RCW 74.09.4951 Children and youth behavioral health work group—Advisory groups—Report to governor and legislature. *(Expires December 30, 2031.)* (1) The children and youth behavioral health work group is established to:

(a) Identify barriers to and opportunities for accessing behavioral health services for children, youth, and young adults and their families;

(b) Strengthen and build a coordinated systemic approach to providing behavioral health care and supports that ensure that all children, youth, young adults, and their families have timely access to high quality, equitable, well-resourced behavioral health education, care, and supports across the continuum when and where they need it, including prenatal care;

(c) Advise and provide recommendations to the children and youth behavioral health leadership council established in RCW 43.06.547 regarding implementation of the Washington thriving strategic plan developed under subsection (6) of this section and the system of care that the strategic plan outlines; and

(d) Advise the legislature on statewide behavioral health services for this population.

(2) The work group shall consist of members and alternates as provided in this subsection. Members must represent the regional, racial, and cultural diversity of all children and families in the state.

(a) The president of the senate shall appoint one member and one alternate from each of the two largest caucuses in the senate.

(b) The speaker of the house of representatives shall appoint one member and one alternate from each of the two largest caucuses in the house of representatives.

(c) The governor shall appoint six members representing the following state agencies and offices: The department of children, youth, and families; the department of social and health services; the health care authority; the department of health; the office of homeless youth prevention and protection programs; and the office of the governor.

(d) Subject to the requirements under (k) of this subsection, the governor shall appoint the following members:

(i) One representative of behavioral health administrative services organizations;

(ii) One representative of community mental health agencies;

(iii) Two representatives of medicaid managed care organizations, one of which must provide managed care to children and youth receiving child welfare services;

(iv) One regional provider of co-occurring disorder services;

(v) One pediatrician or primary care provider;

(vi) One provider specializing in infant or early childhood mental health;

(vii) One representative who advocates for behavioral health issues on behalf of children and youth;

(viii) One representative of early learning and child care providers;

(ix) One representative of the evidence-based practice institute;

(x) Two parents or caregivers of children who have received behavioral health services, one of which must have a child under the age of six;

(xi) One representative of an education or teaching institution that provides training for mental health professionals;

(xii) One foster parent;

(xiii) One representative of providers of culturally and linguistically appropriate health services to traditionally underserved communities;

(xiv) One pediatrician located east of the crest of the Cascade mountains;

(xv) One child psychiatrist;

(xvi) One representative of an organization representing the interests of individuals with developmental disabilities;

(xvii) Three youth or young adult representatives who have experience with behavioral health services;

(xviii) One representative of a private insurance organization;

(xix) One representative from the statewide family youth system partner roundtable established in the *T.R. v. Strange and McDermott*, formerly the *T.R. v. Dreyfus and Porter*, settlement agreement;

(xx) One representative from educational service districts established under chapter 28A.310 RCW; and

(xxi) One substance use disorder professional.

(e) The governor shall appoint two representatives of federally recognized Indian tribes whose traditional lands and territories included parts of Washington, nominated by the governor's Indian health advisory council established in RCW 43.71B.020. The participation of these representatives supports, but does not replace, tribal consultation requirements including an agency's responsibilities under chapter 43.376 RCW.

(f) The superintendent of public instruction shall appoint one representative from the office of the superintendent of public instruction.

(g) The insurance commissioner shall appoint one representative from the office of the insurance commissioner.

(h) The work group shall choose one of the work group's cochairs from among its legislative members and the other cochair must be the representative from the health care authority. The representative from the health care authority shall convene at least two meetings of the work group each year.

(i) The cochairs may invite additional members of the house of representatives and the senate to participate in work group activities, including as leaders of advisory groups to the work group. These legislators are not required to be formally appointed members of the work group in order to participate in or lead advisory groups.

(j) The cochairs may request that the governor appoint additional members of the work group representing specific professions, organizations, or communities. The governor's office may consult with the cochairs as needed on these discretionary appointments.

(k) The terms for work group members appointed under (d) of this subsection after June 6, 2024, may not exceed three years. Work group members appointed under (d) of this subsection before June 6, 2024, may remain in their positions until January 1, 2027, but their terms may not go beyond that date.

(3) The work group shall:

(a) Monitor the implementation of enacted legislation, programs, and policies related to children and youth behavioral health, including provider payment for mood, anxiety, and substance use disorder prevention, screening, diagnosis, and treatment for children and young mothers; consultation services for child care providers

caring for children with symptoms of trauma; home visiting services; and streamlining agency rules for providers of behavioral health services;

(b) Consider system strategies to improve coordination and remove barriers between the early learning, K-12 education, and health care systems;

(c) Identify opportunities to remove barriers to treatment and strengthen behavioral health service delivery for children and youth;

(d) Determine the strategies and resources needed to:

(i) Improve inpatient and outpatient access to behavioral health services;

(ii) Support the unique needs of young children prenatally through age five, including promoting health and social and emotional development in the context of children's family, community, and culture;

(iii) Develop and sustain system improvements to support the behavioral health needs of children, youth, and young adults; and

(iv) Achieve parity of private health insurance coverage for behavioral health conditions with the coverage provided for other health conditions;

(e) Consider issues and recommendations put forward by the statewide family youth system partner roundtable established in the *T.R. v. Strange and McDermott*, formerly the *T.R. v. Dreyfus and Porter*, settlement agreement; and

(f) Use the Washington thriving strategic plan developed under subsection (6) of this section to guide the priorities and efforts of the work group.

