# FINAL BILL REPORT
# 2SHB 1088

**C 359 L 07**
Synopsis as Enacted

**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).

**House Committee on Early Learning & Children's Services**
**House Committee on Appropriations**
**Senate Committee on Human Services & Corrections**
**Senate Committee on Ways & Means**

**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 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. 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.

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 requested the WSIPP 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 the study, the WSIPP found that 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:**

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 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.

Definitions are created for the following terms: family; evidence-based practice; promising practice; consensus-based; research-based and wraparound process.

The effectiveness of the system will be determined by outcome-based performance measures to be developed jointly by: the Department of Social and Health Services (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 solely on a determination the child is highly at-risk or in imminent need of hospitalization of an out-of-home placement. Assessments and diagnoses for children under the age of five years must be determined using a nationally accepted age-appropriate assessment tool. 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 contract for a wraparound pilot program for children with serious emotional or behavioral disturbance. The wraparound pilot will create up to four new sites and will expand up to two existing 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 or other 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 Institute.
A children's mental health evidence-based practice institute (EBP 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 of 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 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. 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 and Medication Management.
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.

In consultation with the EBI Institute, the DSHS must develop and implement policies: to improve prescribing practices and the quality of children mental health therapy through increased use of evidence-based and research-based practices; to improve communication and care coordination between primary care and mental health providers; and to prioritize care in the family home or care which integrates the child's family if out-of-home placement is required.

The DSHS must 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.

The DSHS also must:
(1) review the use of psychotropic medications for children under five years and establish mechanisms to evaluate the appropriateness of the medications;
(2) track prescriptive practices and the use of psychotropic medications with the goal of reducing use of medication; and
(3) encourage use of cognitive behavioral therapies and other evidence-based treatments in addition to or in place of medication where appropriate.

**Votes on Final Passage:**

| | | | |
|---|---|---|---|
| House | 92 | 4 | |
| Senate | 47 | 0 | (Senate amended) |
| House | | | (House refused to concur) |
| Senate | 39 | 0 | (Senate amended) |
| House | 94 | 4 | (House concurred) |

**Effective:** July 22, 2007