and/or to partner with community-based organizations (CBOs) and other licensed providers to provide access to behavioral health services to students.
Legacy **$ TBD**	Expand the number of school- and community-based clinicians serving students and expand the Partnership Access Line (PAL) in Schools pilot statewide To increase the service capacity for schools across the state to provide access to and promote positive outcomes for Tier 2 and Tier 3 mental health interventions for all students: 1. Provide funding to districts to expand the number of school- and community-based mental health practitioners; and 2. Provide funding to expand the Partnership Access Line (PAL) in Schools pilot program statewide. Both these recommendations would target rural and remote schools with unique workforce and mental health service access needs.
Youth and Young Adult Continuum of Care (page 47)	
Legacy **$ TBD**	Behavioral health respite for youth and families Direct HCA to continue to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the DDA and DCYF respite waivers, and to continue to expand the System of Care respite pilots.
New **$ TBD**	Peer services for youth and families Expand access to peer services for parents/caregivers and youth/young adults accessing behavioral health services by funding Center of Parent Excellence (COPE) to sustain the program and add additional staff; add additional opportunities for the Certified Peer Training and testing specifically for youth and families.
New **$ TBD**	Targeted investments in behavioral health and suicidality for indigenous youth To address the massive disparities in behavioral health needs in Indigenous youth, the YYACC recommends monetary assistance given to tribes and Indigenous organizations to spend on behavioral health services as they see fit.
New **$ TBD**	Create a flexible fund to pilot the utilization of technological innovations across the behavioral health continuum of care The YYACC recommends that a pot of flexible funds be created to stimulate broader adoption of technological innovations in the mental health and addiction services sector. A myriad of such technologies exist, including applications and prescription digital therapeutics that address suicide crisis care, addiction recovery support, depression care, opioid use disorder, and more. These technological innovations exist across the behavioral health continuum of care from assessment and early intervention to treatment and recovery support services.
Legacy **$$$**	Parent Portal implementation Develop content of the Parent Portal Behavioral Health 360 (BH360) to include up to 13 different behavioral health challenge areas and culturally responsive resources statewide. Establish community partnerships with local behavioral health organizations and refine a resource mapping model to include in-person entry points to BH360. The technical build will include pulling in provider lists across public and private sectors, a parent profile to store documents, screening questions, personalized resources, and more.

Overarching
2023 Recommendations

Children & Youth Behavioral Health Work Group – *Workforce & Rates Subgroup*
Recommendations Brief – Behavioral Health Medicaid Rate Increase (10-11-22)

Recommendation:

Building upon investments made by the 2022 Legislature, provide necessary stabilization and support to the behavioral health safety-net by appropriating and implementing a substantial Medicaid rate increase for all providers of pediatric behavioral health services in addition to a 15% rate bump for the Children's Long-Term Inpatient Program. The rate increase, effective January 1, 2024, shall be implemented to all behavioral health inpatient, residential, partial hospitalization, intensive outpatient, and outpatient providers receiving payment for services through Medicaid managed care organizations and fee-for-service. The rate increase should apply to both parts of the budget and both parts of the state plan that cover behavioral health provider reimbursement. The CLIP rate bump will implement on July 1, 2023.

1. **What is the issue?**

   Medicaid reimbursement rates continue to remain significantly lower than the cost of care delivery, leaving many providers including unable to offer competitive salaries and benefits to their employees. While this fundamental challenge to workforce recruitment and retention long pre-dates the onset and progression of the COVID-19 pandemic, the exacerbation brought on by ongoing pandemic-related concerns and ever-increasing need for behavioral health services has been severe. Competition for behavioral health workers remains fierce.

   Despite surging demand for services, the current workforce crisis is dangerously reducing capacity and limiting access for communities throughout the state across all provider types.

   A survey conducted by the Washington Council for Behavioral Health last year documented these alarming trends:

   - Over half of surveyed provider agencies had closed or limited access to outpatient services
   - Vacancies for master level clinical staff average 30% and were as high as 60% in rural communities
   - All-staff vacancy rates have continued to climb & annual turnover rates have climbed to 30%
   - More treatment beds were taken offline, and branch office sites closed

   Wait lists for outpatient mental health services are unacceptably long for families across the state. Seattle Children's Partnership Access Line Referral Assist Program continues to see an uptick in the number of contacts they must make before successfully connecting families in need with an appropriate provider for their child or youth.

   Seattle Children's Emergency Department continues to break records in terms of the number of days children and youth presenting in crisis spend in the ED awaiting an appropriate placement at the Seattle Children's Psychiatry and Behavioral Medicine Unit (inpatient) or other settings including partial hospitalization, intensive outpatient and residential.

   Specific to the CLIP program, there is a serious need to incentivize professionals to join the CLIP provider workforce. Currently, CLIP is experiencing significant workforce challenges that result in decreased service capacity. Of the total 54 contracted CLIP bed capacity, the monthly average bed utilization rate is 37 because of ongoing workforce shortages. Currently, clinicians can find more highly compensated roles with other hospitals or inpatient facilities. This increase in reimbursement for CLIP providers will

make these roles more competitive in the market and is therefore so important for the ability of the program to meet the needs of children and adolescents across the state.

2. Recommendation details

Investments made by the 2022 Legislature underscore the state's commitment to support its behavioral health safety-net, but the impact of unprecedented economic inflation and still-rising demand for services emphasize the need for continued (and heightened) support.

We recommend a substantial rate increase in Medicaid reimbursement rates directed to all behavioral health providers with the increase applying to both parts of the state budget and both parts of the state plan related to behavioral health provider reimbursement.

The Washington State Health Care Authority submitted a decision package to the Governor's Office of Financial Management seeking additional support for the CLIP system. The Rates and Workforce Subgroup is actively supporting the 15% CLIP rate increase. Details here:

- 15 percent rate increase for CLIP beds from a per diem rate of $895 to $1,030, effective July 1, 2023, to assist in stabilizing the CLIP workforce.

The decision package includes two other items related to CLIP funding and workforce.

- Additional funding for Habilitative Mental Health to increase the facility per diem rate from $1400 to $1700 and expand the number of beds. This per diem rate allows purchasing of more specialized care for children and youth receiving HMH; the rate also includes startup costs. Funding for HMH also expands the number of HMH beds from 12 to 20;
- Additional funding for training to support a comprehensive treatment model specializing in treating children and youth with co-occurring psychiatric, IDD and ASD conditions successfully. The START and ECHO models have been determined to meet these needs. This request would support the required specialized staffing model and training efforts for staff and caregivers to support complex transitions between levels of care and discharges to the home and community.

3. Given current circumstances, why is taking the recommended action a smart move now?

As was the case in 2021, the workforce shortage crisis continues to force behavioral health providers limit services when capacity should be expanding to meet ever-growing need. Behavioral health has been disproportionately impacted by economy-wide workforce shortages as a result of decades of low reimbursement rates, which build a foundation of correspondingly low staff compensation. While increasing reimbursement rates will not instantaneously solve the workforce crisis, it is crucial to slowing or stopping the loss of qualified workers from this essential safety-net system by improving Medicaid rates and offering competitive compensation.

Washington cannot afford to lose system capacity and infrastructure of the behavioral health safety-net. Once these workers leave, they do not return; once a branch office is closed, it does not reopen; once a treatment facility shuts down, those beds do not come back online. Valuable time, human resources, and facility infrastructure are lost to the community. While the recent 7% Medicaid rate increase was a

vital step toward stabilizing the behavioral health safety net, the combined impact of sharp inflation increases, and an implementation date of January 2023 have made it challenging to measure the impact of this rate increase on the broader system.

Now action is needed because there is a wait list of children and youth in need of CLIP services. The average services wait time is 84.5 days and it contributes to an increase in children and youth who end up stuck in an inappropriate part of the continuum such as the Seattle Children's inpatient psychiatry unit or the emergency departments of hospitals across the state. Additional resources are needed to strengthen the overall capacity of CLIP and entice new CLIP providers, which will have a substantial impact on access and will markedly improve the ability of kids and youth currently waiting and not receiving care in the appropriate setting to receive that care when and where is most appropriate for them.

4. Describe any outreach that helped to develop this recommendation.

Several workgroups, committees, and behavioral health initiatives statewide are working to address this issue. All have pointed to the need for long-term investments in workforce development to encourage and expand the pool of workers entering our field. While essential, these efforts do not provide the more immediate solutions and investments so critical to stabilizing the system.

Child and youth Medicaid enrollees seeking and receiving behavioral health care across all Medicaid providers in this state represent the broadest range of racial and ethnic diversity; most are extremely low-income and live with multiple health and social challenges; many have no other option for receiving care. The patchwork network of systems and services that support young people on Medicaid – including health providers, child/youth-serving systems, schools, and community partners (including law enforcement) rely on providers who are willing to accept Medicaid enrollees to deliver urgently-needed behavioral health services. Other more specific provider types that rely on Medicaid behavioral health access include mobile crisis response services and designated crisis responders, WISe and other intensive community-based treatment and support, specialty treatment to address severe and complex needs, evidence-based early intervention programs, and youth residential treatment programs.

A Medicaid rate increase to community behavioral health agencies will help the behavioral health safety-net to close gaps in access and health outcomes for these children, youth, and families as we build toward a longer term and more transformational solution.

The CLIP program has shared with workgroup members and providers their concerns with a shortage in workforce skilled and trained appropriately to deliver the care needed for kids served by CLIP. The ongoing dynamic of high inflation and increasing labor costs across the entire labor market have put further pressure on the CLIP program to both recruit and retain the clinical and operational staff needed.

Children & Youth Behavioral Health Work Group – Youth and Young Adult Continuum of Care (YYACC) Recommendations Brief – Expanded Services and New Approach for Patients At-Risk of Abandonment and "Stuck" in Hospitals (10-11-22)

Recommendation:

This is a package of recommendations to expanding existing services, explore a potential new service, and codify a consistent approach for serving/supporting the population of youth who currently are at-risk of abandonment by caregivers and are effectively "stuck" in the hospital setting. Four items are a budget ask, the fifth is a policy ask.

1. ## What is the issue?

   There is a population of children and youth, typically profoundly impacted by autism spectrum disorder (ASD) and/or intellectual developmental disability (IDD), who face limited access to services/resources in the community. In some cases, their caregivers – having typically experienced multiple crises – bring them to the hospital setting and are not willing to take them home, even if they do not need an admission.

   Up until about 18 months ago, children in this situation were seen as "abandoned" (legal term) by caregivers and entered dependency, cared for by DCYF. Due to DCYF's change in interpretation of the abandonment statute, these children no longer count as "abandoned" and therefore they stay in the hospital far longer than medically necessary. This contributes to poor outcomes for the child during their hospitalization (as the hospital is not a place for a child to live) as well as capacity issues for hospitals to meet the medical and psychiatric needs of the patient population. These kids are essentially "stuck" – parents won't take them home, DCYF won't place them in dependency, and there are limited out-of-home treatment placements available… so they stay in the hospital. Seattle Children's has had patients admitted for a year or longer who are in this situation. Mary Bridge has had a patient in this situation for 10 months.

   These children and their families *need* and deserve better care. Seattle Children's has convened multiple stakeholders to discuss what additional services would support this population and how we can create a new short-term approach, recognizing that longer-term, innovative, collaborative solutions are still needed. These short-term solutions form our recommendation package.

2. ## Recommendation details

   - **Expand the capacity of DDA in-home and out-of-home services**. (budget item). Many of these items are outlined in DDA's Decision Package entitled "Kids and Adults Stuck In Hospitals" as well as discussed in the DD Ombuds Report entitled "I Want to Go Home"
   - **Expand the capacity and capability of WISe to support high-needs youth**. (budget item) Overall, creating more capacity in WISe is needed – there are interest lists currently of children/youth awaiting these services. For youth with ASD/IDD and mental or behavioral health needs, there is work ongoing to consider how WISe could more effectively serve them and their families: HCA outlined an exciting pilot to integrate ABA supports into WISe teams as well as a pilot for a team called Wraparound with Intensive Behavior Supports (WIBS). These pilots could make in-home supports more accessible and successful for families of children with ASD/IDD and high behavioral needs. Additionally, there are training opportunities through ECHO programs for WISe providers on how to work with youth in this population that are currently funded on a limited basis – extending and expanding this funding could allow experts to share skills and tools with WISe (and WIBS!) teams who serve these children and their families.
   - **Expand access to ABA supports**. (budget item) HCA has a decision package to increase ABA rates, which would make a significantly positive impact.

