HOUSE BILL REPORT
2SHB 1088

As Amended by the Senate

Title: An act relating to children's mental health services.

Brief Description: Improving delivery of children's mental health services.

Sponsors: By House Committee on Appropriations (originally sponsored by Representatives Dickerson, Kagi, Haler, Cody, Appleton, Darneille, Simpson, Takko, Kenney, Williams, Green, McDermott, Roberts, Lantz, McCoy, Ormsby, Schual-Berke, B. Sullivan, Hurst, Pettigrew, O'Brien, Lovick, P. Sullivan, Hasegawa, Hunt, Hudgins, Clibborn, Upthegrove, Morrell, Conway, Sells, Haigh, Quall, Moeller, Goodman, Wallace, Wood and Santos).

Brief History:

Committee Activity:

Early Learning & Children's Services: 1/23/07, 2/8/07 [DPS];
Appropriations: 2/20/07, 3/5/07 [DP2S(w/o sub ELCS)].

Floor Activity:

Passed House: 3/6/07, 92-4.
Senate Amended.
Passed Senate: 4/9/07, 47-0.

Brief Summary of Second Substitute Bill

- Requires the Department of Social and Health Services (DSHS) to recommend revisions to access-to-care standards and the children's mental health benefits package.
- Expands the Medicaid children's mental health outpatient therapy benefit.
- Establishes a children's mental health evidence-based practice institute at the University of Washington.
- Establishes a pilot program to support primary care providers in the diagnosis and treatment of children with mental and behavioral health disorders.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

- Directs the DSHS to expedite Medicaid re-enrollment for eligible youth transitioning out of confinement, and to explore the feasibility of providing Medicaid-funded services to juveniles detained temporarily.
- Requires DSHS to expedite the reinstatement of medical coverage for youth released from confinement.
- Establishes a wraparound services pilot program in up to three counties.

HOUSE COMMITTEE ON EARLY LEARNING & CHILDREN'S SERVICES

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 4 members: Representatives Kagi, Chair; Appleton, Pettigrew and Roberts.

Minority Report: Do not pass. Signed by 3 members: Representatives Haler, Ranking Minority Member; Walsh, Assistant Ranking Minority Member and Hinkle.

Staff: Sydney Forrester (786-7120).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Early Learning & Children's Services. Signed by 27 members: Representatives Sommers, Chair; Dunshee, Vice Chair; Cody, Conway, Darneille, Dunn, Ericks, Fromhold, Grant, Haigh, Hinkle, Hunt, Hunter, Kagi, Kenney, Kessler, Linville, McDermott, McDonald, McIntire, Morrell, Pettigrew, Priest, Schual-Berke, Seaquist, P. Sullivan and Walsh.

Minority Report: Do not pass. Signed by 7 members: Representatives Alexander, Ranking Minority Member; Bailey, Assistant Ranking Minority Member; Haler, Assistant Ranking Minority Member; Anderson, Buri, Chandler and Kretz.

Staff: Amy Skei (786-7140).

Background:

Delivery Structure

State-provided children's mental health services in Washington are delivered through Regional Support Networks (RSNs) established to develop local systems of care. This is the same structure used to deliver adult mental health services. The RSNs consist of counties or groups of counties authorized to contract with licensed service providers and deliver services directly. Thirteen RSNs across the state currently coordinate and deliver children's mental health services. Children's mental health services also are provided through programs operated by the Department of Social and Health Service's Juvenile Rehabilitation Administration (JRA), Children's Administration (CA), and Health Recovery Services

Administration (HRSA). Services include therapeutic foster care, coordinated assistance with youth transitioning from a JRA facility to the community, drug and alcohol substance abuse treatment, and short- and long-term in-patient mental health care.

Access

Access-to-care standards are intended to create standard criteria for accessing services across the RSNs. Current standards utilize two levels of access, both of which depend on a diagnosis of a mental illness; a specific score on a functioning assessment; and one or more functioning impairments, high-risk behaviors, escalating symptoms, or prior hospitalization or treatment within a specified time.

Access to mental health treatment can be achieved through minor-initiated, parent-initiated, or state-initiated options. Each option has a slightly different statutory framework and involves certain determinations made by professionals. Parent-initiated and state-initiated treatment options also involve petitions to the superior court.

