Children and Youth Behavioral Health Workgroup (CYBHWG)

2025 Draft Subgroup Recommendations

Recommendation Summaries

Budget proposals: **$** < $500,000 **$$** = $500,000 -$999,000 **$$$** = $1 million - $10 million **$$$$** > $10 million

Overarching recommendation(s)

	TBD

Subgroup recommendations

Behavioral Health Integration (BHI)	
New **$TBD** **Policy**	**Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates** Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates. Includes rates for individual and family psychotherapy, group psychotherapy and ARNP patient visits.
New **$TBD** **Policy**	**Allow MH professionals to provide BH supports to young children who may present with symptoms that do not merit a diagnosis.** Fund mental health professionals to provide preventive behavioral health services to the youngest children and their families in the first years of life in primary care settings. Focus on the family unit – including supporting parent mental health needs, family financial needs and the needs of the dyad. Identify existing or potential billable opportunities possible in the Medicaid program. (Will be identified before Oct 1.)
Legacy **$TBD**	**Ensure pediatric CHWs are a sustained and viable workforce for patients insured in Medicaid through WA State seeking adequate Medicaid rates from CMS** Seeking Medicare rates for CHWs in Medicaid's state plan amendment proposal to CMS.
New **$**	**RUBI parent training program pilot expansion** $250,000 in funding to conduct a one-year Pilot Site implementation project of the RUBI Parent Training program with behavioral health providers embedded in primary care settings at 10 pilot sites across WA State. The focus is on enhancing primary provider skill in providing care for families of youth with autism/intellectual disabilities (ASD/IDD) and co-occurring behavioral health needs and expanding family access to evidence-based care.
Prenatal through Age 5 Relational Health (P5RH)	
Legacy **$$$**	**Expand Early (birth to three) ECEAP** *Early ECEAP = Birth to three early childhood education and assistance program (ECEAP) (pronounced e-cap)* Expand Early (birth to three) ECEAP service provision by adding 200 slots ($5M). We recommend an expansion of the Early ECEAP program, a comprehensive, childcare partnership model for high-need children 0-3 who need both classroom and family support services. Early ECEAP is modeled after the federal Early Head Start childcare partnership program that has been shown to reduce families' involvement with child protective services (CPS) combines robust trauma-informed approaches with children and parents with high quality early learning.

Legacy **$$$**	**Increase investment in IECMH-C (Holding Hope program)** *IECMH-C = Infant and Early Childhood Mental Health Consultation* **Budget Request: Increase investment in IECMH-C by $1.5 million annually to address unmet need and increase equitable access to IECMH-C for WA's children, families, and adult caregivers in child care.** Funds would be used to (1) expand capacity to provide individualized mental health consultation services to child care providers, children and families; (2) provide IECMH-C services by linguistically and culturally matched consultants, and (3) initiate a community-engaged program evaluation and planning effort to determine access and effectiveness of consultation approach in diverse communities.
Legacy **$$$$**	**Expand the Complex Needs Funds for Child Care and ECEAP.** We support maintaining the level of funding in the previous biennium ($34.8M, of which $29M is maintenance). In FY23-25 ECEAP Complex Needs Received $15M (including $5.8M in one-time funds) and the Childcare Complex Needs Fund received $19.8M.
New **Policy** **$$** **Rule Change**	I**ncrease family psychotherapy reimbursement rate.** Increase family psychotherapy rates to reflect the complexity of providing relationship-focused treatment that includes parents and caregivers, which is best practice in clinical Infant-Early Childhood Mental Health treatment. Current family psychotherapy rates are up to 36% lower than individual psychotherapy rates for services of equivalent duration, which disincentivizes provision of and billing for these essential services.
New **Policy** **Rule Change** **$-$$$**	**Alternative-payment pathways & reimbursement for P-5 providers** *This recommendation is still under development and consists of two potential pathways that could be separated or combined.* Pathway 1: Alternative-payment model for IECMH. Create a model of payment, moving from fee-for-service, which is setting-agnostic, supportive of the workforce without adding administrative burden, and provides a pathway for expanding service provision. Estimated costs to implement a pilot for FY26, not inclusive of implementation costs post-pilot: $1.25m GF-S; $1.25m Federal. Pathway 2: Non-licensed providers in home visiting and early childhood services should be reimbursed for their role in detecting and managing perinatal mental health issues.
New **$**	**Sustainable funding to expand and enhance community providers supporting the parent-infant dyad following NICU stay and/or diagnosis of developmental delays.** Sustainable funding to enhance behavioral health capacity among home visiting providers in supporting the parent-infant dyad following a Neonatal Intensive Care Unit (NICU) stay and/or diagnosis of developmental delays. This capacity building will focus on supporting the emotional well-being of parents, strengthening social-emotional skills within the dyad, and providing targeted support for medically complex infants.
New **$TBD**	**Expand Maternity Support Services (MSS) regional coverage and provision of wraparound supports.** Expand Maternity Support Services (1) provision to all counties; and (2) programming to incorporate individualized, intensive, coordinated, comprehensive, culturally competent, and trauma-informed wraparound services to better meet the needs of pregnant and post-pregnancy individuals with behavioral health conditions.

