HOUSE BILL REPORT
HB 1373

As Reported by House Committee On:
Early Learning & Children's Services

Title: An act relating to equitable access to appropriate and effective children's mental health services.

Brief Description: Concerning children's mental health services.

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

Brief History:
Committee Activity:
Early Learning & Children's Services: 2/3/09, 2/20/09 [DPS].

Brief Summary of Substitute Bill

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

HOUSE COMMITTEE ON EARLY LEARNING & CHILDREN'S SERVICES

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Kagi, Chair; Roberts, Vice Chair; Haler, Ranking

---

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.

Minority Member; Walsh, Assistant Ranking Minority Member; Angel, Goodman and Seaquist.

Staff: Sydney Forrester (786-7120)

Background:

Overview of Children's Mental Health Services.
State-provided children's mental health services in Washington are delivered primarily through Regional Support Networks (RSNs) established to develop local systems of care. The RSNs consist of counties or groups of counties authorized to contract with licensed service providers and deliver services directly. In addition to RSN's, some children receive mental health services through managed care programs, such as Healthy Options, or from private providers on a fee-for-service basis. Access to mental health treatment can be achieved through minor-initiated, parent-initiated, or state-initiated options.

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

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

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

1. a child's access to services not be conditioned solely on a determination the child is highly at-risk or in imminent need of hospitalization or an out-of-home placement; and
2. assessment and diagnoses for children under the age of 5 be determined using a nationally accepted age-appropriate assessment tool.

Managed Care and Fee-for-Service Programs.

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

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

These changes are set to expire July 1, 2010.

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

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

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

Definition of "Severely Emotionally Disturbed" Child.
A severely emotionally disturbed child is one who has been determined by the RSN to have a mental disorder and who meets one of the following criteria:

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

Summary of Substitute Bill:

Definition of "Severely Emotionally Disturbed" Child.
Beginning July 1, 2011, the definition is amended to remove the requirements for a diagnosis by the RSN and that the child meet at least one additional criteria relating to in-patient or out-patient treatment, involuntary treatment, or involvement in the child welfare or juvenile justice system. The amended definition requires that the child have a mental disorder that clearly and significantly interferes with the child's functioning, in the family, at school, in the community, or with peers.

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

For children under age 5, the standards must:

1. recognize there may be significant assessment and behavioral differences between the 5 and under age group and school-age children; and
2. acknowledge the vital importance of the parent-child dyad, including the impact of parental emotional difficulties on the child and the need to provide family inclusive therapy to effectively treat the child.

Implementation of the revised standards must be accomplished within amounts appropriated in the budget and allocated to the RSNs.

Managed Care and Fee-for-Service Programs.
The July 1, 2010, expiration date for the increase in the annual number of office visits and the provision allowing services to be provided by all licensed mental health professionals is eliminated. The annual number of office visits for children receiving outpatient mental health therapy under the managed care and fee-for-service programs is 20 visits per year, and those services can be provided by licensed mental health professionals and persons under their direct supervision. Administration of managed care and fee-for-service programs must comply with federal rules relating to early, periodic, screening, diagnosis, and treatment, and developmental screenings must be used to identify and provide medically necessary treatment.

Regional Support Network Contract Changes.
To assure the special mental health needs of children are met, contracts with RSNs must, beginning October 1, 2009, set minimum standards for collaboration between the RSNs and various divisions with the DSHS, local school districts, medical providers, and local juvenile courts.

Evidence-Based Practice Institute.

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

Substitute Bill Compared to Original Bill:

The substitute bill makes the following changes to the original bill:
1. delays until July 1, 2011, the implementation of the amended definition for "severely emotionally disturbed" child;
2. removes the requirements relating to minimum thresholds for the number of children served in the RSN, both as a percentage of all persons served and as a percentage of total outpatient service hours;
3. removes a requirement that the revised access-to-care standards accommodate use of a nationally accepted assessment tool specifically for use with infants and young children;
4. removes a requirement for submitting an implementation plan for the revised access-to-care standards to the Governor and the Legislature;
5. removes unspecified appropriations relating to implementation of 2SHB 1088 (2007);
6. adds a requirement that managed care and fee-for-service programs be administered to comply with federal rules relating to early, periodic, screening, diagnosis, and treatment and that developmental screenings be used to identify and provide medically necessary treatment; and
7. requires implementation of the modified access-to-care standards be accomplished within amounts appropriated in the budget and allocated to the RSNs.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 1, relating to amending the definition of "severely emotionally disturbed" child, which takes effect July 1, 2011.

Staff Summary of Public Testimony:

(In support of substitute bill) This bill is a continuation of efforts to change the way we work with children who have mental health problems and is grounded in the belief that until we do so we will always have a large adult population of chronically mentally ill adults. The way to decrease the number of chronically mentally ill adults is to work with children who exhibit problems. The legislative goal in 2SHB 1088 was to have an improved children's mental health system in place by 2012. The actions we have taken toward improvement are incorporated in the Governor's proposed budget reflecting that the Governor believes in what we have been doing to improve the system. The substitute bill is the important and necessary next step. It takes a measured approach in moving forward, recognizing the critical budget issues we have. The revisions to the access-to-care standards are delayed until the next

biennium. Overall the bill is a wise investment along the path of ensuring the mental health needs of children are addressed.

The impact will be minimal this year and not too much in the next biennium. The steps we take now will save money in the long run, but we need to prioritize early investment in children's mental health. The DSHS has been pleased to have worked with the bill sponsors and stakeholders.

The state has taken significant steps to start improving the children's mental health system and the changes have been possible because of the Legislature. This has resulted in families being able to access care before a crisis erupts and allowed providers to used early intervention strategies. Second Substitute House Bill 1088 has been instrumental in these gains and this bill will continue increased use of early intervention strategies.

This bill takes us forward in addressing the needs in early childhood. This is critical because we know that children ages birth to 5 years respond to stressors differently than adults. Parents' mental health is of critical importance in the lives of children. Unaddressed mental health problems in early childhood can impair the child's functioning in numerous domains. By increasing the system's capacity to consider and respond to infant mental health we will see benefits.

The partnership consultation line has been very helpful to physicians serving children with mental health treatment needs. The requirement for cross-system collaboration in the RSNs, especially between the mental health and developmental disabilities system, is important.

(With concerns on substitute bill) The revised access to care standards, when implemented, may not be budget neutral. We like the focus on functional impairment but would like to see more standards as the diagnoses could be a bit too subjective. There also may be additional costs with requiring assessments of children birth to 5 years be done by a children's mental health specialist. Licensed clinical social workers are trained to conduct holistic assessments and wraparound programs. A lot of children with significant needs will need more than 20 sessions per year to help them. If we don't attend to their needs now, we will be attending to bigger issues when these children grow into adults.

(Opposed) None.

Persons Testifying: (In support of substitute bill) Representative Dickerson, prime sponsor; Richard Kellogg, Department of Social and Health Services, Mental Health Division; Dr. Eric Trupin, University of Washington; Dr. Sheri Hill; Laurie Lippold, Children's Home Society and Washington Chapter of the American Academy of Pediatrics; Diana Stadden, The Arc of Washington; Cathy Callahan-Clem, Sound Mental Health Family Resource and Support Groups; Jody Schreven; Eleanor Owen, National Alliance on Mental Illness - Greater Seattle; Seth Dawson, Compass Health and National Alliance on Mental Health; and Steve Williams.

(With concerns on substitute bill) Margaret Rojas, North Sound Regional Support Network; and Laura Groshong, Washington State Society for Clinical Social Workers.

Persons Signed In To Testify But Not Testifying: None.