(4) At the direction of the cochairs, the work group may convene advisory groups to evaluate specific issues and report related findings and recommendations to the full work group.

(5) The work group shall convene an advisory group focused on school-based behavioral health and suicide prevention. The advisory group shall advise the full work group on creating and maintaining an integrated system of care through a tiered support framework for preschool through twelfth grade school systems defined by the office of the superintendent of public instruction and behavioral health care systems that can rapidly identify students in need of care and effectively link these students to appropriate services, provide age-appropriate education on behavioral health and other universal supports for social-emotional wellness for all students, and improve both education and behavioral health outcomes for students. The school-based behavioral health and suicide prevention advisory group shall consider the broader behavioral health issues impacting children, youth, and families, while focusing on the issues that are unique to children and families that interface with schools. The work group cochairs may invite nonwork group members to participate as advisory group members.

(6)(a) Subject to the availability of amounts appropriated for this specific purpose, the work group shall convene an advisory group for the purpose of developing a draft strategic plan that describes:

(i) The current landscape of behavioral health services available to families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth in Washington state, including a description of:

(A) The gaps and barriers in receiving or accessing behavioral health services, including services for co-occurring behavioral health disorders or other conditions;

(B) Access to high quality, equitable care and supports in behavioral health education and promotion, prevention, intervention, treatment, recovery, and ongoing well-being supports;

(C) The current supports and services that address emerging behavioral health issues before a diagnosis and more intensive services or clinical treatment is needed; and

(D) The current behavioral health care oversight and management of services and systems;

(ii) The vision for the behavioral health service delivery system for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth, including:

(A) A complete continuum of services from education, promotion, prevention, early intervention through crisis response, intensive treatment, postintervention, and recovery, as well as supports that sustain wellness in the behavioral health spectrum;

(B) How access can be provided to high quality, equitable care and supports in behavioral health education, promotion, prevention, intervention, recovery, and ongoing well-being when and where needed;

(C) How the children and youth behavioral health system must successfully pair with the 988 behavioral health crisis response described under chapter 82.86 RCW;

(D) The incremental steps needed to achieve the vision for the behavioral health service delivery system based on the current gaps and barriers for accessing behavioral health services, with estimated dates for these steps; and

(E) The oversight and management needed to ensure effective behavioral health care; and

(iii) A comparison of the current behavioral health system for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth that is primarily based on crisis response and inadequate capacity with the behavioral health system vision created by the strategic planning process through a cost-benefit analysis.

(b) The work group cochairs shall appoint a chair for the strategic plan advisory group and may invite nonwork group members to participate as advisory group members, but the strategic plan advisory group shall include, at a minimum:

(i) Community members with lived experience including those with cultural, linguistic, and ethnic diversity, as well as those having diverse experience with behavioral health care invited by the work group cochairs;

(ii) A representative from the department of children, youth, and families;

(iii) A representative from the department;

(iv) A representative from the authority;

(v) A representative from the department of health;

(vi) A representative from the office of homeless youth prevention and protection programs;

(vii) A representative from the office of the governor;

(viii) A representative from the developmental disability administration of the department of social and health services;

(ix) A representative from the office of the superintendent of public instruction;

(x) A representative from the office of the insurance commissioner;

(xi) A tribal representative;

(xii) Two legislative members or alternates from the work group; and

(xiii) Individuals invited by the work group cochairs with relevant subject matter expertise.

(c) The health care authority shall conduct competitive procurements as necessary in accordance with chapter 39.26 RCW to select a third-party facilitator to facilitate the strategic plan advisory group.

(d) To assist the strategic plan advisory group in its work, the authority, in consultation with the cochairs of the work group, shall select an entity to conduct the activities set forth in this subsection. The health care authority may contract directly with a public agency as defined under RCW 39.34.020 through an interagency agreement. If the health care authority determines, in consultation with the cochairs of the work group, that a public agency is not appropriate for conducting these analyses, the health care authority may select another entity through competitive procurements as necessary in accordance with chapter 39.26 RCW. The activities that entities selected under this subsection must complete include:

(i) Following a statewide stakeholder engagement process, a behavioral health landscape analysis for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth outlining:

(A) The current service continuum including the cost of care, delivery service models, and state oversight for behavioral health services covered by medicaid and private insurance;

(B) Current gaps in the service continuum, areas without access to services, workforce demand, and capacity shortages;

(C) Barriers to accessing preventative services and necessary care including inequities in service access, affordability, cultural responsiveness, linguistic responsiveness, gender responsiveness, and developmentally appropriate service availability; and

(D) Incorporated information provided by the 988 crisis hotline crisis response improvement strategy committee;