- **Explore a therapeutic educational residential placement in Washington State**. (budget item). Many of these children and youth who are stuck in the hospital are awaiting placement at an out-of-state residential facility paid for through their school district. An evaluation/study of this service and a consideration of whether we should have them in Washington would be prudent especially as CYBHWG undertakes the P-25 Behavioral Health Strategic Plan outlined in HB1890.
- **Codify a new approach to creating a service and placement plan for families**. (new legislation). This bill would mandate that when a hospital identifies a child at-risk of abandonment and in need of services, a lead agency (likely DCYF) is responsible for convening the relevant state agencies and community providers to make a plan for services and placements for the child. This convening would be required to take place within a specific time frame (respecting the urgency of need in ED and inpatient psychiatric settings) and all agencies who are involved with the child's care would be required to attend and collaborate on a plan for services/supports and placements. Parents and caregivers should attend that meeting, with the goal of creating a plan that supports them in taking their child home. If parents/caregivers are still unwilling/unable to take the child home, DCYF is responsible for supporting with a kinship caregiver placement search and a search of voluntary placement options while continuing to work with parents/caregivers. After a specific amount of time and a service plan offered, if parents/caregivers are still unwilling/unable to take their child home, despite services/supports offered to them, the child should be considered abandoned, enter dependency, and should receive the same services/supports in a foster care setting through DCYF. A small multi-disciplinary group plans to convene to discuss the specifics of this legislation – outlined here is a draft vision for this legislation and is subject to change based on discussion.

3. **Given current circumstances, why is taking the recommended action a smart move now?**
   The issue of inadequate services/supports contributing to abandonment is long-standing and that would benefit from a long-term, innovative, thoughtful approach. That work is invaluable and can be part of the HB1890 P-25 Strategic Plan. These recommendations reflect what is critically necessary in terms of immediate, short-term supports. There are children currently admitted unnecessarily to inpatient psych units, waiting in emergency departments, and boarding on medical floors because of this gap in our system. We cannot afford to wait any longer to close the gaps in these safety nets by expanding existing services quickly, exploring what new services to add to our continuum, and changing how we work together to support these children and their families. These recommendations are intentionally presented as a package; codifying a new approach without expanding services will not solve meet their needs, whereas expanding services without outlining changes to process will leave these kids stuck. Both service expansion and process change are necessary to impact this issue. If we wait another session to make these changes, we will have children stuck in hospitals for an additional year – in locked inpatient psych units or in windowless ED rooms. Our children deserve better, and we have to act now.

4. **Describe any outreach that helped to develop this recommendation.**
   Seattle Children's has been regularly convening a group of multiple state agencies including DCYF, DDA, OSPI, and HCA as well as all the state's children's hospitals (Seattle Children's, Mary Bridge, and Sacred Heart), and the Washington State Hospital Association (WSHA). Seattle Children's has also spoken with parents who have lived experience, local community-based organizations that support youth and adults with ASD/IDD, the DD Ombuds, and providers who serve homeless and unhoused youth.

Workforce and Rates
2023 Recommendations

Children & Youth Behavioral Health Work Group – Workforce/Rates Subcommittee
Recommendations Brief – TOPIC/TITLE (10-11-22) – Address Education Debt Burden
Recommended length: No more than 2 pages

Recommendation: Bill and Budget
In order to address education debt burden and increase the behavioral health workforce, we recommend a three pronged strategy: Allocate $25m to recruit and support 325 master-level students with $75k conditional grants to diversify the behavioral health workforce by 2028; Create a loan repayment fund of $XX million specifically targeted to individuals employed in community behavioral health agencies; and allocate $XX to support behavioral health loan repayment awards to address retention challenges within a variety of settings, and conduct an evaluation of program outcomes.

1. **What is the issue?**
   WA State has a critical behavioral health workforce shortage. The crisis affects the state's capacity to serve WA's most vulnerable behavioral health populations, including children and youth, who struggle with both poverty and chronic, severe behavioral health issues. Community behavioral health agencies (BHAs), as well as a variety of other settings, continue to face a critical workforce shortage. Medicaid reimbursement rates are significantly lower than the cost of care delivery, leaving BHAs unable to offer competitive salaries and benefits to their employees. Competition for behavioral health workers remains fierce and the growing compensation gap between community BHAs and other provider settings continues to expand. While offering competitive salaries would help with respect to workforce retention, many BHA leaders have identified educational loan debt as one of the largest factors driving workers out of the public behavioral health system.

   While loan repayment for a variety of settings is identified as a key retention strategy, a suite of tools is needed to accomplish behavioral health workforce goals. Conditional grants (scholarships) are considered a significant recruitment strategy, offering the individual financial assistance in return for an agreement to work in certain sectors. This strategy can go far to change the racial, ethnic, gender and geographic composition of the workforce, something critical to ensuring that behavioral health services meet the needs of those seeking help.

2. **Recommendation details**
   Regarding conditional grants, the recommendation is modeled after the WA State BH Workforce Development Initiative (WDI), funded by the Ballmer Group will bring an additional 325 students into the workforce pipeline. These students will commit to working in CBHAs, tribal health centers, K-12 schools, and primary care centers for at least 3 years post-graduation. In addition to providing scholarships, funds will support training sites, targeted recruitment efforts, career supports, and the WSAC to manage the grant transactions.

   Regarding loan repayment, the average loan balance for all of the licensed mental health counselors applying to the Health Corps was $126,450.71 and the loan balances ranged from $12k to as much as $500k. Given that the avg. 2022 salary for a licensed mental health counselor, which requires a master's degree and 3,000 hours of post-graduate supervision, is $56,500, some individuals are burdened by student debt that can be 2-10 times their annual salary.

   The WA Health Corps continues to receive many more applications from behavioral health clinicians than it can award within the current allocated funds. The gap is occurring without significant

advertising of the program and within the current constraints on what types of settings and service types qualify. There is considerable investment in the Health Corps program (including the BH program) and a desire for the program to continue to receive significant appropriations to increase its scope. Additionally, however, community BH workers continue to carry substantial educational debt burdens paired with relatively low compensation. Addressing educational costs by developing a funding source to provide loan repayment specifically to the workforce and credentials employed by community BHAs would go far to retain this crucial component of the BH safety net upon which other child-serving systems depend.

3. **Given current circumstances, why is taking the recommended action a smart move now?**
BHAs are struggling now more than ever to retain workforce in all areas of care provision. Competitive compensation packages are not a reality and the public behavioral health system, that serves a significant number of children and youth, requires creative investments to address these challenges. And while some BHA workers qualify for current loan repayment eligibility, agency affiliated counselors, who include direct service staff who hold master's degrees, workers with bachelor's degrees, and others who may not have completed a degree program yet carry educational debt, do not. Further, current loan repayment programs require recipients to spend a percentage of time serving clients in a clinic setting; however, staff who serve folks in community settings outside of a clinic often do not qualify. Nonetheless, they often carry significant educational debt burdens, making continued employment in CBH extremely challenging.

   This means that a number of BH professionals working in settings such as mobile crisis response, homeless shelters, schools, and the homes of clients, do not currently qualify for loan repayment. To truly meet the needs of children, youth, and families, the BH system must have the flexibility to work in non-traditional settings and not penalize the practitioners by precluding them from seeking loan repayment.

   And, as previously discussed, we must recruit more students to pursue BH professions. This is the role conditional grants can effectively play. At present the graduate level trained BH workforce is undersized with respect to the number of clinicians needed; lacking the necessary diversity and cultural competence; and burdened by an unfavorable student-debt-to-salary ratio, creating barriers to recruiting and retaining the best and brightest students to the field.

   Finally, to better ensure that loan repayment and conditional grants are achieving the intended results to bring significantly more diversity into the field and retain BH professionals, funding for an evaluation of the programs is essential.

4. **Describe any outreach that helped to develop this recommendation.**
Ongoing outreach has taken place in individual and group meetings with BHA employers, the Health Care Authority leadership, Healthcare Industry Leadership Table members, WA Council for BH staff, and state legislators. And while the current conditional grant program funds students who make a commitment to work in a CBHA we know that not all children and youth receive services in a variety of settings so there needs to be a way to ensure that universities offer an expanded array of services and sites, and that the needs of the training sites are being met.

   Additionally, the Washington Council for Behavioral Health met with staff from the WA Student Achievement Council (WSAC). Highlighted in the discussion was the need to make the loan repayment program more flexible as previously described, given adequate funding is made available. The majority

of applicants who are turned down for loan repayment are not rejected due to lack of qualification but rather insufficient funds to meet existing demand. More resources are needed to address the barriers that exist and allow more individuals to benefit from the program, and as a result, increase the workforce so that the needs of children, youth, families, and others can be met.

Children & Youth Behavioral Health Work Group – Workforce/Rates Subcommittee
Recommendations Brief – Workforce Barriers
Recommended length: No more than 2 pages

Recommendation: Policy and potentially administrative
In order to address barriers to retaining and expanding the Behavioral Health workforce it is recommended that: 1. The RCWs are amended in order to allow for the inclusion of WA in the national Counseling Compact; and 2. Administrative burdens are reduced and/or eliminated.

1. **What is the issue?**
   Regarding the Compact, licensed mental health counselors who obtain licensure in another state must adhere to Washington's licensing requirements in order to practice. This can mean needing to take more credits or supervision hours - both of which are a setback for someone who has practiced for many years elsewhere but is moving into Washington. By joining the compact, licensed mental health counselors (LMHCs) who obtain licensure in an affiliated compact state will be able to begin working in Washington immediately. This will increase the number of licensed therapists in Washington and improve access to care through telemedicine. It also will unify licensing requirements within all counseling compact member states and will allow each state the ability to regulate themselves according to current standards.

   And with respect to administrative barriers, while Integrated Managed Care (IMC) has resulted in significant steps forward in terms of the integration of physical and behavioral health, it has also led to unanticipated complexities, specifically the extensive administrative burdens placed on Community Behavioral Health Agencies (CBHAs), that leave the system in a fragile position and must be addressed. CBHA staff have identified time consuming administrative tasks or regulatory requirements that do not add value for the service recipients as one of the primary reasons for leaving their job at a CBHA. The rise in administrative requirements is causing significant increases in costs of care and new requirements are being added continuously. Each small requirement added results in substantial work by the CBHAs and can mean that new processes have to be developed in order to meet requirements that are often uniquely interpreted and applied by each MCO or ASO.

2. **Recommendation details**
   In order to be compliant with the compact's requirements, the language in the RCW for licensure must specify 60 semester/90 quarter credits. All Master's in Counseling, Master's in School Counseling, and Master's in Counseling Psychology programs in Washington meet the 60/90 credit requirement so no additional schooling is required for those who graduate from any of these programs. Legislation
   must be passed to include Washington as a compact state.

   One of the administrative issues is the number of funding entities with which the CBHAs contract. They are likely to have 5 or 6 funding entities and may also be funded by counties, state block grants, Accountable Communities of Health and more. Each of these is required to ensure regulatory compliance as well as service quality, member satisfaction, and other measures. Each entity presents a substantial quantity of unique administrative tasks and requirements and each designs their own methodology or framework, requiring that CBHAs complete each report, record review, etc., 5-8 or more different ways. Additionally, many CBHAs are accredited by one or more national accrediting bodies, all of which have different auditing processes that take considerable time and resources.

While the structure of IMC has many strengths, it is resulting in: constant audits/reviews, extensive and time-consuming contract negotiations, revenue cycle complexities, delayed contract negotiations for a needed rate increase, cost increases due to adding multiple FTEs to meet the requirements of multiple entities, decreased retention of clinical staff due to administrative burdens that must be passed on to them, decreased retention of administrative staff, and most importantly, delayed access to care.

