SENATE BILL REPORT
2SHB 1088

As Reported By Senate Committee On:
Human Services & Corrections, March 29, 2007
Ways & Means, April 2, 2007

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

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

Sponsors: 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: Passed House: 3/06/07, 92-4.
Committee Activity: Human Services & Corrections: 3/20/07, 3/29/07 [DPA-WM].
Ways & Means: 4/02/07 [DPA, w/oRec].

SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Hargrove, Chair; Regala, Vice Chair; Stevens, Ranking Minority Member; Brandland, Carrell, Marr and McAuliffe.

Staff: Indu Thomas (786-7459)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended.
Signed by Senators Prentice, Chair; Fraser, Vice Chair, Capital Budget Chair; Pridemore, Vice Chair, Operating Budget; Brandland, Carrell, Fairley, Hatfield, Hobbs, Keiser, Kohl-Welles, Oemig, Parlette, Rasmussen, Regala, Roach, Rockefeller and Tom.

Minority Report: That it be referred without recommendation.
Signed by Senators Zarelli, Ranking Minority Member; Honeyford and Schoesler.

Staff: Tim Yowell (786-7435)

Background: Early and Periodic Screening, Diagnostic, and Treatment: The federally mandated early and periodic screening, diagnostic, and treatment services (EPSDT) program for children from birth to 21 years entitles Medicaid eligible children to services found

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necessary to diagnose, treat, or ameliorate a defect, physical or mental illness, or a condition identified by an EPSDT screen. The original 1967 legislation gave states the option to cover treatment services not covered under the state's Medicaid plan. In 1989, Congress strengthened the mandate by requiring states to cover all treatment services, regardless of whether those services are covered in the state's Medicaid plan. As a result, the EPSDT component now covers an array of Medicaid services, such as services for children with serious emotional disturbances, including parental skill training in behavior management techniques.

Priority Populations: Current Washington State statutes relating to children's mental health services emphasize the need for appropriate prevention, early intervention, self or parent-directed care and involuntary treatment as appropriate. These statutes further encourage voluntary treatment whenever clinically appropriate and allow parents to exercise reasonable, compassionate care and control of their minor children. A high priority is placed on serving emotionally disturbed and mentally ill children, potentially dependent children and families in conflict, juvenile offenders, and children in need of long-term care and assistance. The state has established priorities for treatment of the individuals with mental disorders including severely emotionally disturbed children.

Access to Care: Children in Washington State receive mental health services from a variety of sources. Thirteen Regional Support Networks (RSNs), consisting of counties or groups of counties, coordinate and deliver publically funded, short-term in-patient, and outpatient mental health care. Children's mental health services are also provided through programs operated by the Department of Social and Health Services's (DSHS) Juvenile Rehabilitation Administration (JRA), Children's Administration (CA), and Health Recovery Service Administration (HRSA). HRSA's Mental Health Division provides long-term in-patient mental health care. HRSA's Medical Assistance Administration administers the Medicaid managed care program for low income people in the state of Washington, which offers eligible children under 19 years of age, 12 outpatient visits each year.

Care Coordination: Coordination and planning for EPSDT services is required. Local planning efforts are to include DSHS, Juvenile courts, Public Health departments, School Districts, Educational Service Districts, Head Start or Early Education and Assistance Programs, Community Action Agencies, Children's Service Providers, and parents of children in need of mental health services. DSHS is further required to work with the Office of the Superintendent of Public Instruction (OSPI).

Wraparound Process: Wraparound is a term used to describe a family-centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people achieve important outcomes by assisting them to meet their unmet needs both within and outside of formal human services systems. Wraparound services is the term used to refer to comprehensive, home-based mental health treatment, and case management services designed to support severely emotionally disturbed youth between the ages of four and twenty-one years old in the least restrictive environment appropriate to their needs. Components of wraparound services include individual counseling, family counseling, case management, crisis intervention, behavior management/parenting education, and communication skills counseling.

Summary of Second Substitute Bill: Early and Periodic Screening, Diagnostic, and Treatment: 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 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 to Care: 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.

DSHS 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. 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 (DOH).

Pilot Programs: 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. DSHS must contract with RSNs, Educational Service Districts (ESDs), 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: DSHS must 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. DSHS also must collaborate with other entities to promote speedy eligibility determinations for youth likely to be eligible for medical assistance service upon release from confinement. 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: 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. 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 CHANGES MADE BY RECOMMENDED STRIKING AMENDMENT(S) AS PASSED COMMITTEE (Human Services & Corrections): The striking amendment adds the integration of educational support services that address students' diverse learning styles and decreased involvement with the juvenile justice system to the list of outcome measures. Reliance on evidence-based practices is prioritized; however, the use of evidence-based, research-based, promising, and consensus practices are permitted.

The definitions of child, family, evidence-based, and promising-practice are modified to be consistent with definitions used in current code. Definitions for consensus-based and research-based practices are added to the bill. The definition for wraparound process is refined to incorporate the ten principles of the process.

Provisions regarding the reduction of reliance on medication alone and improper prescriptive practices are strengthened. DSHS is required to review psychotropic medications of all children under the age of five and establish mechanisms to evaluate the appropriateness of that medication. DSHS is also required to encourage the use of cognitive behavioral therapies rather than medication where such therapies are indicated. DSHS is required to report to the Legislature on progress and findings with respect to medication practices by January 1, 2009.

The increased mental health out-patient benefits package is changed from a statewide implementation to a pilot program in the areas that receive the wraparound pilot program. ESDs may partner with a Regional Support Network in order to respond to a Request for Proposal to deliver wraparound services.

EFFECT OF CHANGES MADE BY RECOMMENDED STRIKING AMENDMENT(S) AS PASSED COMMITTEE (Ways & Means): The increased mental health outpatient benefits package is changed from a pilot program limited to the areas selected for the wrap-around pilot to a statewide, two-year pilot.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony (Human Services & Corrections): PRO: 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. Expedited Medicaid determinations are an excellent addition to this bill.

Since at least 1969, the needs of children are particularly underserved in this nation. Even with relatively advanced health services' systems and generous Medicaid benefits, less than half of the mentally ill children get the help they need. 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.

CON: We have a psychiatric system that 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: (Human Services & Corrections) PRO: Representative Dickerson, prime sponsor; Jean Wessman, Washington State Association of Counties; Seth Dawson, National Alliance on Mental Illness-Washington, Compass Health, Washington Council of Child and Adolescent Psychiatrists; Michael Watte, Special Education Advisory Board; Ann Christian, Washington Community Mental Health Council; Laurie Lippold, Children's Home Society; Donna Christensen, Washington State Catholic Conference.

CON: Ruth Martin, Citizens Commission on Human Rights; Gregory Martin, citizen.

Staff Summary of Public Testimony (Ways & Means): PRO: The bill emphasizes early intervention and prevention, which will save money down the road.

CON: Behavior isn't equivalent to illness, and it is dangerous and expensive to assume that it is, as this bill does. Increasing the age of a "child" to twenty-one will increase costs. The bill potentially creates additional liability for the state, because it doesn't provide sufficient safeguards against unnecessary and inappropriate treatment for children and families.

Persons Testifying (Ways & Means): PRO: Seth Dawson, National Alliance for the Mentally Ill of Washington; Lauri Lippold, Children's Home Society and Washington Academy of Pediatrics.

CON: Steve Pierce, Citizens Commission on Human Rights (CCHR); Christopher Steuart, CCHR; Gregory Kauffman, CCHR.