Evidence-Based Practice

In 2003, the Legislature directed the Washington State Institute for Public Policy (WSIPP) to review research assessing the effectiveness of prevention and early intervention programs concerning children and youth. The Legislature required the WSIPP to use the research to identify specific research-proven programs that produce a positive return on the dollar compared to the costs of the program. As a result of that study, the WSIPP found some prevention and early intervention programs for youth can give taxpayers a good return on their dollar. The study identified several programs, including some mental health programs, likely to reduce taxpayer and other costs in the future if properly implemented.

Summary of Second Substitute Bill:

The legislative intent statement for children's mental health services is revised to place an emphasis on early identification, intervention, and prevention with a greater reliance on evidence-based and promising practices. The expressed goal of the Legislature is to create by 2012, a children's mental health system with the following elements:

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

The definition of *child* is revised to include persons up to age 21. Definitions are created for the following terms: *family; evidence-based practice; promising practice;* and *wraparound process. Family* is defined to include kinship care placements and kinship care-like

placements for children in the custody of the Department of Social and Health Services (DSHS).

The effectiveness of the system will be determined by outcome-based performance measures to be developed jointly by the DSHS; mental health practitioners, experts, and researchers; parents and other caregivers; youth; tribes; and other stakeholders.

Access

The DSHS is directed to revise the access-to-care standards to assess a child's need for services based on behaviors exhibited by the child and interference with a child's functioning in family, school, or the community, as well as a child's diagnosis. Receipt of services should not be conditioned on a determination the child is highly at-risk or in imminent need of hospitalization of an out-of-home placement. The revised standards should provide for children under the age of six years to receive services without the need for a specific diagnosis. The DSHS also is directed to revise the benefits packages for children's mental health services to reflect the revised legislative intent. Revised access-to-care standards and benefits packages are due to the Legislature by January 1, 2009.

The DSHS also must revise its Medicaid managed care and fee-for-service programs to improve access to children's mental health services. By January 1, 2008, outpatient visits are increased from 12 to 20 per year, and by July 1, 2008, outpatient therapy services may be provided by any mental health professional licensed by the Department of Health.

Pilot Programs

The DSHS will submit requests for proposals (RFP) for: (1) a pilot program for supporting primary care providers in assessing, diagnosing, treating, and tracking outcomes for children with mental and behavioral health disorders; and (2) a wraparound pilot program for children with serious emotional or behavioral disturbance. The wraparound pilot will create up to three sites for providing wraparound services to children who are at immediate risk of residential or correctional placement, or psychiatric hospitalization. The DSHS must contract with RSNs, Educational Service Districts, or entities licensed to provide mental health services. Contractors must provide care coordination services and a network of services and supports using strength-based and highly individualized services and must demonstrate a commitment from community partners.

Evidence-Based Practice

A children's mental health evidence-based practice institute is established at the University of Washington Division of Public Behavioral Health and Justice Policy for the purpose of:

(1) serving as a statewide resource to the DSHS and other entities on child and adolescent evidence-based and promising practices;
(2) participating in the identification outcome-based performance measures for monitoring quality improvement processes in children's mental health services;
(3) partnering with youth, families, and culturally competent providers to develop information and resources for families regarding evidence-based and promising practices;

(4) consulting with communities for the selection, implementation, and evaluation of evidence-based children's mental health practices relevant to the communities' needs; and
(5) providing sustained and effective training and consultation to licensed children's mental health providers implementing evidence-based or promising practices.

The institute must collaborate with other public and private entities engaged in evaluating and promoting the use of evidence-based and promising practices in children's mental health treatment. Indirect costs for administration of the institute are limited to 10 percent of appropriated funds.

Medicaid Services and Juvenile Detention and Confinement

The DSHS shall adopt rules and policies to ensure that Medicaid coverage of eligible youth who were enrolled in Medicaid at the time of entering confinement will be reinstated on the day of release from confinement, subject to any expedited review of continuing eligibility that may be required. The DSHS also must collaborate with other entities to promote speedy eligibility determinations for youth likely to be eligible for medial assistance service upon release from confinement.

The DSHS must explore the feasibility of obtaining a Medicaid state plan amendment to allow providing Medicaid-funded services to youth who are confined temporarily in juvenile detention faculties.

Care Coordination

The DSHS will identify children with emotional or behavioral disturbances who may be at high-risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers, and to establish one or more mechanisms to evaluate the appropriateness of medications being prescribed. These mechanisms should include second opinions from experts in child psychiatry.