3. **Given current circumstances, why is taking the recommended action a smart move now?**
The legislature has repeatedly stated that there is a workforce shortage for Licensed Mental Health Counselors. By joining the compact, we will increase our numbers as and also be able to offer Telehealth to residents who move out of state. This is not a single solution to fix access to care, but it is a step that will help many people, especially military families who have a LMHC in their household. With the high demand for more LMHC's, we hope this will increase the number of people who can work in Washington. Washingtonians could utilize telemedicine to access counselors in their compact states as well.

   Addressing administrative barriers will also result in fewer behavioral health professionals leaving their positions within a CBHA. Tough decisions have to be made and while a cap on the number of audits alone will be unlikely to result in significant change, decreasing the number of MCOs awarded Medicaid contracts might. It is critical to continue exploring meaningful changes that will impact the workforce. This will transpire throughout the remainder of the interim and beyond with the expectation that barriers that can be addressed administratively are considered and whenever possible, implemented, and that strategies that require legislation can be advanced in the 2023 session.

4. **Describe any outreach that helped to develop this recommendation.**
The WA Mental Health Counselors Association (WMHCA) has been actively working with the Department of Health, American Mental Health Counselor Association, the Department of Defense, and other stakeholders to vet and develop the recommendation. The Association has thoroughly researched other states that are on the path to joining this compact and we are continuing to follow any setbacks or successes they have incurred so that we can be prepared as we bring this to the legislature.

   It is important to note that the Compact has reached the threshold to become operational- 17 states currently signed on in 2021 & 2022 and a compact commission is in process of forming. By passing these bills, Washington will have the opportunity to join early and therefore will be at the table while decisions are being made.

   Regarding administrative barriers, a number of providers have identified compounding requirements that are clearly leading to increased turnover among clinical and administrative staff (e.g., monthly audit prep, extensive reporting requirements, constant contract amendments, revenue-cycle complexities, etc.). The legislature addressed issues recently by mandating a meaningful update of the BH WAC chapter for the purpose of reducing or eliminating any WAC-requirement that does not add value for those we serve. This six-month process was extremely successful in decreasing regulatory requirements in WAC. This legislative mandate was effective! Unfortunately, multiple administrative requirements have emerged throughout IMC implementation that continue to compound, directly related to the number of entities (MCOs, ASOs, etc.) with whom CBHAs contract. It is agreed by many inside and outside of the CBHA system that other strategies need to be

advanced. Therefore, focusing on barriers such as limiting the number of MCOs and resulting audits is essential.

Children & Youth Behavioral Health Work Group – Workforce/Rates Subcommittee
Recommendations Brief – LEGACY -- CCBHC
Recommended length: No more than 2 pages

Recommendation: Provide continuation funding for planning and development of Certified Community Behavioral Health Clinics -- Budget

Build on foundational work from FY2022 to develop a sustainable, prospective payment system for comprehensive community behavioral health services by refining the Certified Community Behavioral Health Clinic (CCBHC) model, pursuing federal demonstration state status, conducting related actuarial analysis, obtaining continued technical assistance from the National Council for Mental Wellbeing, and proposing a pathway for statewide implementation of CCHBCs.

1. What is the issue?

   Low Medicaid rates paid to BHAs are directly tied to low wages and the current workforce drain. Many BHAs are struggling to remain viable. Medicaid rate increases and/or provider relief funds can help stem the tide; however, these have been piecemeal, short-term approaches, and a longer term, transformational solution is needed. The CCBHC model would accomplish this by bringing consistency in program standards and accountability for quality metrics while establishing a payment model that is tied to actual costs of providing care.

2. Recommendation details

   Community behavioral health agencies (BHAs) are essential safety net providers for children, youth, and families experiencing mental health and/or substance use disorders. Chronically low Medicaid rates leave BHAs unable to offer competitive salaries and compensation to their employees. This historical baseline has been exacerbated by a growing national behavioral health workforce shortage and simultaneous loss of workers due to pandemic-related concerns (e.g., no childcare, family illness). Competition for behavioral health workers is extreme and accelerating, and the compensation gap is growing.

   It is critical to ensure focus on integration and care coordination with primary/pediatric care to support whole person care for children, youth, and families in the setting of their choice. [Note: For behavioral health agencies (BHA) this would include linked referrals to primary care, care coordination, co-location of staff and/or primary care screening on-site at the BHA, all of which would advance integrated care.]

3. Given current circumstances, why is taking the recommended action a smart move now?

   Continued work on this is essential in order to be positioned to obtain federal demonstration state status, conduct related actuarial analysis, obtain continued technical assistance from the National Council for Mental Wellbeing, and propose a pathway for statewide implementation of CCHBCs. The State of WA has been taking the necessary steps with respect to CCBHC work and needs X to continue the work.

4. Describe any outreach that helped to develop this recommendation.

   This is a legacy item as it was a priority for the CYBHWG in 2022 and had been developed in partnership with CHBAs, national experts, the Workforce/Rates subcommittee, and others.

Children & Youth Behavioral Health Work Group – Workforce/Rates Subcommittee
Recommendations Brief – Teaching Clinic Enhancement Rate
Recommended length: No more than 2 pages

Recommendation: Allocate funds for a .5 FTE at the HCA to participate in a public/private partnership to implement the behavioral health teaching clinic demonstration project led by the WA council for Behavioral Health -- Budget

1. What is the issue?

Community Behavioral Health Agencies (CBHAs) serve a vulnerable population of people living with serious mental illness, serious emotional disturbance, and/or substance use disorder. Children and youth served by CBHAs struggle with substantial behavioral health needs frequently complicated by issues related to poverty such as housing instability, food insecurity, transportation needs, insecure or underpaid employment of a parent, etc.

In addition to clinical care and care coordination, CHBAs often serve as the training ground for the entire behavioral health workforce by providing the clinical supervision needed for new graduates to obtain licensure. Once licensed, clinicians leave for private practice, or better paying positions with hospitals or managed care organizations. We should recognize that this churn happens and support the infrastructure of the community behavioral health system. A teaching clinic designation would be one way to recognize that, much like a teaching hospital, these BHAs are training the broader behavioral health workforce in cutting-edge treatments, including crisis interventions, wraparound care, and other evidence-based practice treatment modalities.

There is a significant cost related to supervising interns and new graduates, as it takes clinicians away from providing billable direct services to patients. The 2021 Legislature charged the Health Care Authority (HCA) with convening a workgroup to develop a recommended teaching clinic enhancement rate to help compensate BHAs for these training and supervision costs. The final report of this workgroup, including actuarial analysis from Mercer, is expected by the end of 2022. Simultaneously, the Washington Council for Behavioral Health (Council) received a $1.1 million grant from the Ballmer Group to launch a demonstration project to collect data and demonstrate the value of a teaching clinic designation for BHAs in Washington. The Council has identified six (6) volunteer BHAs who will serve as demonstration sites over the next two years, providing data and feedback necessary to validate and/or adjust the proposed rate developed by HCA and Mercer as needed, to ensure it covers the true cost of the BHAs training and supervising students and those seeking their certification or licensure.

2. Recommendation details

In order to build upon the efforts of the legislative workgroup and maximize the opportunity for public/private partnership, it is imperative for HCA to remain involved and engaged with the demonstration project as it progresses. Pending the results of the demonstration, advocacy will be needed to successfully implement the teaching clinic enhancement as a statewide, scalable model; HCA will be an important partner in this work. Funding for a 0.5 FTE at HCA will enable the agency to remain engaged with the demonstration without hampering or detracting from its many other endeavors and responsibilities to the state's behavioral health system.
This rate enhancement concept has worked well for teaching hospitals, and in fact, it was proposed for the UW Behavioral Health teaching facility that will serve patients on 90–180-day civil commitment

orders. A group that came together to work on this issue proposed that the teaching facility should receive a 15% enhancement in the base rate for the facility in order to compensate it for the additional costs associated with teaching and training a workforce.

3. Given current circumstances, why is taking the recommended action a smart move now?
   The work has gotten underway, the Ballmer Group is funding demonstration sites, and it appears that we are close to having a clear sense of what it takes to supervise students and/or individuals getting their degree or working on obtaining the necessary hours to get their license. Not continuing would make it very difficult to identify the rate necessary to maintain an adequate pool of sites that are positioned to help individuals get what they need to graduate and/or obtain their license/credential.

4. Describe any outreach that helped to develop this recommendation.
   The recommendation was first developed and advanced in 2021. As highlighted above, significant efforts and state investment have already been invested in the teaching clinic rate enhancement concept; this recommendation is the logical next step in advancing this work. The legislative workgroup included key partners such as the Department of Health, Workforce Training & Education Coordinating Board, the Council, and stakeholders from community-based settings. Additionally, the demonstration project request for interest yielded responses from nearly double the number of available demonstration sites, underscoring the commitment to, and support for, the concept in practice settings.

Children & Youth Behavioral Health Work Group – [Workforce and Rates]
Recommendations Brief – Scaling up culturally affirming mental health care for children and families (10-11-22)
Recommended length: No more than 2 pages

Recommendation:
The workgroup requests funds (budget request) to continue support the next phase (two years) of the CARE project (culturally affirming mental health care for children and families) ($800,000).

1. **What is the issue?**
   The CARE project is statewide, collective impact initiative that is engaging multisector, diverse groups to re-envision specialty mental health care for children, youth, and families in Washington State. The focus on culturally-responsive, evidence-informed care came from a multi-sector policy planning effort in the summer of 2021 to identify a high priority need in Washington State not already being addressed by other initiatives. Families of color in Washington State, particularly Black and Native American families, experience higher rates of interpersonal trauma and violence exposure yet are less likely to engage in mental health care. The lack of effective, strengths-based care contributes to expensive and harmful downstream practices. For example, Black youth in Washington State are nearly 4 times as likely to be charged as adults and detained in adult prisons (Minority and Justice Commission Annual Report, 2018). The Washington State public mental health system is struggling to meet mental health needs and policy approaches will need to employ multiple tools to address current gaps. The CARE project is important to sustain as the only state initiative focusing on both culturally affirming care and increasing the available workforce to meet mental health demand.

2. **Recommendation details**
   The CARE project is currently in a development phase, bringing together diverse communities and sectors to collaboratively develop a three-pronged effort to 1. Expand a culturally diverse, child mental health workforce; 2. Train licensed child mental health providers in culturally affirming care; 3. Support specialty child mental health leaders to lead organizational change efforts to support these workforce shifts. The effort is being designed for sustainability and scale with regional and funder partners (Accountable Communities of Health, Managed Care Organizations) while being co-led by BIPOC organizations and families/youth with lived experience of the mental health system.

   The approach being used to develop the materials and implementation strategy draws from coproduction and codesign principles. Rather than approaching the issue with an expert mindset (typically led by academic centers), the approach facilitates shared learning and the integration of multiple types of expertise drawn from lived experience, community knowledge, service delivery expertise, and the relevant research evidence-base. The project is currently integrating information from a community sounding board of diverse, Washington State residents, systematic reviews of the research evidence literature on culturally responsive workforce development models, and advisory input from multiple sectors (lived experience, payers, service delivery providers, culturally-specific advocacy, and mental health organizations, see below for a list of partners).

By June 2023, the CARE project will have designed a suite of clinical training tools for 1. Community health workers; 2. Specialist mental health providers; 3. Community mental health agency leaders. The project is seeking funds to support a central training hub and regional trainers to begin roll out in ACH regions (Better Health Together, North Sound ACH, Greater Columbia, ACH, King County ACH) in 2023-2024. The initiative will continue to seek private and industry investments to sustain training and support efforts.

3. **Given current circumstances, why is taking the recommended action a smart move now?**
Washington State is facing two significant child mental health crises, rising rates of child and youth mental health need and crisis services use, and a lack of culturally affirming mental health care leading to poor access and engagement among BIPOC families when services are available. CARE is the only initiative focused on both crises, increasing the mental health workforce through expanded job pathways with supporting transformations in the existing child mental health workforce to adopt culturally aware practices.