New **Policy** **$TBD**	**Explore consumer tax models to create sustainable financing for P-5 initiatives.** Create a Legislative Task Force to explore consumer tax models and create a tax policy on smoking products (tobacco and marijuana) as a sustainable financing strategy for Prenatal through Five (**P5**) initiatives.
School-based Behavioral Health & Suicide Prevention (SBBHSP)	
Legacy **$**	**Continue funding for Mental Health Literacy Coordinator** Maintain OSPI budget allocation, originally allocated in the 2024 supplemental budget, funding mental health instruction implementation coordinator charged with facilitating the addition of mental health education in schools. Expand the role to include national collaboration with other state education agencies and the US Department of Education. ($300K per biennium) 5950-S.SL.pdf (wa.gov) – pg. 660, Sec. 501 (1)(m), $150,000 for FY24
Legacy **$TBD**	**Funding for School Districts** Provide funding directly to local education agencies (LEAs) to plan, coordinate, and/or provide school-based supports that address the emergent mental health crises in their student populations and meet the requirements of RCW 28A.320.127. (In the absence of funding for all school districts, provide $5M to establish a statewide grant for school districts.)
New **Policy** **$TBD**	**Growing the behavioral health workforce in schools** Pass legislation that will increase the number, skills and diversity of physical, social, emotional support (PSES) staff in school buildings. This legislation will: 1. define school social work and their role as school mental health professionals in alignment with the the national model for school social work 2. conduct a landscape analysis of legislature's investment in PSES staff in 2022 (House Bill 1664) 3. develop an advanced behavioral health skills certificate for PSES staff 4. train school adminstrators on the roles of PSES staff and the importance of each type of professional 5. provide matching grants to high need, rural school districts to hire school social workers that don't currently have the resources to do so 6. provide conditional scholarships for 30 news students in UW's Workforce for Student Well-being program along with skills-building (a potential joint recommendation with the Workforce and Rates subgroup)
New **$TBD**	**Expansion of behavioral health student assistant professionals (SAP) program** Request for additional funding for the state-funded AESD Behavioral Health Student Assistance Professionals (SAP) program. The program currently deploys embedded SAPs to provide behavioral and mental health and substance abuse prevention and intervention services in small, rural and areas with low access to behavioral and mental health services across our state.
New **$**	**Develop and publish a School Health Hub playbook** Develop and publish a playbook to help Washington schools, behavioral health agencies, and local/state governments build and sustain coordinated, school-based behavioral heath programs/services/systems of care (SBIRT, MTSS, ISF) during the 2025-2026 school year. Request funding for 2 FTE (~$250K, one-time) to support the development and publication of the playbook.

Previous Policy $$$	**Designate and fund a lead agency for school-based behavioral health** Designate a statewide leadership authority for student behavioral health and wellbeing, with a mandate to ensure student access to a continuum of effective behavioral health services in school and interconnected community settings. Provide funding to the leadership authority to act on that mandate.
Workforce & Rates (W&R)	
Legacy Policy $TBD	**Ensure viable and appropriate implementation of the CCBHC model** *CCBC = Certified Community Behavioral Health Clinic* The Legislature should take necessary steps to provide legislative and budgetary support to ensure implementation of the CCBHC model by FY2027, including participation in the federal demonstration and/or executing a State Plan Amendment.
Previous Policy $TBD	**Behavioral Health Teaching Clinic designation & enhancement rate** The Legislature should enact legislation codifying the Behavioral Health Teaching Clinic Designation & Enhancement Rate into law; appropriate funds necessary to enact and adequately fund the enhancement rate; and direct the Health Care Authority (HCA), during the FY26-27 biennium, to take necessary steps to submit the Behavioral Health Teaching Clinic Designation & Enhancement Rate for approval by the Centers for Medicare and Medicaid Services (CMS).
Legacy $TBD	**Fund the supervisor stipend program** The recommendation is to include funds in the '25-'27 biennial budget to implement the supervisor stipend program as established by the legislature in HB2247 (2024). At this point the exact amount needed is TBD as we are awaiting information from DOH about a possible DP.
Legacy Policy $TBD	**Conditional Scholarships** A policy change is needed to direct WSAC to work with a UW-led consortium of 13 institutions of higher education statewide to recruit a diverse cohort of master's level candidates. Funding is needed for: 1) conditional scholarships ($50k/student; 180 students); 2) three concentration areas to provide skills training to candidates in alignment with employers' needs ($10k/student); and 3) continuing program evaluation beyond one-year of funding ($150K).
Legacy $-$$$	**Maintenance funding expansion for Partnership Access Line (PAL) & Referral Service** To keep PAL and Referral Service both operating at full capacity with no service cuts over the upcoming biennium, we request budget increase for those two programs together to be a total of $2.211 million dollars over the biennium. Because HCA receives large contributions of funding for PAL and the Referral Service from the state's commercial insurers (due to previous legislation) and from Federal matching dollars, we understand that the state commitment component of that amount would be on the order of ~$370,000 state general funds over the biennium (subject to HCA's final confirmation)
Previous Policy $-$$	**Well-Being Specialist designation** Policy ask: State adopts a plan to incentivize referral to wellness services from primary care, details forthcoming. Funding for FY25 ($780,000): I. Scholarships to support OJT pathways subsidized by the state for 50 WBS.$100,000 II. Clinic incentives to participate in wellness specialist training program that help pay for step increases in pay, supervision and ongoing training costs for 10 participating agencies. $300,000 (if the agency rates vary in cost, we will look to expand the number of participating agencies)