The DSHS also will convene representatives from RSNs, community mental health, and managed care systems to: (1) establish mechanisms and contact language to ensure increased coordination of and access to Medicaid mental health benefits for eligible children and families; (2) define contractual performance standards that trace access and utilization data; and (3) set standards for reducing numbers of children who are prescribed anti-psychotic drugs without also receiving outpatient mental health services.

EFFECT OF SENATE AMENDMENT(S):

Creates definitions for and includes references to research-based, emerging best, and consensus-based practices.

Revises the definitions for promising practice and evidence-based practice.

Revises the definition of family to exclude informal kinship care and other care arrangements for a child.

Revises the definition of wraparound process for purposes of the wraparound pilot program.

Changes the directive to the DSHS regarding revisions to access to care standards to focus on "persistent impaired functioning" as compared to "interference with a child's functioning" when assessing a child's need for mental health services.

Removes the provision in the original bill extending eligibility for children's mental health services up to age 21 years.

Adds to the outcome-based performance measures upon which the children's mental health system will be evaluated a performance measure for the reduction in use of prescribed medications where cognitive behavioral therapies are indicated.

Adds additional components to requirements for improving prescribing practices, including reviewing psychotropic medications being prescribed for children under age five and establishing mechanisms to evaluate the appropriateness of use of such medications; tracking of prescriptive practices with respect to psychotropic medications, with the foal of reducing use of such medications; and encouraging use of cognitive behavioral therapies and other treatments in addition to or in place of prescription medications where appropriate.

Appropriation: None.

Fiscal Note: Available. Fiscal note requested on second substitute March 5, 2007.

Effective Date: The bill takes effect 90 days after adjournment of session in which bill is passed. Sections 4, 5, 7, 8 and 10 of the bill are null and void unless funded in the budget.

Staff Summary of Public Testimony: (Early Learning & Children's Services)

(In support) This bill is designed to improve access to and quality of children's mental health services. It sets goals for establishing an accountable and outcome-based children's mental health system and takes the initial steps toward meeting these goals by the year 2012. This system will include early intervention and prevention services, greater equity and access, services that are child and family-centered, and an increased use of evidence-based practices by qualified and ethnically diverse providers.

Over the last several years during numerous hearings on children's mental health, we have heard over and over again from parents, youth, and providers that children simply do not have the services they need. Some children do get quality mental health service, but all too many kids do not get the services they desperately need. Countless meetings have been held over the past four years to try and design a better system for children's mental health. There has been some progress made, but progress appears to be moving at a somewhat glacial pace. When the need is so great, it is incumbent on us as Legislators to speed up the pace of progress. Over the past six months more than 60 organizations have worked together to bring this bill forward.

The current access-to-care standards prevent many kids in the foster care and juvenile justice systems from accessing much needed services. Other kids might get 12 visits through the Health Options Program and then there is nothing else available for them the remainder of the year. We have a dearth of providers to provide quality children's mental health services and

we have family doctors and pediatricians who don't have access to consultations they need when children come to them with mental health needs.

Over 60 percent of young people in our juvenile justice system have serious mental health needs. A very high percentage of foster youth also have significant mental health needs and the Braam Oversight Panel has said the state needs to address these needs. Twenty-five percent of children who are being prescribed anti-psychotic medications for the most severe mental illnesses do not have access to clinical treatment.

We have invested in the adult mental health system. Now it is time to invest in children's mental health. The children of today become the chronically mentally ill of tomorrow. This is an investment we must make. It will reduce costs associated with criminal activity, child welfare, hospital costs, and emergency services, and it will pay off handsomely by providing more humane treatment for children and their families.

This bill opens the door for dealing with the access-to-care standards and aligns itself with the mental health transformation grant. It also reflects considerable community input. The National Alliance on Mental Illness supports this bill because we believe nurturing problems need nurturing solutions. The current system is unnaturally bureaucratic and unnecessarily harsh to many of our state's families.

This is a creative strategic idea whose time has come. We know so much more about what works and what doesn't work with children and families. We are at a point in time in this state where we should move aggressively and assertively to implement practices that serve children and families in a way that improves outcomes and uses the resources of our state effectively. We are very well-staged to move in this direction due to a number of related initiatives already underway.

The models described in this bill are well researched. We already have demonstrated the capacity of the communities to make decisions based on their needs. We like the opportunity presented for the various schools at the UW to better support training of providers. Addressing the access-to-care standards and benefits package would be helpful. Expanding service eligibility to detained youth would help reduce recidivism. More flexibility in contracting with providers is also important. The increase in wraparound services is a research-demonstrated approach that improves outcomes for children. The EBP institute would allow for working closely with communities and providers to educate and empower local communities.