4. **Describe any outreach that helped to develop this recommendation.**
The CARE project is being co-led by the following codesign and advisory partners:

Codesign team: BIPOC caregivers (2); BIPOC youth (1); White caregiver (1); Public health partners (2); Child mental health county administrator (1); Community-led child mental health nonprofit (Native American; East African; 2); Research experts on culturally-affirming models of child mental health care (focus on Latinx and cultural responsivity, broadly, 2).

Advisory team: University of California, San Diego; New Americans Alliance for Policy and Research; Allies in Healthier Systems for Health and Abundance in Youth (AHSHAY); Washington State Health Care Authority; University of Central Florida; Deconstructing the Mental Health System; Molina Healthcare; Asian Counseling and Referral Service; Community Health Plan of Washington; Partners for Our Children; Behavioral Health Institute; Washington Youth spark Program; Seattle Children's; Washington State Department of Health.

Project Amplifiers: Youthnet; Technology Access Foundation; Deconstructing the Mental Health System; Washington State University; Molina Healthcare; Renton Technical College; Solid Ground; Families of Color Seattle; MENTOR Washington; Jefferson Healthcare; Compass Health; Health and Justice Recovery Alliance; Washington State Health Care Authority; Yakama Nation; Ryther; Commission on Hispanic Affiars.

Behavioral Health Integration
2023 Recommendations

Behavioral Health Integration Subgroup:

2023 Recommendations to the Children & Youth Behavioral Health Work Group

Recommendation #1 (pages 1-4): Direct the HCA to adopt Medicaid billing codes that would reimburse primary care clinics for care coordination activities on behalf of children and teens with behavioral health problems. Fiscal estimate TBD.

Recommendation #2 (pages 4-7)**:** Support the Partnership Access Line (PAL) and Washington's Mental Health Referral Service for Children and Teens (aka Referral Assist) to continue and expand its services in support of primary care clinics across the state to address the behavioral health needs of pediatric patients more effectively. $1,720,000

Recommendation #1: Financing Care Coordination for Kids' Behavioral Health

1. What is the issue?

Primary care is the logical point of entry for families whose children or teens have complex medical needs, especially behavioral health (BH) problems. Currently, BH issues are the main concern at about half of pediatric primary care visits in our state. Some BH needs can be addressed entirely within a primary care practice, particularly if there is an integrated BH provider in the clinic. However, most clinics do not currently have integrated BH professionals and need to refer children out to other agencies. Further, many children and teens also need to receive care in other systems, such as schools, from specialty BH providers, or even in hospital emergency rooms or intensive outpatient or inpatient programs. Kids and families often need support while waiting for appropriate services to be available, which, given the current workforce shortage, can take many months.

Often, the task of coordinating care across settings to ensure that that there is an effective plan of care and providing support to families awaiting services falls on primary care providers. Even in more serious cases, there is typically no care coordination available from hospitals or BH clinics following discharge from inpatient care to ensure that appropriate and timely follow-up care occurs. Care coordination at the primary care level has been well documented to improve outcomes; it can help normalize the need for services and ensure that there is regular support and oversight for children, teens, and their families. Without a coordinated plan of care, services are fragmented, with gaps that can result in adverse outcomes.

Care coordination has been defined in policy set by the American Academy of Pediatrics as

> *[A] patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes*.[1]

[1] Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems, *Pediatrics,* 133:5, May, 2014

Recent data shows that approximately 30% of children in the US have a chronic medical condition, ~ 19% are categorized as children with special health care needs (CSHCN) and ~ 1-5% are categorized as children with medical complexity. Children from minority communities and those on public insurance, are overrepresented in all of these categories. Circumstances such as the presence of other children in the home who also require care, the demands of employment, and economic insecurity, make it especially difficult for parents living at low incomes to obtain coordinated, timely and effective care for their children in the absence of professional care coordination.

Unfortunately, in Washington there is very limited to no compensation for the provision of care coordination. Often, these services do not involve face-to-face encounters that generate fees but do require spending time on communication with other providers, social service agencies, and schools, record gathering, drawing up plans of care, and other related activities. Medicaid allows for these services to be billed, with federally matched funds, but Washington has not adopted the applicable billing codes.

Care Coordination for Children & Teens with Mental Health Conditions

Children with mental health conditions have substantial need and unmet need for care coordination. Provision of care coordination is inequitable. Unmet need is more likely for families with children with anxiety disorder and lower income, and less likely for those who report social support and family-centered care.

In a study of 7,500 children with mental health conditions, representing an estimated 5,750,000 children, the need for care coordination was 43%. 41% of families in this group who merited care coordination did not receive the help they needed. Families who had a child with an anxiety disorder, parenting stress, lower income, and or public or no insurance were more likely to have unmet needs.

P*ediatrics 2014;133:530–e537*

2. Recommendation details

The BH Integration Subgroup recommends that legislation be enacted that directs the Health Care Authority to adopt the following codes covering care coordination activities for children and youth with BH conditions. The BH Integration Subgroup also recommends that funding be appropriated to cover the cost of reimbursement at the same level as care coordination reimbursement under Medicare in line with our state's demonstrated commitment to adequate Medicaid reimbursement for pediatric care.

It is of critical importance that care coordination be appropriately resourced so that clinics 1) can proactively identify the populations that will most benefit from the service 2) have financial support for a team member to coordinate care, and 3) can provide services that are family-centered and appropriate to families' strengths, culture and identified goals.

Behavioral Health Integration

Behavioral Health Integration Services (cms.gov)

99484 - Providers use CPT code 99484 to bill monthly services delivered using BH Integration models of care, other than CoCM [Collaborative Care programs that meet strict federal requirements], that also include service elements such as systematic assessment and monitoring, care plan revision for patients whose condition isn't improving adequately, and a

continuous relationship with an appointed care team member. CPT code 99484 may also be used to report models of care that do not involve a psychiatric consultant, or an appointed BH care manager (although these personnel may deliver General BH Integration services).

Transition Care Management

Transitional Care Management Services (cms.gov)

Transition care management (TCM) are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making (MDM) during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or skilled nursing (FS)/nursing (FS) to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences on the date of discharge and continues for the next 29 days and requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. (Not for patients discharged from the emergency department)

99495 - Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision-making (MDM) of at least moderate complexity during the service period; Face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision-making of high complexity during the service period; face-to-face visit, within 7 calendar days of discharge.

3. Given current circumstances, why this action is a smart move now

As we transition to more care integration, and ultimately toward Primary Care Transformation, primary care is being tasked with an increasing role in coordinating care for children and youth, but without the funds to cover the cost of doing so. Primary care cannot fulfill these much-needed functions for children and youth without funding for these services. Given the importance of care coordination to good BH outcomes and, indeed, to the success of primary care transformation, implementing compensation now will speed up the process of adopting this model. Adopting these codes now will also provide important information about the amount of care coordination needed in the pediatric population to inform future VBP amounts.

As the acuity and breadth of children and teens' BH needs have increased precipitously over the past two+ years, care coordination is an important resource to prevent inpatient hospital readmissions for psychiatric reasons, which are the number one reason for hospital readmissions at children's hospitals nationwide. We appreciate the robust requirements of the Transitional Care Management codes to drive rapid primary care outreach to patients and to ensure prompt patient engagement in outpatient care after an inpatient hospitalization. In our experience, such prompt, reliable engagement is not currently provided to kids from other care settings (hospitals or community BH providers.)

Care coordination is also a critical resource for children and teens whose symptoms are not improving in outpatient settings, for whom further attention is needed for an effective treatment plan. In both cases, the application of care coordination can prevent symptoms worsening and the need for more costly care.

4. Outreach that helped to develop this recommendation

Our Subgroup includes a broad spectrum of providers, MCO representatives, research and policy organizations, and other stakeholders who have been actively engaged in the process of arriving at the Subgroup's recommendations. We held six meetings May through September, 2022 and considered five potential interventions to advance BH integration for children and youth. After learning about these potential approaches to advance BH integration for kids, we conducted a survey of our members, in which 27 votes were received, and reimbursement for care coordination was voted our #1 priority.

Recommendation #2: Support the Partnership Access Line (PAL) and Washington's Mental Health Referral Service for Children and Teens (aka Referral Assist) to advance BH Integration

1. What is the issue?

Children and teens in this state are experiencing mental health challenges at crisis levels and families are increasingly reaching out for professional help to address these challenges. Primary care is the place of first resort to find needed services, yet primary care providers and clinics have typically not been trained in or compensated for providing behavioral health (BH) services. The state is moving rapidly toward making effective BH care or referral assistance more available in primary care, including with recent funding for Behavioral Health Integration in 10 clinics statewide and in its work on Primary Care Transformation. However, primary care clinics need support to provide those services, including training in brief, evidence-based therapies, referral assistance for kids and families to appropriate specialty care, and psychiatric consultations for more complex cases, and for kids who are not responding to treatment.

For over ten years, the State has provided funding for the Partnership Access Line /Referral Assist (PAL) program run by Seattle Children's Hospital to support primary care providers across the state who are doing their best to treat children with BH problems. With the explosion of need and the significant ramping-up of BH services in primary care, PAL does not have the resources to provide the support those clinics will need; indeed, it is stretched to the limit now. This recommendation seeks State funding to ensure that PAL is ready to meet the needs of the additional providers who will be integrating some form of BH services or assistance in their clinics.

2. Recommendation Details

a. FAST (First Approach Skills Training)

FAST is a set of training programs and materials developed by child psychologists at Seattle Children's and the PAL team, providing instruction in evidence-supported care within a very limited number of sessions (ex 4-6). Brief interventions for certain common conditions is typical of care that can be effectively delivered within a primary care based mental health system. Modules developed include addressing anxiety, depression, disruptive behavior problems, parenting teens, and post-traumatic stress. While FAST was developed for primary care-based therapists, any therapist delivering brief oriented interventions may benefit from the model. The current FAST program funding is expected to end June 2023.

https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/fast/

The effect of FAST has been shown to be significant for disruptive behaviors (Gonzalez E et al 2021). FAST interventions have been adopted and applied by HopeSparks in four Pediatrics Northwest clinics in Pierce and King Counties. An evaluation of 261 kids supported with FAST

in 2020-2021 in this integrated program found significant reductions in anxiety and depression and improvement in general psychological functioning, as measured by validated instruments. Given the efficacy of FAST, the need for "through-put" to make care available to as many children and teens as possible in all settings, and that primary care clinics are treating the BH needs of kids at unprecedented levels, we are requesting that FAST training be funded at expanded levels.

Proposal:

1. Televideo case-based trainings to continue beyond June 2023 to be offered for all state primary care-based therapists and, potentially, for primary care providers
2. Initiate televideo case-based trainings for interested mental health center-based therapists to learn the FAST model
3. Develop new materials and improve FAST materials for language access and cultural sensitivity.
4. Add post-doctoral student support on data and analysis

Budget: $355,000 year one, $370,000 year two

b. Referral Assist Service

The Health Care Authority and Seattle Children's collaboratively operate Washington's Mental Health Referral Service for Children and Teens, whose goal is to connect parents with an available therapist or two matching their insurance, location, and child's therapeutic needs. The service's workforce has been increased each year to address year over year increases in parent requests for assistance. Family requests for assistance during July through December 2021 increased by 21% over the year prior, and for January through June 2022 increased by 57% over the year prior. The program provided referrals for over 3500 families in the preceding year.

The search for available providers is unfortunately not getting easier and is a process which continues to take large amounts of time. Last winter, before the new staff could be brought on board, parents would have to routinely wait for more than a month to receive their referral services. Referral service staff size is now adequate to address a repeat of last year's service volumes, but the service's response times for families will again become significantly delayed should request volumes increase significantly over last year's volumes, which seems likely given continuing increases in demand and the increasing focus on BH needs in primary care.

Proposal:

Add more referral service staff to minimize any wait times families experience for initiating their referral assistance help.

Budget--- $270,000 year one, $270,000 year two

c. PAL offering psychiatry support for Collaborative Care

The Health Care Authority will be selecting ten primary care clinics to receive $200,000 to build BH integration for children and teens. The clinics will spend the next two years developing and training their multidisciplinary teams and establishing reliable office workflows and systems.