	III. Continued funding for agency culturally responsive and leadership training for 10 agencies. $130,000 IV. Administration, evaluation and technical assistance. $250,000
New $TBD	**Fund youth-focused curriculum for Behavioral Health Support Specialists (BHSS)** A Behavioral Health Support Specialist will be a new bachelor level provider type with a scope of practice that includes mental and behavioral health interventions delivered under clinical supervision. UW Seattle is a catalyst for this workforce project and received funding from Ballmer Group to develop an adult curriculum. The BHSS program is seeking funding for a youth focused curriculum that will be disseminated by colleges and universities across Washington State.
Youth and Young Adult Continuum of Care (YYACC)	
New Policy $TBD	**Expand access to peer support services** Expand access to peer services (especially youth and family peer services) by creating and enforcing network adequacy standards, lowering barriers to insurance billing, maximizing billing for current programs to expand services and ensure sustainability, and investing in wellness programs and professional development for the peer workforce.
New Policy $TBD	**Support expansion of recovery high schools** Convene an advisory committee to establish a statewide network of recovery high schools. Work may include reviewing strategies used by other states, reading the Association of Recovery Schools Toolkit for starting a school, conducting outreach and needs assessments, identifying potential long-term funding sources, and developing a structure for evaluation and communication of student characteristics and outcomes. This recommendation is based on Oregon's demonstrated success in designing a strategic plan outlining the path forward. Initial investments would likely include a portion of an FTE to staff the proposed advisory committee and stipends for some committee members.
New Policy $$-$$$	**Fund administration of CAPS and streamline pathway to First-Episode Psychosis care** *CAPS = Central Assessment of Psychosis Services* Despite the increased availability of First Episode Psychosis services across our state, pathways to FEP care remain difficult for families to navigate and teams are often under-equipped to meet the need. The Central Assessment of Psychosis Service (CAPS) seeks to streamline the pathway to FEP care in Washington State and address obstacles to early detection of psychosis by creating one front door for young people as well as their families and practitioners who have a psychosis-related concern. A stable source of funding is needed to launch and sustain this statewide service in SFY2026.
Previous Policy $TBD	**Expand the Bridge Residential housing program** Expand the number of Bridge Housing programs that serve young people exiting inpateient behavioral treatment. The Bridge Housing are 6-10 bed, 90-day, residential programs that provide mental health and substance use disorder support onsite and in the community. Cost is $1.5M annually per additional house.
New $$	**Increase and sustain funding for Youth Wellness Zones** Support four model Youth Wellness Zones in Washington state to give time for these sites to demonstrate proof of concept and build political momentum: NE Spokane Zone, Renton Innovation Zone Partnership, Parkland Youth Wellness Zone, Yakima Valley Partners for Education. Each site is requesting $100,000 ($400,000 combined), with additional funds going to a convening organization ($50,000) and ongoing evaluation and technical assistance ($100,000). The Youth Wellness Zones effort will seek additional matching funds to extend and

	sustain the work moving forward. Each site is informed by a youth team, which also aligns with Washington state's efforts to have policies guided by youth voice in matters affecting their well-being.
Legacy Policy	**Extend the timeline of House Bill 1580 (2023)** Extend the timeline of House Bill 1580 (2023 State Session, sponsored by Rep. Callan) to ensure the team can fully build a process to support children who remain hospitalized unnecessarily due to barriers to discharge. HB1580 was passed with a timeline that ran only for the 2023-2025 biennium and will expire in June 2025 if not extended. We recommend extending both the positions and flexible funding elements of the bill for at least another biennium.
New $-$$	**Support the ASD/IDD workforce serving youth and young adults** Fund a one-year pilot program to enhance program coordination and system navigation by non-licensed professions, and expand training for licensed professionals assisting with diagnosis.

Recommendation Details

Overarching

TBD

Behavioral Health Integration (BHI)

Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Policy	**Recommendation Summary.** Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates. Includes rates for individual and family psychotherapy, group psychotherapy and ARNP patient visits. **[Fiscal Impact]** *Our understanding is with the Health Plan Assessment we would draw down enough Federal dollars to allow for Medicaid:Medicare parity without additional GFS dollars.*	
What is the issue?	Outside of Collaborative Care (CoCM) billing, Medicaid rates for mental health counseling in primary care is not sustainable. While Collaborative Care billing can cover cost of care (when programs are built intentionally for children and for the associated billing parameters/requirements), not all children and teen's clinical needs match with the Collaborative Care model, nor are all clinics able to implement the CoCM model. Multiple clinics with BH Integration report needing both CoCM and traditional psychotherapy billing in order to meet the varying needs of pediatric patients. Raising Medicaid mental health counseling rates by 30% would 1.) ensure that existing BH Integration programs are financially viable and can continue, 2.) BH integration programs can most appropriately serve children and teens presenting clinical needs, and, 3.) increase the number of primary care clinics able to provide BH Integration for children and teens. Furthermore, at these higher, more sustainable rates, some private practice mental health providers who do not currently accept Medicaid may open their doors to children and teens insured in Medicaid.	