Children's Hospital absolutely supports this bill to focus on and improve children's mental health services in Washington. We see a very great need that is getting greater. The rate of psycho-social problems that appear in primary care physician offices has increased from 7-18 percent over the past 20 years and shows no sign of improving. The state has only 6.6 child psychologists for every 100,000 children in the state and most are located only in major metropolitan centers. We should look at how to use our child mental health professionals more wisely though access to rapid consultation services. Children's Hospital is eager to help in this regard through developing more details and accountability based on our own program.

The Superintendent of Public Instruction supports this bill because it focuses on the mental health services that many of our most at-risk students need. It also runs parallel with the Superintendent's drop-out prevention program using a wraparound approach to meeting the child's needs. We also believe this is the kind of down payment approach to support students staying in school.

The Juvenile Court Administrators and the Superior Court Judges Association support this bill because it recognizes the tremendous need for children's mental health services. More and more youth on probation caseloads and in detention facilities have diagnosable mental health disorders. The mental health needs of our youth are shocking. Children in detention facilities are being provided anti-psychotic and psychotropic medications daily. In addition to youth in detention facilities, children in foster care and those at-risk would benefit by the resources in this bill. The juvenile court detention facilities have become dumping grounds for kids with mental health disorders who are not being assisted in their own community. We like the idea of offering mental health services to kids while they are in detention since this is when they may be most agreeable to participating. We also like the provisions for expediting review of their eligibility for medical assistance when they are released into their communities, so they can continue to access needed mental health services.

Mental health needs are the primary issues that come up when we talk with juvenile justice providers about what would help rehabilitate juvenile offenders. Mental health issues expressed in a public setting can very quickly become law enforcement issues creating a pipeline into the juvenile justice system and the jails. Creating diversion options for treatment of mental health disorders would better meet the mental health needs of more children.

The City of Seattle and the Association of Washington Cities support this bill. We understand the connection between not getting necessary mental health treatment and the greater likelihood of becoming homeless, entering the juvenile justice system, or needing special education. Historically, kids have been systematically excluded from the mental health system. We need to take a more proactive approach before kids end up in detention and in jail. The RSNs support this bill and would like to continue to work on refining the language to support the logistics of implementation.

Primary care physicians often are faced with assigning specific labels and diagnoses to children in foster care in order for them to be eligible for services. These labels can impede the child's success of being adopted because these labels must be disclosed. The consulting functions can significantly support primary care physicians in their ability to care for children with pressing needs when mental health providers are not immediately available or when emergencies arise. Increasing the number of qualified providers is going to be the cornerstone of this approach. As the former surgeon general Jocelyn Elders said, the solution to crime rests not in the electric chair but in the high chair. Early intervention is the key. Children are the future of the state and of our country. There is no greater investment we can make at this time to support children with mental health disorders.

This bill acknowledges the fact that our current mental health system does not work for our children. It is in all our interests to serve children's needs up front. We appreciate the

recognition of the needs of children of color in the bill. Quality mental health care would bolster in other efforts to prevent children from entering the juvenile justice system. We appreciate the focus on prevention and early intervention as well as the change to the access-to-care standards and the innovation in the wraparound model.

Effectiveness of wraparound services has been well-demonstrated. Investing in a full continuum model using a strengths-based approach is critical. This bill will take the first step in transforming a system that is primarily reactive to one that is proactive and preventative in its approach. Extending the age for eligibility for services is both bold and necessary. Given what we know about the psychological, emotional, and cognitive development of young adults, extending the reach of children's services is a wise investment. The emphasis on culturally responsive services is important from a therapeutic standpoint and also to enable systems integration to occur. This is important in order to empower more families to navigate their way in the children's mental health system.

Continuity of care is what allows children to improve. This bill will support continuity and access. We would like to see a few changes to make some of the definitions consistent with the definitions used at the federal level. Access to health and mental health services should be as easy as getting vaccinated. This is as important as the other programs we support to help kids be ready to learn in school. We are pleased this is new money focused on children rather than taking it from the adult system. We would like to suggest putting the wraparound models in smaller administrative systems for greater efficiency.

(Neutral) We are concerned about the lack of linkage between medication and mental health treatment for children. Many of the medication provided has not been tested on children. In addition, therapeutic treatments should also be provided if medications are used.

(Opposed) We don't feel this bill adequately safeguards children against the danger of psychiatric drugs or educates parents against these same dangers.