One key challenge for these primary care practices is to obtain a reliable child psychiatrist consultant to provide regular oversight and support to the clinics' behavioral health professionals. Child psychiatrists statewide are well recognized to be in very short supply, and the ability to coordinate their engagement into burgeoning collaborative care systems is a challenge to "add in" to their already long list of practice time requests.

To help facilitate the growth of BH integration in primary care practices, the relatively deeper bench of child psychiatrists at Seattle Children's and the PAL team would offer a coordinated system of assuring that HCA grantees can access a core level of support to their new systems. Providing each of these clinics with access to a child psychiatrist for an hour a week will allow them to refine and modify care for more challenging cases and receive both specific case and general caseload management support. This resource will significantly help grant recipients in their ability to ensure that each patient gets the right care and to build sustainable programs.

Proposal:

Seattle Children's PAL group would offer one hour a week of child psychiatrist time to each of the clinics receiving these grants for the next 2 years. That provider would also spend time before and after each clinic scheduled time communicating/documenting, and there would be administrative time to support this work.

Budget----- $225,000 year one, $230,000 year two

3. Given current circumstances, why is this recommended action a smart move now?

As explained above, an investment is needed at this time of expansion of primary care to ensure that clinics can be successful in meeting the BH needs of our children and youth. Medicaid and HCA are distributing grants and developing alternative payment models to encourage primary care clinics to serve as medical homes for children and families and to take responsibility for seeing that both their physical and BH care needs are met. Yet most clinics are not currently equipped to reliably identify and effectively treat BH conditions. Whatever model an individual clinic chooses to follow, whether fully integrating with a BH professional on site or screening kids and referring out those who need treatment to specialty BH care, they will need the support that PAL and Referral Assist can offer.

5. Outreach that helped to develop this recommendation

Our Subgroup includes a broad spectrum of providers, MCO representatives, research and policy organizations, and other stakeholders who have been actively engaged in the process of arriving at the Subgroups recommendations. We held six meetings May through September 2022 and considered five potential interventions to advance BH integration for children and youth. After

learning about these potential approaches to advance BH integration for kids, we conducted a survey of our members, in which 27 votes were cast, and investment in PAL/Referral Assist was voted the second highest priority of the Subgroup. In addition, Subgroup leads reached out to programs who have integrated or are working to do so in regions across the state and learned that there is broad interest in increasing the availability of and their access to the services PAL offers.

Prenatal to Age Five Relational Health
2023 Recommendations

Children & Youth Behavioral Health Work Group – [Prenatal through 5 Relational Health Subgroup]
Recommendations Brief – Child Care and ECEAP Complex Needs Funds (10-11-22)

Recommendation - Budget Request: Strengthen funding for the Child Care and ECEAP complex needs funds so that children ages 0-5 can experience fewer disruptions in early learning programs and providers can access crucial resources in responding to an overwhelming demand for behavioral health supports. $31.08M total for the 2023-2025 biennium. This includes:

- ECEAP Complex Needs Fund – Invest an additional $11.08M over the 2023-2025 biennium ($4.806M in SFY24; $6.278M in SFY25).
- Child Care Complex Needs Fund – Invest an additional $20M over the 2023-2035 biennium ($10M in SFY24; $10M in SFY25)

1. **What is the issue?**
   Early learning providers across Washington State report significant and increased need for support to care for children who have complex needs, particularly in response to the COVID-19 pandemic. Washington's two existing Complex Needs Funds (CNFs), including the Child Care CNF and the Early Childhood Education and Assistance Program (ECEAP) CNF, provide vital state funding to support children with developmental delays, differing abilities, or behaviors adults find challenging. Early learning providers have submitted far more requests for CNF supports than the available funding. Our state has an opportunity to support children, families, providers, and early learning programs in expanding and securing critical program-level supports as our communities continue to grapple with the impacts of the pandemic.
2. **Recommendation details**
   Strengthen funding for the Child Care and ECEAP CNFs to $31.08M total for the 2023-2025 biennium. This includes:
   - ECEAP Complex Needs Fund – Invest an additional $11.08M over the 2023-2025 biennium ($4.806M in SFY24; $6.278M in SFY25).
   - Child Care Complex Needs Fund – Invest an additional $20M over the 2023-2035 biennium ($10M in SFY24; $10M in SFY25)

ECEAP Complex Needs Fund

The Department of Children Youth and Families (DCYF) **ECEAP CNF** provides vital state funding to support children in ECEAP and Early ECEAP with developmental delays, differing abilities, behaviors adults find challenging due to complex trauma. **Due to limited funding, DCYF was only able to provide for approximately 55% of the funds requested by ECEAP programs, leaving many unmet needs.**

In its most recent round for the 2022-2023 funding year:

- ECEAP CNF had $4.6M available for grants; however,
- DCYF received 43 applications that totaled $8.3M requests to serve 8,315 children for FY23.

ECEAP provides crucial and cost-saving early intervention support for some of the most vulnerable children in our state. ECEAP Complex Needs Funds:

- Are to be used for children currently enrolled in ECEAP
- Aim to support developmental and learning gaps for children who would otherwise start kindergarten behind and continue to fall behind in later school years
- Can be applied to children who do not have an individualized learning plan (IEP)
- May be accessed for children currently receiving services through a Developmental Preschool Program if the identified support is beyond the child's current individualized education goals

With the cumulative impacts of more than two years of the COVID-19 pandemic, children, families, and ECEAP and childcare providers urgently need more support. To address this overwhelming demand, DCYF requests $11.08M in the 2023-25 Biennium to support the ECEAP Complex Needs Fund and the P5RHS recommendation mirrors DCYF's request outlined in their decision package.

Child Care Complex Needs Fund

Modeled after the ECEAP CNF, the Child Care CNF supports children with developmental delays, disabilities, behavioral needs, or other unique needs in childcare settings while supporting providers' efforts to promote inclusion of children with special needs in the least restrictive environments. **Due to limited funding, DCYF was only able to provide for a little more than 5% of the funds requested for DCYF's Child Care CNF in its first round of funding.**

In its first grant cycle the Child Care CNF received:

- A biennial investment of $4.6M with $1.5M available for the first round of applications.
- DCYF received over 1,400 applications that totaled $86M in funding requests from eligible childcare providers.

The Child Care CNF addresses a much-needed resource for providers serving children with developmental delays, disabilities, behavioral needs, and other unique needs. DCYF is requesting in their decision package an additional $7,698,000 for FY24 and $7,698,000 for FY25, assuming $2,302,000 will be in maintenance each of these years. The P5RHS believes the need is even greater than this and is thus requesting a total of $20M ($10M for SFY24 and $10M in SFY25).

3. **Given current circumstances, why is taking the recommended action a smart move now?**
   While scientists are unable to predict all the impacts of the COVID-19 pandemic on future generations, experts agree that the pandemic has caused major physical, psychological, educational, developmental, behavioral, and social health consequences for young children. Early care and education (ECE) workers have also suffered job-related stressors that threaten the sustainability of the workforce. In a 2021 survey of ECE workers in Washington 57% of ECE workers reported moderate or high levels of stress.

   Washington must act quickly to expand the capacity of the ECEAP and Child Care CNFs to address the needs of our most vulnerable children and support our essential early childcare workers. A vibrant economy depends on the strength of a resourced childcare infrastructure that provides the high-quality care that families and children need.

4. **Describe any outreach that helped to develop this recommendation.**
   The P5RHS conducted intentional outreach with our members, including ECEAP and childcare providers, parents, and caregivers with lived experience with children with complex needs. This outreach included one-on-one discussions with parents and a formal presentation and discussion with members of Childcare Voice.

   One provider described a child whose unmet complex needs often led them to escalate into violent outbursts in the classroom. Through the ECEAP Complex Needs Fund, the provider was able to implement targeted interventions that resulted in significant improvements in the child's behavior and capacity for learning. All participants in our outreach overwhelmingly agreed on the need for expanded CNF investments.

Children & Youth Behavioral Health Work Group – *Prenatal-5 Relational Health Subgroup (P5RHS)*
Recommendations Brief – Infant Early Childhood Mental Health Consultation (IECMH-C) Expansion

Recommendation:

Budget Request: Increase investment in IECMH-C by $2 million annually (on-going) to address unmet need and increase equitable access to IECMH-C for WA's children, families, and adult caregivers in childcare. These funds would be used to (1) provide IECMH-C services by linguistically and culturally matched consultants; (2) attend to the wait list by offering "one to many" types of supports for childcare providers needing support; (3) expand capacity to provide individualized mental health consultation services to more providers, and (4) address on-going program needs to maintain quality and access to a variety of intensity of services. These funds will be used to hire 13 additional mental health consultants.

1. **What is the issue and how are children, families, providers, and communities Impacted?**
   More funding is needed to help children, families, and caregivers. Child Care Aware of WA (CCA of WA) currently employs and provides professional development and supervision for 15 Mental Health Consultants (MHCs) across the state. The MHC team is talented and diverse, with 9 of 15 consultants representing various communities of color and 9 fluent in languages other than English including Spanish, Somali, Swahili, Indonesian, and Vietnamese. There are currently 4,791 licensed childcare providers statewide with a licensed capacity of 146,944 children.[i] At current funding levels, this means that we have one MHC for every 319 licensed childcare providers or one MHC for every 9,800 children in care. MHC caseloads are currently full. With full caseloads, the team of MHCs should typically serve around 130-150 childcare programs at any given point in time, but our consultants currently have 176 open cases, exceeding the recommended caseload. They are able to provide quality services for now, but it is not sustainable. Most childcare sites served have multiple child/family concerns and classroom/programmatic needs which consultants are supporting in partnership with Early Achievers Coaches. We currently have 110 providers waiting for IECMH-C services, and referrals continue to come in.

Childcare providers report critical need for IECMH-C services. Per the 2022 survey of all licensed childcare providers statewide:[ii]

- 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 childcare providers report that they need social/emotional, behavioral, inclusion for special needs, or mental health supports.
- 67% of providers reported that they have seen an increase in social/emotional challenges with children.

High and disproportionate rates of suspension and expulsion impact Black and dual language learning students as well as students with disabilities. Black children's preschool expulsion rate is nearly two times as high as Latino and white children.[iii] 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.[iv] 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.[v]

IECMH-C addresses these concerns. 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.[vi] It is also an effective practice to interrupt bias and disproportionate expulsions and suspensions of young children of color in child care and early learning, providing more equitable opportunities for children to participate in high-quality child care and early learning experiences. IECMH-C leads to many positive results for children and families including, increased social-emotional skills and self-regulation, reduced challenging behavior, and reduced expulsion rates.[vii] For caregivers, it increases positive interactions with children and reduces stress and turnover among other positive results.[viii]

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

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

Unaddressed mental health challenges are costly. The 2020 annual cost of treating mental health disorders in the U.S. is $280 billion. "The mental health crisis facing Americans imposes significant costs to the well-being of affected individuals, their loved ones, and society as a whole. This crisis took hold long before the onset of the COVID-19 pandemic, but its effects were amplified as the pandemic resulted in the loss of lives and livelihoods and unprecedented social isolation."[ix] Ranked 46th of 50, Washington is one of the worst states in the nation for mental health care and has even fewer resources for specialized mental health care during pregnancy and postpartum.[x] Clearly, earlier investments in mental health supports for young children and families can reduce future health, educational, and criminal justice costs.

Investment in IECMH-C leads to reduced turnover rates of childcare providers. Replacing and retraining childcare providers is very costly for an already economically stressed childcare system.

Reopening and supporting the economy is closely tied to childcare and early learning services and the mental health of these providers impacts children. In early May 2020, 3,355 members of New York's early childhood workforce responded to a survey about the impacts of COVID-19.[xi] Ninety-one percent of respondents report their emotional well-being had been affected, of which 38 percent said it had been affected "greatly" or "a lot".[xii] The pandemic has caused substantial stress and anxiety for early learning providers. Their mental health impacts their engagement with children and families.