	Please note, this proposal would only help a small number of community mental health centers – and does not impact a preponderance of community mental health center funding. Nor does it apply to Federally Qualified Health Clinics.
What do you recommend?	We recommend passing a health plan assessment for ultimate Medicaid:Medicare parity for psychotherapy and ARNP visits.
Why is taking the recommended action a smart move now?	Today only about 25-30 primary care clinics across the state are providing BH Integration tailored to the unique needs of children and teens*. BH Integration is a proven model for breaking down stigma, reducing access barriers for BIPOC, and helping children with mild and moderate needs as soon as a need is identified. Futhermore, if private practice providers who are currently closed to Medicaid would allow access for Medicaid, it would create some degree of capacity not currently available in the system. 95% of primary care and mental health agencies surveyed report the proposed rate increase would address unmet community need and 85% would expand services with a rate increase of this magnitude. A large majority of practice providers surveyed (69%) who do not currently take Medicaid would open their doors to kids in Medicaid with this rate increase. **(Please note, while many Federally Qualified Health Clinics have BH Integration – oftentimes their service remains a light touch – providing about 2 brief BH interactions per patient. Thus our description of only about 25-30 clinics providing peds BH integration to the best of our knowledge.)*
What outreach has helped develop this recommendation?	We conducted 9 key informant interviews with primary care providers, child advocates, community mental health agencies, independent (private practice) mental health counselors, and child & adolescent psychiatrists on the impact Medicaid:Medicare parity for psychotherapy could have on access and their services. We also surveyed primary care, mental health agencies and private practice providers and received 123 survey responses from across the state. All interviews and survey responses indicate a significant potential impact from a rate increase of this size. The BHI Subgroup and the Workforce and Rates Subgroup have had meetings on this topic in the past three months (at least 3 meetings) including broad-based stakeholders from multiple sectors.
Is there any additional collaboration needed to further develop this recommendation?	Workforce and Rates and P-5 Subgroups are supportive.

Allow mental health professionals to provide BH supports to young children who may present with symptoms that do not merit a diagnosis

Type of Recommendation	☐ Legacy* CYBHWG Recommendation	☒New Recommendation ☐Previous Subgroup Priority
☒Policy ☒Budget **[Fiscal Impact]** ***Unsure. Need HCA guidance.***	**Recommendation Summary.** Fund mental health professionals to provide preventive behavioral health services to the youngest children and their families in the first years of life in primary care settings. Focus on the family unit – including supporting parent mental health needs, family financial needs and the needs of the dyad. Identify existing or potential billable opportunities possible in the Medicaid program. (Will be identified before Oct 1.)	
What is the issue?	Today MH professionals must assess and diagnose to provide and bill for BH services to children, but in the first years of life (in most cases) a diagnosis is not appropriate to provide the preventive BH supports from which children and families would most benefit, such as addressing post-partum mental health needs or families' social/financial needs—to promote relational health. Providing ways for BH professionals to provide preventive BH services to children and families in the first years of life has been demonstrated to increase adherence to preventive well-child care, decrease ED use, and prevent future BH problems in adolescence for the child.	
What do you recommend?	We recommend partnering with the HCA to understand the opportunities and approaches to finance preventive BH services and supports in the first years of life. We seek HCA support to BH Integration Subgroup in September to understand opportunities like the dyadic model CA has in place.	
Why is taking the recommended action a smart move now?	The science of early childhood development and early relational health demonstrates upstream evidence-based supports at the earliest juncture can have lifelong impacts. Today, the financial incentive is to treat children and teens only once they warrant a full-fledged diagnosis. This funding would allow us to help children in the first years of life and prevent future mental illness.	
What outreach has helped develop this recommendation?	We have met with the HCA and are learning from MN and CA. At the 8.27.24 BHI Subgroup it became clear that the MN approach is not ideal. At the 9.3.24 BHI Subgroup we learned from CA and their approach holds promise.	
Is there any additional collaboration needed to further develop this recommendation?	We anticipate the P-5 Subgroup would support this concept and need ongoing partnership and expertise from the HCA and states who already have this benefit.	