(ii) A gap analysis estimating the prevalence of needs for Washington state behavioral health services for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth served by medicaid or private insurance, including:

(A) The estimated number of families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth who need clinical behavioral health services or could benefit from preventive or early intervention services on an annual basis;

(B) The estimated number of expectant parents and caregivers in need of behavioral health services;

(C) A collection and analysis of disaggregated data to better understand regional, economic, linguistic, gender, and racial gaps in access to behavioral health services;

(D) The estimated costs of providing services that include a range of behavioral health supports that will meet the projected needs of the population; and

(E) Recommendations on the distribution of resources to deliver needed services to families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth across multiple settings; and

(iii) An analysis of peer-reviewed publications, evidence-based practices, and other existing practices and guidelines with preferred outcomes regarding the delivery of behavioral health services to families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth across multiple settings including:

(A) Approaches to increasing access and quality of care for underserved populations;

(B) Approaches to providing developmentally appropriate care;

(C) The integration of culturally responsive care with effective clinical care practices and guidelines;

(D) Strategies to maximize federal reinvestment and resources from any alternative funding sources; and

(E) Workforce development strategies that ensure a sustained, representative, and diverse workforce.

(e) The strategic plan advisory group shall prioritize its work as follows:

(i) Hold its first meeting by September 1, 2022;

(ii) Provide a progress report on the development of the strategic plan, including a timeline of future strategic plan development steps, to be included in the work group's 2022 annual report required under subsection (10) of this section;

(iii) Provide a progress report on the development of the strategic plan, including discussion of the work group recommendations that align with the strategic plan development thus far, to be included in the work group's 2024 annual report required under subsection (10) of this section;

(iv) Provide a draft strategic plan, along with any materials produced by entities selected under (d) of this subsection, to the work group by August 1, 2025. The draft strategic plan must be developed in coordination with the joint legislative and executive committee on behavioral health established in section 135(15), chapter 475, Laws of 2023, the department of health, and the health care authority related to the implementation of the 988 crisis hotline.

(f) The work group shall discuss the draft strategic plan and adopt a final strategic plan that must be submitted to the governor and the appropriate committees of the legislature at the same time as the work group's 2025 annual report required under subsection (10) of this section.

(7)(a) Staff support for the work group, including administration of work group meetings and preparation of full work group recommendations and reports required under this section, must be provided by the health care authority.

(b) Additional staff support for legislative members of the work group may be provided by senate committee services and the house of representatives office of program research.

(c) Subject to the availability of amounts appropriated for this specific purpose, the office of the superintendent of public instruction must provide staff support to the school-based behavioral health and suicide prevention advisory group, including administration of advisory group meetings and the preparation and delivery of advisory group recommendations to the full work group.

(8)(a) Legislative members of the work group are reimbursed for travel expenses in accordance with RCW 44.04.120. Nonlegislative members are not entitled to be reimbursed for travel expenses if they are elected officials or are participating on behalf of an employer, governmental entity, or other organization. Except as provided under

(b) of this subsection, any reimbursement for other nonlegislative members is subject to chapter 43.03 RCW.

(b) Members of the children and youth behavioral health work group or an advisory group established under this section with lived experience may receive a stipend of up to $200 per day if:

(i) The member participates in the meeting virtually or in person, even if only participating for one meeting and not on an ongoing basis; and

(ii) The member does not receive compensation, including paid leave, from the member's employer or contractor for participation in the meeting.

(9) The following definitions apply to this section:

(a) "A member with lived experience" means an individual who has received behavioral health services or whose family member has received behavioral health services; and

(b) "Families in the perinatal phase" means families during the time from pregnancy through one year after birth.

(10) Beginning November 1, 2020, and annually thereafter, the work group shall provide recommendations in alignment with subsection (3) of this section to the governor and the legislature. Beginning November 1, 2026, the work group shall include in its annual report a discussion of how the work group's recommendations align with the final strategic plan described under subsection (6) of this section.

(11) This section expires December 30, 2031. [2026 c 93 s 1; 2024 c 372 s 1; 2022 c 76 s 1; 2020 c 130 s 1; 2019 c 360 s 2; 2018 c 175 s 2.]

Findings—Intent—2019 c 360: "(1) The legislature finds that the children's mental health work group established in chapter 96, Laws of 2016 reported recommendations related to increasing access to mental health services for children and youth and that many of those recommendations were adopted by the 2017 and 2018 legislatures. The legislature further finds that additional work is needed to improve mental health support for children and families and that the children's mental health work group was reestablished for this purpose in chapter 175, Laws of 2018.

(2) The legislature finds that there is a workforce shortage of behavioral health professionals and that increasing medicaid rates to a level that is equal to medicare rates will increase the number of providers who will serve children and families on medicaid. Further, the legislature finds that there is a need to increase the cultural and linguistic diversity among children's behavioral health professionals and that hiring practices, professional training, and high quality translations of accreditation and licensing exams should be implemented to incentivize this diversity in the workforce.

(3) Therefore, the legislature intends to implement the recommendations adopted by the children's mental health work group in January 2019, in order to improve mental health care access for children and their families." [2019 c 360 s 1.]