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

IECMH-C works. 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.[xiii] IECMH-C is also an effective practice to interrupt bias and disproportionate expulsions and suspensions of young children of color in child care/early learning, providing more equitable opportunities for children to participate in high-quality child care and early learning experiences.[xiv]

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

One-half of all lifetime cases of mental health disorders are estimated to start before age 14. Earlier investment in school based mental health programming including social emotional learning is a promising strategy for increasing early detection of mental health disorders and access to treatment. Strong social emotional skills in childhood are associated with positive academic and social and mental health outcomes.[xvi]

4. Given current circumstances, why is taking the recommended action a smart move now?

The pandemic has taken a toll on child, family, and caregiver well-being. Fourteen percent of parents report that their children had developed more serious mental health and behavioral challenges since the start of the pandemic.[xvii] During the pandemic, verbal, motor and social-emotional development for the youngest children has been negatively impacted by the following: the number of words spoken by parents to children was lower than in the past two years, restricted opportunities for physical play and interaction with peers, high parental stress, depression, anxiety, social isolation and reduction of personal and family interaction.[xviii] Additionally, rates of social-emotional and behavioral challenges were one to four times higher among racial and ethnic minorities.[xix]

5. Describe any outreach that helped to develop this recommendation.

The Prenatal through 5 Relational Health Subgroup conducted intentional outreach with our members, including ECEAP and childcare providers, parents, and caregivers with lived experience with children with complex and relational health needs. This outreach included one-on-one discussions with parents and a formal presentation and discussion with members of Childcare Voice.

[i] Child Care Aware of Washington (August 2022)
[ii] The Athena Group, CCA of WA 2022 Provider Survey
iii National Center of Early Childhood Wellness. Understanding and Eliminating Expulsion in Early Childhood Programs. https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/understanding-eliminating-expulsion-early-childhood-factsheet.pdf
iv 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. https://www2.ed.gov/about/offices/list/ocr/docs/2013-14-first-look.pdf
[v] 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
[vi] 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*). http://www.iecmhc.org/documents/CoE-Evidence-Synthesis
[vii] 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.*
[viii] Davis, A., Perry, D. & Tidus, K. (2020) Center of Excellence for Infant and Early Childhood Mental Health Consultation. *Annotated Bibliography: The Evidence Base for Infant and Early Childhood Mental Health Consultation (IECMHC*). http://www.iecmhc.org/documents/CoE-Evidence-Synthesis
[ix] White House Briefing Paper (May 31, 2022) Reducing the Economic Burden of Unmet Mental Health Needs https://www.whitehouse.gov/cea/written-materials/2022/05/31/reducing-the-economic-burden-of-unmet-mental-health-needs/#:~:text=The%20Federal%20Government%20covers%20some,from%20the%20U.S.%20Medicaid%20program.
[x] Adult Ranking 2020. Mental Health America. DOI: https://www.ncbi.nim.gov/pmc/articles/PMC8256336/#bib11.
[xi] Tarrant, K., and Nagasawa, M. (June 18, 2020). *New York Early Care and Education Survey: Understanding the Impact of COVID-19 on New York Early Childhood System.* https://earlychildhoodny.org/research/docs/NY%20ECE%20Workforce%20COVID%20Survey%20Full%20Report.pdf
[xii] Nagasawa, M., and Tarrant, K. (September 7-15, 2020). *Who Will Care for the Early Care and Education Workforce? COVID-19 and the Need to Support Early Childhood Educators' Emotional Well=being.* https://educate.bankstreet.edu/cgi/viewcontent.cgi?article=1000&context=sc
[xiii] 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*). http://www.iecmhc.org/documents/CoE-Evidence-Synthesis
[xiv] 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.*
[xv] Adapted from ZERO TO THREE Infant Mental Health Task Force, 2001
[xvi] White House Briefing Paper (May 31,2022)
[xvii] Patrick, S. W., Henkhaus, L. E., Zickafoose, J. S., Lovell, 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.
[xviii] McGuire, Tona, WA Department of Health (2022). Update on Youth Behavioral Health During COVID.
[xix] 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/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mentalhealth-and-substance-use/.

Children & Youth Behavioral Health Work Group –*Prenatal through 5 Relational Health Subgroup* (P5RHS)
Recommendations Brief – Parent and Caregiver Awareness and Navigation Supports 10-11-2022

Recommendation: Budget recommendation for $200,000 (one-time).
Require the Health Care Authority (HCA) to direct an analysis about opportunities to improve family awareness and navigation supports for families in the perinatal stage and children through age five. This analysis will examine developmentally, culturally, and linguistically appropriate services for optimal development and infant and early childhood mental health. The analysis should focus specifically on the experiences of families of color and multilingual families, as well as supports provided by family/peer/community-run organizations.

1. **What is the issue?**
   There have been concerted efforts to expand equitable and culturally relevant understanding and practice of early childhood mental health and relationship-based supports in WA among systems and practitioners, but corollary efforts are needed to understand barriers and ensure that parents and caregivers can effectively understand, navigate, access, and participate in programs and services.
   Expanded parent and caregiver awareness of and access to developmentally appropriate assessment, diagnosis, and treatment of our youngest Washingtonians will improve child and family outcomes and address significant equity gaps in accessibility for families. Parents and caregivers are experts in their children and partners in improving child outcomes but have been offered limited resources to learn about the growing array of infant and early childhood mental health (IECMH) and relationship-based services, and how they benefit young children. This work is a complement to existing and future efforts to expand provider awareness and access to referral pipelines and will be primarily informed by the lived experience of parents and caregivers.
2. **Recommendation details**
   The Health Care Authority (HCA) should direct a comprehensive analysis of relationally based awareness and navigation supports that is directly informed by parents/caregivers with lived experience seeking support for medical issues, developmental delays, and/or mental health systems, along with research from and participation by "By and For" providers[1], HCA staff, policy makers, and other relevant parties. This analysis will be used to develop trainings and education resources that center the empowerment of parents and caregivers and potentially inform practices with existing services.

The analysis should be grounded in anti-racist practices and include the following components:

1. **Landscape Analysis**
   a. This component will identify existing relationship-based referral and education/awareness services the continuum of developmentally appropriate supports. In addition, this research will examine the demographics of current users of these services. This work will build on existing efforts for capacity building and systems change, with an intention to leverage and strengthen existing services and assets that effectively support families. Examples of relationally based awareness and navigation supports include peer services, parent support groups, referral lines, case management services, mental health training, and more.
2. **Corresponding Gap Analysis**
   a. This component will analyze parent/caregiver **barriers to awareness** and knowledge of developmentally, culturally, and linguistically appropriate diagnosis, assessment, and treatment for families in the perinatal stage and children through age five in Washington

1 A "By and For" organization has a primary mission and history of supporting and providing services to BIPOC and unserved communities. They are culturally based and individuals from the population served direct and substantially control the organization.

state. This analysis should emphasize the experiences of families of color, multilingual families, and families receiving Medicaid and examine how families learn about and become aware of relevant services.

b. This component will analyze parent/caregiver **barriers to access** for parents in the perinatal stage and children through age five relational health interventions in Washington state, including the logistical, emotional and cultural barriers families experience in this process. This analysis will focus on the experiences of families who cannot, or prefer not to, access these services. Building upon the landscape analysis, the gap analysis will identify service gaps by relevant demographic factors. State agencies will be directed to make every effort to share available program user demographic information.

3. Best Practices Analysis

a. This component will analyze existing research (in Washington and nationally) regarding parent/caregiver beliefs and preferences regarding participation in diagnosis, assessment, and treatment for families in the perinatal stage and children through age five in Washington state, with an emphasis on the experiences of families of color, multilingual families, and families receiving Medicaid.

b. This component will assess promising practices for relationship-based information sharing, including access to developmentally appropriate and culturally relevant assessment, referral and treatment. This research will include an overview of effective practices for improving accessibility and referral pipelines for families in the perinatal stage and children through age five.

4. Next steps recommendations for Washington state

a. This analysis will result in a set of final recommendations for Washington state to explore in strengthening parent and caregiver awareness and access to early intervention services. These recommendations should be offered as a complement to existing efforts to strengthen provider awareness and referral pipelines for families in the perinatal stage and children through age five.

3. **Given current circumstances, why is taking the recommended action a smart move now?**

The COVID-19 pandemic has underscored the importance of culturally and linguistically responsive health education and the vital role that trusted messengers[2] play in engendering trust for developmental, behavioral, relational, and health interventions and supports. Due to a variety of factors, including systemic racism, past harm, or a lack of cultural or linguistic match between families and providers, parents and caregivers may not view their health care provider as a primary trusted source of information. As a result, health systems must adapt to identify effective relational strategies to strengthen and empower parent/caregiver awareness of and access to developmentally, culturally, and linguistically appropriate services for families in the perinatal stage through age five. These efforts will better equip parents and caregivers to identify challenges, seek care, and navigate services if a need or crisis arises[3].

4. **Describe any outreach that helped to develop this recommendation.**

This recommendation was directly raised by a parent with lived experience who serves as a member of the P5RHS. It is consistent with what at least three other parents with lived experience have raised in past years and what we hear from parents in our various one on one outreach efforts to learn from parents. Following the subcommittee review process, the recommendation was shared with all P5RHS

2 "Trusted messengers" are people deemed trustworthy, honest and credible

3 https://www.zerotothree.org/resource/the-fundamentals-of-infant-early-childhood-mental-health/

members, including direct engagement with a diverse set of parents with lived experience. The subgroup strongly supports this recommendation.

Student Behavioral Health and Suicide Prevention

2023 Recommendations

Children & Youth Behavioral Health Work Group – School-based Behavioral Health & Suicide Prevention Subcommittee

Recommendations Brief – Designating a Lead Agency (10-11-22)

Recommendation:

Policy & Budget Request: Designate a lead agency responsible for ensuring student access to the continuum of behavioral health and wellness services in school settings. In Year One, allocate funding for the designated lead agency to develop a work and project plan. In Year Two, include flexible funding to education service districts (ESDs) and school districts for development of comprehensive behavioral health services, support in becoming a licensed behavioral health provider, and/or to partner with community-based organizations (CBOs) and other licensed providers to provide access to behavioral health services to students.

1. What is the issue?

Behavioral health and wellness support for K-12 students in Washington are fragmented and uncoordinated. The Office of the WA State Auditor's 2021 Performance Audit on K-12 Student Behavioral Health in WA provided the basis for this recommendation[i]. Their report summarizes the issue as follows:

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

Subcommittee members support the recommendation to designate and fund a lead agency. Members emphasized that the state does not have a comprehensive, unified working plan for school-based behavioral health with corresponding organizational oversight. No state agency is accountable or responsible for ensuring, facilitating, or supporting student access to school-based behavioral health services. As a result, our youth are being left underserved in a critical time of their development.

Behavioral health prevention, intervention, and treatment services offered in the state are siloed. Students encounter barriers to access that need to be coordinated across billing and provision systems to increase access and sustain efforts (i.e., Medicaid, insurance, grants, and federal dollars). Members noted that the state lacks a dedicated financial infrastructure to support school-based behavioral health. Grants and time-bound funding are not a viable solution. Effective and equitable statewide coordination for student behavioral health services requires a behavioral health lead agency with resources, knowledge, and capacity to connect state, regional, and local stakeholders related to school-based services.

2. Recommendation details

Using language from the audit, funding should be allocated to the lead agency with requirements to establish and maintain an advisory council with representatives from across the school-base behavioral health continuum of care with responsibilities including:

- Establishing strategic direction and goals for programming around the full continuum of services funded under this legislation

- Developing outcome and performance measures and reporting them to the Legislature annually
- Providing guidance to school districts and service districts on how funds can be used.

ESDs and school districts are critical partners in addressing the needs of their students. Legislation should provide funding to ESDs and school districts to help them develop comprehensive behavioral health services, either directly in schools or through community partnerships. Legislation should also provide upfront funding to ESDs and school districts seeking to become Medicaid behavioral health providers.

3. Given current circumstances, why is taking the recommended action a smart move now?

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

The Subcommittee is hopeful that this recommendation will be prioritized given the Governor's directive to take action to address the behavioral health crisis so many children and youth are facing.