Ensure Pediatric Community Health Workers (CHWs) are a sustained and viable workforce for patients insured in Medicaid through WA State seeking adequate Medicaid rates from CMS

Type of Recommendation	☒ Legacy* CYBHWG Recommendation	☐New Recommendation ☐Previous Subgroup Priority
☒Budget **[Fiscal Impact]**	**Recommendation Summary.** Ensure Pediatric Community Health Workers (CHWs) are a sustained and viable workforce for patients insured in Medicaid through WA State seeking adequate Medicaid rates from CMS.	
What is the issue?	The Washington State Legislature invested in the Pediatric CHW workforce through a 2-year grant program beginning in January 2023 and has directed the HCA to submit a state plan amendment to CMS to make CHWs a Medicaid benefit beginning in July 2025. The HCA has indicated that the rates they seek will not cover CHW salaries. Today pediatric CHWs are in over 40 clinics including 10 tribes and are making meaningful differences in BH and health related social needs for children, teens and families. If the rate WA seeks from CMS does not cover the cost of employing CHWs, clinics will no longer employ the workforce, nor will it grow. This would be an enormous lost opportunity for workforce extenders, a culturally-congruent workforce, more timely access to BH care, and support for Health Related Social Needs.	
What do you recommend?	Seeking Medicare rates for CHWs in Medicaid's state plan amendment proposal to CMS.	
Why is taking the recommended action a smart move now?	Clinics with CHWs have already seen significant impacts in their ability to address the health-related social needs of children ages 0-18 and their families, help kids access behavioral health services, and build trusting, collaborative relationships with families. Recent research also found that incorporating CHWs in primary care improved children's receipt of preventive care services, further demonstrating the importance of the CHW role in closing healthcare access gaps and achieving health equity (Coker et al., 2023). CMS and the Biden Administration have prioritized Community Health Workers and a new code for reimbursement for Community Health Workers was released in November 2023 (G0019 for community health integration services.) As the HCA applies for a state plan amendment to sustain and scale CHWs **it is of critical importance that Washington:** 1. **maximize federal reimbursement for these services, seeking Medicare rates for CHWs;** 2. **ensure no gap in payment for the existing pediatric CHW workforce;** 3. ensure that funding mechanisms on Medicaid are sufficient for clinics to employ CHWs.	
What outreach has helped develop this recommendation?	Broad-based support from CYBHWG, BH Integration and P-5 Subgroups, First Year Families, Champions for Youth and others.	

Is there any additional collaboration needed to further develop this recommendation?	Primary care clinics would be happy to help HCA model rates and services in light of salaries needed to employ CHWs.

RUBI parent training program pilot expansion

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation ☐Previous Subgroup Priority**
☒Budget **$250k [one-time]**	**Recommendation summary.** We propose $250,000 in funding in order to conduct a one-year Pilot Site implementation project of the RUBI Parent Training program with behavioral health providers imbedded in primary care settings at 10 pilot sites across WA State. The focus is on enhancing primary provider skill in providing care for families of youth with autism/intellectual disabilities (ASD/IDD) and co-occurring behavioral health needs as well as expanding family access to evidence-based care.	
What is the issue?	Delivering the required specialized treatments to individuals with autism spectrum disorder and related intellectual and developmental disabilities (ASD/IDD) is an area of increasing challenge for our current mental health systems of care. While Applied Behavior Analysis is the standard of care recommended for youth with ASD/IDD, its complex, resource-intensive nature (personnel, intensity of hours) has created significant issues with accessibility, resulting in families waiting for months, if not years to receive care. While waiting, families are turning to their front-line care teams (primary care providers) for needed resources, support, and guidance. This need for support is elevated for families of ASD/IDD youth with co-occurring challenging behaviors, such as meltdowns or shutdowns, self-injury, as well as verbal and physical aggression, as these behaviors can have safety implications and reduce overall quality of life. These behaviors are frequently exacerbated by delays in obtaining services and lack of caregiver training in how to address these challenging behaviors. Not addressing these through early intervention can impact the youth's ability to engage in self-care, educational activities, community activities and peer relationships. Unfortunately, they also increase the risk for needing more intensive services at school and in the community. Uncertainty on how to navigate these behavioral challenges amplifies caregiver stress and affects broader family functioning. To try and address this service access gap, there is a need to expand the accessibility of evidence-based, low intensity service models that can work in	

	primary care settings and are effective in supporting ASD/IDD youth needs and be delivered by non-specialty providers imbedded in primary care. The RUBI Parent Training program is a time-limited, evidence-based, and manualized parent training program for families of youth with ASD/IDD and co-occurring challenging behaviors. Grounded in behavior analytic principles, RUBI creates a structured approach for providers to support caregivers in the building of a behavioral management "toolbox." It has been found to be acceptable to caregivers, reliably delivered by providers, and effective in reducing youth challenging behavior. RUBI has been studied extensively (over 20 published pilot and randomized clinical trials) and is now demarked an evidence-based treatment (Level 2 rating from the California Evidence-Based Clearinghouse for Child Welfare).
What do you recommend?	We propose $250,000 in funding in order to conduct a one-year Pilot Site implementation project of the RUBI Parent Training program with behavioral health providers imbedded in primary care settings at 10 pilot sites across WA State. The focus is on enhancing primary provider skill in providing care for families of youth with autism/intellectual disabilities (ASD/IDD) and co-occurring behavioral health needs as well as expanding family access to evidence-based care. Deliverables include (1) providing high-quality training in the RUBI intervention that is tailored to the needs of providers serving families at one of 10 selected primary care settings, (2) facilitating pilot site delivery of RUBI with a minimum of 10 families. The goal is to improve the ability of community-based providers to accommodate and support individuals with intellectual and developmental disabilities and maximize treatment benefit and supports for caregivers and youth in their community setting. Providing access to evidence-based interventions at this initial point of care creates points of action for families while they are waiting for more intensive services and may reduce the need for more intensive services.
Why is taking the recommended action a smart move now?	Research has proven early intervention is the key to reduce costs and improve outcomes for children with intellectual and/or developmental delays. RUBI empowers the caregiver to incorporate the principles of ABA into the ongoing to development needs of their child. Targeting RUBI training with providers imbedded in primary care embraces the provision of integrated care with physical health and behavioral health, focusing on whole person care.
What outreach has helped develop this recommendation?	This proposal is built off of prior pilot funding of RUBI provider training by the MolinaCares Foundation (initial 40k proof-of-concept feasibility trial of RUBI training for behavioral health providers imbedded in primary care) and the Washington State Health Care Authority (RUBI training for WISe Team providers). In both of these training efforts, there was high provider acceptability of the intervention, endorsing the appropriateness of RUBI in front-line care settings and with non-specialty care providers. This proposed funding initiative would support an effort to scale up dissemination, with a targeted focus on elevating access to care (i.e. deliverables move beyond