Staff Summary of Public Testimony: (Appropriations)

(In support) We have a mental health system that is broken. It fails to focus on effective treatment and is not really a system at all. This gap for children has very real fiscal impacts for the state. This bill is geared toward getting children the services they need so they won't end up in the juvenile justice and child welfare systems or our emergency rooms or psychiatric hospitals. This bill also deals with the problem of overmedication. As a judge, I had parents before me who were crying for help for young people who were unable to get services until they committed a felony. The number one issue in a recent survey of hundreds of stakeholders was mental health, including problems with access. The loss of human capital is tremendous. This bill is part of the comprehensive improvement of Washington's health care system. Education and health care and mental health are all intertwined. Wraparound and intensive crisis stabilization services are very effective for high-need children and focus on treatment of the family unit. They focus on real-life settings and help avoid expensive out of home placements. Clark and Pierce County Regional Support Networks have some of the lowest inpatient psychiatric utilizations because of these services. It is time to focus on a

coordinated system for children's mental health. Consistency in practice and access to services will be improved by this bill.

(With concerns) We appreciate the spirit of collaboration behind this bill's development. We have two technical concerns. We believe that section 6 of the bill, requiring Medicaid payment for youth temporarily placed in a juvenile detention unit prior to adjudication, is counter to federal law and could increase risk for payback. This would have to be done with state only dollars and would represent a new obligation for the state. Our second concern is the effective date of the change in provider type allowed under the bill and the difficulty in making this change while our new Medicaid payment system, Provider One, is under development. We would request a change in the effective date to June 30, 2008, to avoid an additional cost impact of about $2 million. Funding for this bill is not in the Governor's budget.

(Opposed) We have a psychiatric system that does not produce the results that we want, and this bill continues that. The system we have emphasizes drug delivery. Psychiatric drugs are treatments, not cures, and lead only to continued demand for treatment. The fiscal impact of this bill is not fully disclosed in the fiscal note and does not include the cost to individuals of losing a loved one or a child due to psychiatric drugs.

Persons Testifying: (Early Learning & Children's Services) (In support) Representative Dickerson, prime sponsor; Cecilia V. Saari, King County Long-Term Care Ombudsman; Betty Scott, National Alliance on Mental Illness, Washington; Ann Varpness; E.D. Bryan, Parent and Advocate with Catholic Community Services; Susan Spieker and Eric Trupin, University of Washington; Jean Robertson, King County Referral Service Network; Jean Wessman, Washington State Association of Counties; Robert Hilt, M.D., Children's Hospital; Shelly Maluo and Ned Delmore, Juvenile Court Administration; Sarah Cherin, Children's Alliance; Michelle Terry, M.D.; Janice O'Mahony, Governor's Juvenile Justice Advisory Committee; Laura Groshona and Lucy Homans, Washington State Society of Psychological Association; Richard Kellogg, Assistant Secretary, Mental Health Division, Department of Social and Health Services; Jean Nist, Teamchild; Donna Christiansen, Catholic Conference; Kip Tokuda, City of Seattle and Association of Washington Cities; Laurie Lippold, Children's Home Society; Kyra Kester, Office of Superintendent of Public Instruction; Niran Al-Agba, M.D.; Sherry Axson, Peer Parent Support; John E. Dunne, M.D., University of Washington, Department of Psychiatry and Doctor of Child Psychiatry; and Stephen Woolworth, Pierce County Referral Service Network.

(Neutral) Sheri Hill, Center on Infant Mental Health, University of Washington.

(Opposed) Ruth Martin, Citizens Commission on Human Rights.

Persons Testifying: (Appropriations) (In support) Representative Dickerson, prime sponsor; Beth Harvey, MD, American Academy of Pediatrics; Justice Bobbe Bridge, Washington Supreme Court; Donna Christensen, Catholic Conference; and Michelle Terry, MD.

(With concerns) Richard Kellogg, Department of Social and Health Services.

(Opposed) Steven Pearce, Citizens Commission on Human Rights of Seattle.

Persons Signed In To Testify But Not Testifying: (Early Learning & Children's Services) Marie Manlangit, Services Employees International Union, 1199 Northwest; David Lord, Washington Protect Advocacy System; Kate Naeseth, Valley Cities Counseling, Village Project II; Sue Ellen Phillips and Mary Campbell, Village Project II.; Casey Trupin, Columbia Legal Services; and MaryAnn Murphy, Parents with Families.

Persons Signed In To Testify But Not Testifying: (Appropriations) None.