The audit provides further impetus for pursuing this recommendation now:

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

Behavioral Health Navigator Survey Data
Data from the 2019-21 Behavioral Health Navigator Survey further illustrates the lack of consistency of school-based behavioral health services offered across the state. 48% of districts surveyed said that all students in their school community do not have access to behavioral health services. Only 47% of districts indicated that they offer behavioral health services to students both directly and through partnerships with outside agencies; while 11% said they offer services through school staff only, 35% said they offer services through partnerships with outside agencies only and 7% of districts said they offer no behavioral health services at all.

Interview data also indicated that school districts use a wide variety of often inconsistent funding sources to fund behavioral health services for students. In total, districts surveyed cited 69 different funding sources. Within this patchwork funding environment, one district noted *"Only one (provider) will take private insurance. School does not provide funding. One agency provided services through a grant for all students under the age of 9, but they needed to pull those services."* Another said: *"It is really patch work funded, a little from here and little from over there. We scrape it together to try and just have something."*

4. Describe any outreach that helped to develop this recommendation.

The SBBHSP Subcommittee consists of 34 members including youth, family members, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations. The Subcommittee developed recommendations across five Zoom workshops. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. This recommendation is a combination of one recommendation to designate a lead agency and another to fund a lead agency, which members ranked first and fifth respectively.

ESD Behavioral Health Navigators collected the data reference above through interviews with school district staff from 2019-2021[ii]. 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.

The Subcommittee gathered community input from a Youth & Family Engagement Forum on October 4, 2022. Staff shared insights with members to supplement recommendation deliberations.

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

[ii] For more information about the Behavioral Health Navigator Program, visit OSPI's Youth Suicide Prevention, Intervention, and Postvention website at: https://www.k12.wa.us/student-success/health-safety/mental-social-behavioral-health/youth-suicide-prevention-intervention-postvention

Children & Youth Behavioral Health Work Group – School-based Behavioral Health & Suicide Prevention Subcommittee

Recommendations Brief – School-based Behavioral Health Workforce Support (10-11-22)

Recommendation:

Budget Request: To increase the service capacity for schools across the state to provide access to and promote positive outcomes for tier 2 and tier 3 mental health interventions for all students, the Subcommittee recommends: (1) providing funding to districts to expand the number of school- and community-based mental health practitioners; and (2) providing funding to expand the Partnership Access Line (PAL) in Schools pilot program statewide. Both these recommendations would specifically target rural and remote schools with unique workforce and mental health service access needs.

1. **What is the issue?**

   Students and school staff lack of access to behavioral health clinical expertise at the school building level across the state. Schools, and the communities they operate within, lack the staff capacity necessary to meet the tier 2 and 3 needs of students. When community providers are available to support students, schools have difficulty engaging community providers because of access, scheduling, and funding issues, making integrating services into the school system through the participation on school teams across the tiers difficult. At times, confidentiality can be a perceived barrier to accessing support from community mental health providers. Overall, the current behavioral health workforce is too small. As a result, school staff are too often asked to provide interventions and supports they are not trained to deliver. In some cases, the least trained staff are serving the most acute needs in students. Complex behavioral health issues need well-trained, licensed professionals to serve them. Many students and families do not have access to behavioral health providers that look like them, have similar backgrounds as them, and/or speak the same languages as they speak at home and many remote and tribal communities do not have equitable access to services that meet their behavioral health needs.

   Behavioral Health Navigator Survey Data

   Data from the 2019-21 Behavioral Health Navigator Survey further illustrates the shortage of behavioral health clinicians available to provide supports for K-12 students. 48% of districts surveyed said that all students in their school community do **not** have access to behavioral health services. The most frequently cited barriers to student access were: 1) school mental health support staffing shortages, 2) lack of staff qualified to meet the specific mental health support needs of students, and 3) lack of community mental health provider capacity.

   The Subcommittee heard from youth, parents, and staff at community health providers that emphasized the need for better access to mental health support staff for students in WA schools. Youth cited the lack of school-based mental health staff available to students, and long wait times for accessing community supports after a referral from a school staff member, as barriers to accessing mental health supports through their school. Youth wanted more mental health professionals present in the school community and more check ins those already there. Parents experienced long waiting lists for community-based services and emphasized the need for more resources available to students **in school**, with one noting that when a school based social worker was present, they were able to provide support that felt more helpful than a teen helpline to call. Staff at community health providers identified misalignment between professional expertise and student mental health needs as a significant barrier, explaining that school counselors, and other student support staff, are asked to do things outside of what they are trained to do. They cited long wait times for students referred for services at a community provider, an overall lack of community mental health providers, and a lack of mental health staff

available to serve students at schools, all within a context of heightened student need resulting from the COVID-19 pandemic and the stress associated with it.

The Partnership Access Line (PAL) for Schools is one program that exists in Washington designed to increase school capacity to meet tier 2 and 3 needs of students within an MTSS framework. PAL for Schools, through a 3-year proviso-funded pilot project, provided designated school personnel at secondary schools in two districts, Medical Lake and Sumner-Bonney Lake, with access to psychologists via telephone and televideo consultations. School staff received support in determining the services and supports needed for their students and in accessing this care if outside of the school system. Staff also received professional development trainings in school mental health topics.

2. Recommendation details

The legislature should establish a statewide grant targeted toward local education agencies (LEAs) with the least access to behavioral health services, with the goal of providing more equitable access to, and more equitable outcomes for, direct behavioral health services in schools, within an MTSS framework that is interconnected with child-serving organizations.

Allowable expenditures should include: 1) Building level staffing of school and community-employed mental health providers, 2) Funding for agreements and non-billable activities (e.g., attending team meetings across the tiers) with local behavioral health providers, and 3) telehealth services.

Funding to expand the PAL in Schools pilot program statewide should be done in accordance with following priority areas, as described by operating team of the pilot program:[i]

- Prioritize PALS in districts invested in implementing an MTSS for behavioral and mental health
- Expand staff consultations to include elementary schools
- Provide comprehensive onboarding and an overview of PALs processes to new districts
- Provide more school districts with access to PALS training and consultation supports
    - Trainings and consults offer a strategy for districts advanced tier supports within the WA MTSS Framework.
- Increase staffing for consultations allowing faster access to mental health professionals

3. Given current circumstances, why is taking the recommended action a smart move now?

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

This recommendation offers a path toward supporting access to school-based mental health services, without requiring that schools support expanded access by directly hiring additional school-based clinical staff. Increased access through coordination with a community-based provider or the procurement of telehealth supports may better meet the needs of some school communities across the state, particularly in rural communities or in communities where community providers offer more representative, culturally-embedded services.

Subcommittee members with students and staff in schools, emphasized the conflict and challenge many school administrators face because of ongoing, crisis-level mental health needs of students. Expanding the PAL in Schools program is an easy and efficient way to provide more students with supports.

4. Describe any outreach that helped to develop this recommendation.

The SBBHSP Subcommittee consists of 34 members including youth, family members, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations. The Subcommittee developed recommendations across five Zoom workshops. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here is combination of the workforce recommendations ranked second and third by members.

ESD Behavioral Health Navigators collected the data reference above through interviews with school district staff from 2019-2021[ii]. 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.

The Subcommittee gathered community input from a Youth & Family Engagement Forum on October 4, 2022. Staff shared insights with members to supplement recommendation deliberations. In addition, insights pertaining to mental health workforce in schools is included above.

[i] The PAL in School pilot program was a joint effort run by Seattle Children's Hospital and the University of Washington School Mental Health Assessment, Research, & (SMART) Training Center.

[ii] For more information about the Behavioral Health Navigator Program, visit OSPI's Youth Suicide Prevention, Intervention, and Postvention website at: https://www.k12.wa.us/student-success/health-safety/mental-social-behavioral-health/youth-suicide- prevention-intervention-postvention

Youth and Young Adult Continuum of Care

2023 Recommendations

Children & Youth Behavioral Health Work Group – Youth and Young Adult Continuum of Care Recommendations Brief –Respite Services for families of youth with behavioral health challenges
Recommended length: No more than 2 pages

Recommendation:
Continue to direct HCA to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the DDA and DCYF respite waivers and to continue to support and expand System of Care Respite Pilots

1. **What is the issue?**
   Behavioral Health respite continues to be a need within the structure of services for youth and families. Families and system providers continue to express a need for this type of care. The need for respite care for behavioral health challenges was elevated to the Statewide FYSPRT in 2017. Up to July 1st, 2012, respite services were provided through Medicaid as part of the 1915(b) waiver. When this waiver was terminated due to Legislative action and proposed budget cuts, funding for respite became dependent on other funding available in the regions. In 2017, only 1 region had behavioral health respite for youth ages 10-18 which was paid for regional tax dollars. In 2021, funding was provided through legislation to direct HCA to explore Medicaid waiver options for respite care for families of youth with behavioral health challenges without adversely impacting DDA and DCYF respite waivers. HCA had contracted with Mercer to compile information and also consulted with DDA and DCYF. Mercer explored how other states fund respite services through waivers and were to share their findings with HCA by June 30th, 2022. HCA will submit the report to the Legislature for review. Currently, the final report is not ready for review and there has not been an opportunity to explore options for this request.

2. Recommendation details To continue to fund the exploration of a Medicaid waiver option for youth with behavioral health options and support and expand the System of Care Respite Pilots

3. **Given current circumstances, why is taking the recommended action a smart move now?**
   Respite care for behavioral health continues to be a need expressed by families, youth and providers throughout the state. The information needed to make decisions regarding next steps has not been finalized. There is additional time needed to explore the options for respite care.
   Also, families within Washington state are struggling and need respite to lighten the load on other systems such as emergency departments, the crisis system, and other higher levels of care and to provide breaks from potentially volatile situations, practice skills in safe environments, improve family functioning, avoid family conflict, stabilize the household, and support safety.

4. **Describe any outreach that helped to develop this recommendation.**
   There was an initial review of the Mercer report, but it is still needing to go through additional steps before finalized. In addition, HCA was able to utilize System of Care grants to fund 2 respite pilot programs in Spokane and Seattle. They were intended to meet the needs of the gaps in the continuum of care and to improve crisis response. Both were funded starting in June 2021 through September 2022. The pilots were community based, structured day respite, facilitated over-night planned and had a warm line.

Children & Youth Behavioral Health Work Group – Youth and Young Adult Continuum of Care Recommendations Brief – Expand access to parent and youth peer services
Recommended length: No more than 2 pages

Recommendation:

Expand access to peer services for parents/caregivers and youth/young adults accessing behavioral health services by funding the COPE (Center of Parent Excellence) project to sustain the program and add additional staff, add additional opportunities for the Certified Peer Training and testing specifically for youth and families.

1. **What is the issue?**

Families and young people are currently struggling to access support as they navigate the Behavioral Health System. Peer support is an under-utilized service in the state of Washington. While there are parent and youth peers in some settings, there is an opportunity to increase peer support. The current landscape of the Behavioral Health workforce is not adequate and increased Peer Services can help bridge the gap. Peers can help families and youth navigate systems, support recovery, help work towards increased meaning and purpose, promote personal responsibility, develop supportive relationships, build community connections, and self-advocate. Most Peer Services are a Medicaid service and there is an opportunity and need to support agencies that are providing support that is insurance blind. The COPE (Center of Parent Excellence) project provides a pathway for families accessing and navigating the behavioral health systems for their child to have peer support that is not tied to insurance. Currently, the COPE project serves the entire state of Washington and are doing so with only 3 Lead Support Specialists. In addition, there are numerous challenges with accessing the Certified Peer Counselor training. At the end of September 2022, the waitlist for the training was 1200. While it is unclear how many on the list were parents/caregivers and youth, this highlights the need to increase the number of trainings offered with a focus on parent and youth training. Increasing peer supports for families and youth aligns with the System of Care Values which are 1) family and youth driven, 2) community based, and 3) culturally and linguistically competent.

2. **Recommendation details**

The recommendation is to use funds $$$$ to sustain the COPE project and increase staffing and to fund $$$ to increase training and testing opportunities for the Certified Peer Counselor Training

3. **Given current circumstances, why is taking the recommended action a smart move now?**

Peer services has been a topic brought up in other subgroups of the Children Youth Behavioral Health Workgroup. Including YYACC, it has also been mentioned from the PreNatal-5 and Workforce & Rates subgroups. Expanding access to peer services helps supports the current workforce and it provides families and youth with supports that address their individual needs and recovery goals that come from an individual with lived experience.