	provider training to include implementation of RUBI by a minimum of 10 families per pilot site).

Prenatal through Age 5 Relational Health (P5RH)

Expand Early (birth to three) ECEAP

Early ECEAP = Birth to three early childhood education and assistance program (ECEAP) (pronounced e-cap)

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Budget **$5M (200 slots)**	**Recommendation summary.** Expand Early (birth to three) ECEAP service provision by adding 200 slots.	
What is the issue?	**Lack of access to high intensity, family-supportive services for children 0-3 in center-based settings** Birth to Three ECEAP is our state's intersection between early childhood mental health and early learning. Birth to Three ECEAP targets low-income children (100%) with CPS involvement (11.3%), experience with homelessness (14.6%), on Individualized Family Service Plan (IFSP, this is an early intervention plan) (7.9%), and other priority factors such as substance abuse (10.8%), family violence (11.3%), loss of a parent (7.1%), mental health issues in family, etc. We currently serve less than 7% of eligible children in Early ECEAP and Early Head Start combined.	
What do you recommend?	We recommend an expansion of the Birth to Three ECEAP program, a comprehensive, childcare partnership model for high-need children 0-3 who need both classroom and family support services. Early ECEAP is modeled after the federal Early Head Start childcare partnership program that has been shown to reduce families' involvement with child protective services (CPS) combines robust trauma-informed approaches with children and parents with high quality early learning.	
Why is taking the recommended action a smart move now?	Families who need an early learning approach that incorporates intensive family support and mental health services have very little to choose from, and our ECEAP classrooms are seeing far more children arrive when they are 3 or 4 with significant developmental delays and behavior challenges. The legislature has signaled support for Birth to Three ECEAP with a significant rate increase in 2023, and there is high demand (as shown in ECEAP Request for Application) for B-3 ECEAP expansion in child care deserts and areas with high incidence of CPS involvement, substance use disorder, homelessness and 0-3 child care deserts. This item was a high priority item of the CYBHWG in the 2024 legislative session, but was not funded.	
What outreach has helped develop this recommendation?	Washington State Head Start and ECEAP (WSA), the state ECEAP and Head Start association, worked closely with parents and early learning providers around what needs are unmet in the 0-3 space. In their assessment, the need for	

	center-based comprehensive 0-3 services has greatly increased over the last few years. It is strongly supported in the WSA 2024 state advocacy survey; among Spanish-speaking respondents it was the top-rated advocacy goal (out of 14 options).

Increase investment in IECMH-C (Holding Hope program)

IECMH-C = Infant and Early Childhood Mental Health Consultation

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation ☐Previous Subgroup Priority**
☒Budget **$3M**	**Budget Request: Increase investment in IECMH-C by $1.5 million annually to address unmet need and increase equitable access to IECMH-C for WA's children, families, and adult caregivers in child care.** Funds would be used to (1) expand capacity to provide individualized mental health consultation services to child care providers, children and families; (2) provide IECMH-C services by linguistically and culturally matched consultants, and (3) initiate a community-engaged program evaluation and planning effort to determine access and effectiveness of consultation approach in diverse communities.	
What is the issue?	**More funding is needed to help children, families, and caregivers in Washington.** Child Care Aware of WA (CCA of WA) Holding Hope IECMH-C currently employs a diverse and talented team of Mental Health Consultants statewide, with 14 of 16 consultants representing various communities of color and 9 consultants fluent in languages other than English, including Spanish, Somali, Tagalog and French. We are also currently hiring additional consultants to fill positions created though new FY 2025 funds. As of August 2024 there are 5,994 licensed child care providers statewide with a licensed capacity of 200,239 children.[i] At current funding levels, including new funding this year, we have one MHC for every 240 licensed child care providers or one MHC for every 8,010 children in care. **With full caseloads, the team of MHCs can typically serve roughly 4% of licensed providers at any given point in time**. Most child care sites served have multiple child/family concerns and classroom/programmatic needs which consultants are supporting in partnership with Early Achievers Coaches. **MHC caseloads are currently full and even as we are hiring and onboarding new staff, there are 86 providers waiting for services, and referrals continue to come in.** Additional investment will allow us to serve more of our waitlisted providers, which is a critical short-term goal. Additionally, based on the data below, we know that the actual need for Mental Health Consultation in the child care community is much greater, and **our long-term goal is to have enough IECMHC funding to serve 10% of child care providers** at a time. **Child care providers in WA report critical need for IECMH-C services.** Per the 2022 survey of all licensed child care providers statewide:[ii]	

	• 41% of providers report that 50% or more of the children in their care could benefit from additional support with behavioral or social emotional concerns. 9% of providers reported that ALL of their children need additional support. • 59% of providers report that they do not have sufficient access to a child care health or mental health consultant to support children's health, developmental or behavior concerns. • 60% of child care providers report that they need social/emotional, behavioral, inclusion for special needs, or mental health supports. • 67% of providers reported that they have seen an increase in social/emotional challenges with children. **High and disproportionate rates of suspension and expulsion impact Black and dual language learning students as well as students with disabilities.** Black children's preschool expulsion rate is nearly two times as high as Latino and white children.[iii] And while Black children represent 19% of preschool enrollment, they account for 47% of preschool children receiving one or more out-of-school suspensions. In comparison, white children represent 41% of preschool enrollment, but 28% of preschool children receiving one or more out-of-school suspensions.[iv] Federal data indicates that a disproportionate number of male students representing minority populations are expelled, along with English Language Learners and students with disabilities, all of whom could benefit from daily attendance in preschool programs.[v] Because Holding Hope IECMHC is built on a national evidence- based model that is proven to reduce suspension and expulsion, we are asking for expansion funds to serve underserved communities, assure fidelity to the national model and disrupt expulsion practices and trends here in WA.
What do you recommend?	**We recommend increased investment in IECMH-C, which addresses concerns stated above.** IECMH-C is an evidence-based prevention-oriented, multilevel intervention that results in improved caregiver social-emotional support for young children and improved children's social-emotional well-being.[vi] It is also an effective practice to interrupt bias and disproportionate expulsions and suspensions of young children of color in child care and early learning, providing more equitable opportunities for children to participate in high-quality child care and early learning experiences.[vii] IECMH-C leads to many positive results for children and families including: increased social-emotional skills and self-regulation, reduced challenging behavior, and reduced expulsion rates.[viii] For caregivers, it increases positive interactions with children, reduces stress and turnover, and improves caregiver self- efficacy and knowledge, among other positive results.[ix]
Why is taking the recommended action a smart move now?	**The pandemic and aftermath have taken a substantial toll on children, families and the child care community.** Fourteen percent of parents report that their children had developed more serious mental health and behavioral challenges since the start of the pandemic.[x] During the pandemic, verbal, motor and social-emotional development for the youngest children has been negatively impacted by the following: the number of words spoken by parents to children was lower than in the past two years, restricted opportunities for

	physical play and interaction with peers, high parental stress, depression, anxiety, social isolation and reduction of personal and family interaction.[xi] Additionally, rates of social-emotional and behavioral challenges were one to four times higher among racial and ethnic minorities.[xii] **Rates of caregiver depression are extremely high, and caregivers report significant increases in young children's behavioral challenges**. A 2023 national study revealed that 55% of Washington child care providers screened positive for symptoms of clinical depression.[xiii] These symptoms among caregivers result in less responsive and attuned interactions with young children and indicate a need for increased caregiver support. This same study also revealed an alarming increase in young children's challenging behaviors. 65% of ECE professionals in Washington reported that they had children with increased externalizing and internalizing behaviors in their classrooms or programs since the Pandemic.[xiv] Further, there was significant staff turnover of child care providers during the pandemic, resulting in a less experienced, newer workforce that needs training, professional development and ongoing support to offer quality social emotional learning experiences and environments for young children.[xv] As the Holding Hope IECMH-C model is built on the national model with evidence of reduced staff stress and turnover and reductions in childrens' challenging behaviors, we believe that increased investment will have a positive impact on these trends in WA. **The need for mental health support for Washington's caregivers, children and families is significant**, and IECMH-C is an evidence-based prevention-oriented, multilevel intervention that results in improved caregiver social-emotional support for young children and improved children's social-emotional well-being.[xvi]
What outreach has helped develop this recommendation?	In years past, the Prenatal through 5 Relational Health Subgroup has had extensive exploration and outreach on IECMH-C which involved learning from a national expert, several subgroup conversations involving diverse perspectives, and outreach to non-members like ECEAP and child care providers, parents, and caregivers with lived experience with children with complex and relational health needs. Further, CCA of WA regularly solicits direct feedback from providers and families served through Holding Hope IECMH-C, showing high levels of satisfaction with services, positive changes for staff/children and recommendations from providers for increased funding for IECMH-C services.