4. **Describe any outreach that helped to develop this recommendation.**

The YYACC group had a panel discussion regarding Parent Peer in September 2022. Concerns brought up during this conversation were lack of access and need for more community-based peer support. There was also a presentation at YYACC from JASPR Health. JASPR Health is using technology combined with lived experience to help stabilize crisis situations. People with lived experience inform all aspects of their products and research. There is data that shows having peer support helped decrease substance misuse, emergency department visits, inpatient stays, days considering suicide and suicide attempts. Additionally, peer support helped increase social connectedness. Finally, at the CYBHWG meeting on September 15th, 2022, the Ballmer Group gave a presentation on the

Behavioral Health Workforce Grant Making Update. One of their goals is to improve access to high-quality behavioral health treatment for low-income Washingtonian. Certified Peer counselors were noted to be an occupational type that has the capacity to grow.

Children & Youth Behavioral Health Work Group – Youth & Young Adult Continuum of Care Subgroup

Recommendations Brief – Targeted investments in behavioral health and suicidality for Indigenous youth

Recommended length: No more than 2 pages

Recommendation:

To address the massive disparities in behavioral health needs in Indigenous youth, the YYACC recommends monetary assistance given to tribes and Indigenous organizations to spend on behavioral health services as they see fit.

1. ### What is the issue?

   Briefly and persuasively describe the issue or problem. E.g., illustrate the impact on different groups (children, families, communities, society), highlight inequitable outcomes, and/or provide data on the incidence/prevalence at the population level. Include human and financial costs of *not* addressing the issue.

   Indigenous youth face elevated behavioral health needs in comparison to their non-Indigenous peers. In the United States, Indigenous young adults experience the highest rates of suicide among all ethnic and racial groups. In addition, Indigenous young adults face higher rates of substance use disorder and tend to begin substance use at an earlier age than non-Indigenous youth. Indigenous communities face unique risk factors for behavioral health challenges and suicidality, including high levels of poverty and food insecurity, general trauma, and discrimination.

   While Indigenous youth face unique and significant behavioral health needs, access to behavioral health resources are limited in many tribal communities. In addition, the behavioral health services available are not culturally response. Many Washington organizations and treatment facilities have seen great success from services that embrace traditional approaches to healing. It is vital that the legislature address the behavioral health crisis among Indigenous youth in a way that is responsive to the community's unique needs.

2. ### Recommendation details

   The YYACC recommends a budget request toward behavioral health services for Indigenous youth. Recognizing that the Indigenous community knows their own needs best, these funds will be distributed to federally recognized tribes and Indigenous advocacy organization through a competitive grant program administered by the Health Care Authority.

   These funds will be available for any programs that provide services in prevention, early intervention, identification, screening, assessment, treatment, and support addressing suicidality and behavioral health issues in Indigenous youth. The grant requests and will be evaluated based on potential to help address the issues described above.

3. ### Given current circumstances, why is taking the recommended action a smart move now?

   Indigenous communities know their own needs best and know what they need to address the behavioral health crises within their communities. As such, these broad investments into Washington's Indigenous communities address the significant gaps in behavioral healthcare, while supporting the autonomy of tribes. This specific funding model is an efficient way to address the unique needs of Indigenous communities.

4. **Describe any outreach that helped to develop this recommendation.**
   The YYACC conducted extensive community outreach to arrive at this recommendation, including with Indigenous community members. Our subgroup, with its membership of parents, youth, legislators, and industry professionals, collaboratively arrived at this recommendation through an emphasis on community- based stakeholder engagement. This recommendation was agreed upon at the consensus of the group.

Children & Youth Behavioral Health Work Group – Youth and Young Adult Continuum of Care
Recommendations Brief –Enhance utilization of technological innovations in behavioral health treatment and recovery services
Recommended length: No more than 2 pages

Recommendation:

Create a pot of flexible funding to pilot the utilization of various technological innovations across the behavioral health continuum of care.

1. What is the issue?

- **Workforce crisis:** We are facing an unprecedented behavioral health workforce crisis. One tool that can be wielded to address the worker shortage is to ensure that clinicians are practicing at the top of their license and to extend clinician bandwidth through the use of technological applications.
- **Rural access:** We also face a huge shortage of behavioral health providers in rural areas. Technological applications can assist with this rural equity issue.
- **Waitlists:** COVID has led to exponentially long waitlists to get into behavioral health care, as well as causing some community behavioral health providers to stop accepting new referrals altogether. Technological innovations can be utilized with limited clinician oversight to provide some modicum of treatment for individuals who are waiting to get into inpatient or outpatient care.
- **Lack of BIPOC providers and culturally appropriate services:** We lack sufficient BIPOC behavioral health providers who reflect the communities they are serving. There are BIPOC-specific technological applications that were developed by communities of color and center the voices of BIPOC folks. Such tools could be utilized even in the absence of BIPOC providers.
- **Emergency departments over capacity:** Both pediatric and adult departments across the state are absolutely overwhelmed and overrun with behavioral health patients, many of whom are experiencing suicidal crises. Psychiatric patients spend longer in emergency departments than any other patient population and EDs are a notoriously terrible place for individuals in psychiatric distress. EDs are the opposite of a therapeutic environment. Furthermore, there is data to suggest that individuals experiencing suicidal ideation are more likely to answer truthfully on an electronic platform, as opposed to an in-person screening. A suicide crisis care application that was designed by people with lived experience for use in emergency department settings could assist with this.
- **Lack of SUD beds:** We lack adequate SUD residential capacity, but there are technological innovations that replicate the intensive content taught in a 28-day residential program in application form.
- **High ROI for investing in recovery support:** The highest potential return on investment in the SUD space is to help individuals who are in early recovery maintain their disease remission. This is achieved by investing in recovery support services, which can include technological applications that improve relapse prevention and patient adherence with treatment and recovery plans.
- **Limited proliferation of EBPs:** Though there are many evidence-based practices, few patients have access to services that implement those practices with fidelity. There are technological applications and prescription digital therapeutics that exist, which utilize EBPs, like cognitive behavioral therapy and contingency management, with great efficacy. If these applications were more broadly utilized, more patients could benefit from evidence-based care.

Technological innovations in the behavioral health sphere could help address all of the aforementioned challenges, but they are wildly underutilized.

FInalized: 10/12/2020

2. Recommendation details

The YYACC recommends that a pot of flexible funds be created in order to stimulate broader adoption of technological innovations in the mental health and addiction services sector. A myriad of such technologies exist, including applications and prescription digital therapeutics that address suicide crisis care, addiction recovery support, depression care, opioid use disorder, and more. These technological innovations exist across the behavioral health continuum of care from assessment and early intervention to treatment and recovery support services.

3. Given current circumstances, why is taking the recommended action a smart move now?

This recommendation is particularly timely because it can be easily scaled. The technological applications already exist and if funding is made available, they can be deployed immediately. Furthermore, because the suite of existing technological innovations is very broad, the funding can be creatively utilized to address the panoply of issues enumerated in question one above—perhaps most notably, issues related to the workforce crisis.

4. Describe any outreach that helped to develop this recommendation.

The YYACC hosted a presentation from Jaspr Health, one creator of technological innovations in the behavioral health sector. Jaspr has a number of applications that support youth and young adults with behavioral health challenges, including a tool specific to suicide crisis care, a tool for indigenous youth, and a tool for parents of youth with conduct disorder. The Jaspr presentation was incredibly well received and YYACC members were particularly impressed with the outcome data related to reduction in suicide attempts. This presentation led to a broader, highly engaging discussion regarding the underutilization of technological innovations in behavioral health care and the enormous promise such interventions have.

Potential criteria (developed by the Prenatal through 5 Relational Health subgroup):

1. **COMMUNITY-INFORMED -** Prioritizes approaches and ideas that strengthen child and family well-being, as shared by members of impacted communities and those that serve them
2. **CENTERS & ADVANCES EQUITY** – Holds the promise to measurably closes the gaps in health access and outcomes
3. **REALISTIC & ACHIEVABLE** – Size and scope are appropriate for Washington's budget context policy landscape
4. **CAPACITY** – Implementation could be described and executed well and quickly
5. **STRENGTHENS/TRANSFORMS** – Helps to build, sustain, or transform foundational systems
6. **FIT** – Fits within the CYBHWG scope and avoids duplicating the work of other groups.

FInalized: 10/12/2020

Children & Youth Behavioral Health Work Group – Youth and Young Adult Continuum of Care Recommendations Brief –

Parent Portal - Behavioral Health 360

Recommendation:

Develop content of the Parent Portal Behavioral Health 360 (BH360) to include up to 13 different behavioral health challenge areas and culturally responsive resources statewide. Establish community partnerships with local behavioral health organizations and refine a resource mapping model to include in-person entry points to BH360. The technical build will include pulling in provider lists across public and private sectors, a parent profile to store documents, screening questions, personalized resources, and more.

1. ## What is the issue?

   The number of children in need of behavioral health support is rising, while provider shortages make it increasingly difficult to find care. People with marginalized identities such as BIPOC and LGBTQI+ face the most significant challenges, while resources for them are furthest from reach. Rates of suicide and state dependency are worsening in part due to the lack of on-demand access to effective and culturally competent care, including early identification of behavioral health conditions.
   Our existing systems intended to assist with early identification for behavioral health needs for youth and teens are disparate and disconnected (schools, pediatricians, justice system, etc.). This creates an onus on the parent or caregiver, who doesn't inherently embody a wealth of behavioral health knowledge, to put together the pieces and take early action.

2. ## Recommendation details:

   To continue to fund the Parent Portal Behavioral Health 360
   Moving forward will include seeking public-private mixed funding model to ensure a product that will be an impactful resource to families across the state. The total ask from the State of Washington is $955,000. This includes

   Landscaping efforts in Kent and Spokane $300,000
   Content development costs (50% of cost) $300,000
   Technical build costs (50% of total cost) $355,000

   Primary features include screening tools to narrow the search toward appropriate diagnoses and earlier intervention. Information will be tailored by behavioral health topic area and help caregivers understand and utilize suggested resources. Families will be supported in becoming advocates for the mental health needs of their children by learning skills. Families will have the ability to search for local providers (both in the public and private sector) across the spectrum of needs, including cultural fit. The program will filter the search based on insurance, location, and specialized need (e.g.age, diagnosis, cultural preference). The platform will be a forum to build community and connect people with similar paths. Screening tools and search capabilities connect families to community resources (e.g., school-based programs, support groups, social determinants of health resources (such as food banks, public library classes, Family Resource Centers).

3. **Given current circumstances, why is taking the recommended action a smart move now?**
   Since February of 2021 the Parent Portal committee has been meeting on a regular basis. In 2022 with HB 1800 the Parent Portal BH 360 was funded $76,000 to continue the work of designing the web-based platform supporting caregivers, children, and youth on their behavioral health wellness journey. With the hours that have been invested in the last two years, it is prudent that the project moves forward for the wellbeing of our families.

4. **Describe any outreach that helped to develop this recommendation.**
   Behavioral Health 360 is a collaborative effort across organizations including Washington State community Connectors, RPrime Foundation, and Healthy Minds, Healthy Futures. BH 360 is a one-stop resource for caregivers to access information, guidance, resources, and evidenced-based tools, empowering them to create a behavioral health wellness journey for their loved ones in need.
   HB 1800 is a communications bill to connect the latest information on Behavioral Health to the families that experience behavioral health issues. The Parent Portal was part of HB 1800 and passed the legislature with nonpartisan support in 2022. But Work began in February 2021 with a small private grant and a vision of a parent activist, Peggy Dolan. Progress has continued with funding from passage of HB 1800 in 2022. Key activities:

   Stakeholder engagement with family caregivers, providers, community organizations Input from philanthropists focused on behavioral health initiatives
   Strategic partnerships to lead the work moving forward Presentations on the Bh360 platform
   Development of a proof-of-concept site: BH Connected.com

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