Expand the Complex Needs Funds for Child Care and ECEAP

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Budget **$34.8M, of which $29M is**	**Recommendation Summary.** Expand the Complex Needs Funds for Childcare and ECEAP.	

maintenance (biennium)	
What is the issue?	**Additional Supports for ECEAP and Child Care providers to meet the needs of children with trauma and special needs** The legislature has recognized the need for additional resources for programs serving children with special needs and physical and behavioral health challenges. Programs use these funds to support extra staff in the classroom, mental health specialists, training for staff around trauma and behavior support, and necessary curriculum or equipment.
What do you recommend?	In FY23-25 ECEAP Complex Needs Received $15M (including $5.8M in one-time funds) and the Childcare Complex Needs Fund received $19.8M. We support maintaining these amounts.
Why is taking the recommended action a smart move now?	Early learning providers will attest to the huge challenges they are facing with a combination of more children arriving developmentally behind and without age-appropriate social emotional skills and staff turnover and burnout. The Complex Needs Fund has been critical in providing extra support to staff by increasing their skills to meet the new challenges and providing help in the classroom by reducing the adult-child ratio. Stabilizing the early learning workforce is critical, and this is a key piece.
What outreach has helped develop this recommendation?	The Complex Needs Fund is hugely popular with both childcare and ECEAP providers, making serving very high needs children possible. For ECEAP, the Complex Needs Fund was one of the top 3 priorities from providers and staff.

Increase family psychotherapy reimbursement rate

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Policy **☒Budget** **$1M annually, $500k GF-S, $500k federal** **☒Rule Change**	**Recommendation Summary.** Increase family psychotherapy rates to reflect the complexity of providing relationship-focused treatment that includes parents and caregivers, which is best practice in clinical Infant-Early Childhood Mental Health treatment. Current family psychotherapy rates are up to 36% lower than individual psychotherapy rates for services of equivalent duration, which disincentivizes provision of and billing for these essential services.	
What is the issue?	• National and Washington-specific data suggest that young children are less likely than older children and youth to receive needed mental health care, and challenges with accessing insurance reimbursement for services likely contributes to families' difficulties accessing care (Ghandour et al., 2019; Health Care Authority, 2022). While IECMH specialization is extremely limited in Washington's behavioral health workforce, a 2020 survey found that many of the existing IECMH providers experience challenges being reimbursed for their services (Oxford & Lecheile, 2022).	

- Although best practice in clinical IECMH services is to work with the parent/caregiver and the infant/young child together, only about 46% of licensed behavioral health agencies reported providing this type of dyadic treatment service in the 2022 Behavioral Health Provider Survey.
- Currently, the maximum allowable rates for family psychotherapy codes in the Apple Health fee schedules are significantly lower than those for individual psychotherapy services even if the duration and intensity of services is comparable. This rate gap

Maximum Allowable Apple Health Reimbursement Rates: Fee for Service (Mental Health Fee Schedule) vs. Community Behavioral Health (Specialized Mental Health Fee Schedule)

CPT Code	Service	MH	Specialized MH*	Rate Difference**	% Difference**
90836	Individual psychotherapy ("45 minutes")	$64.02	$140.40	*$76.38*	54.40%
90837	Individual psychotherapy ("60 minutes")	$107.18	$147.78	*$40.60*	27.47%
90846	Family Psychotherapy W/O Patient present	$68.16	$124.39	*$56.23*	45.20%
90847	Family Psychotherapy W/Patient present	$71.60	$140.30	*$68.70*	48.97%

**Higher "Specialized Mental Health" reimbursement rates are only available for Community Behavioral Health Agencies (CBHAs), presumably to offset administrative costs such as documentation, medical billing, clinical and administrative supervision, training, audits, records management, CQI, and other business administration tasks. Primary care clinics and mental health providers who are not licensed CBHAs must still complete all of these tasks but without the additional compensation for the necessary time and personnel.*

***$ or % by which reimbursement rates for the exact same services provided by primary care, MH small businesses, and other FFS providers are lower than reimbursement rates for CBHAs*

Comparison: Individual vs. Family Psychotherapy Rates

CPT Code	Comparison	MH	Specialized MH*
90846	% less than 90836	NA	11.40%
	% less than 90837	36.41%	15.83%
90847	% less than 90836	NA	0.07%
	% less than 90837	33.20%	5.06%

serves to disincentivize provision of and billing for family psychotherapy services.

What do you recommend?

- HCA should utilize internal processes to propose increased family therapy reimbursement for young children that promote IECMH best practices for developmentally appropriate dyadic treatment and should seek CMS approval for implementation.

	• In alignment with prior implementation of SHB 1325 (2021) (Mental Health Assessment for Young Children, MHAYC), this effort should align Apple Health policy and reimbursement with national best practices in IECMH.
Why is taking the recommended action a smart move now?	• Some longitudinal administrative research has found that family therapy can have a greater impact on reducing health care costs in the years following treatment than individual therapy, making family therapy a cost-effective intervention strategy (Crane et al., 2012) • Adjusting the rates for family psychotherapy could increase the willingness of the limited number of IECMH clinicians whose services are in high demand to contract with Medicaid MCOs, increasing availability of this highly specialized service to Apple Health enrolled infants, young children, and their caregivers. • This rate increase would support the sustainability of current parallel IECMH initiatives in Washington State that are focused on training in dyadic models of therapy (e.g., Child-Parent Psychotherapy, NeuroRelational Framework).
What outreach has helped develop this recommendation?	This year, the P5RH Subgroup engaged stakeholders in a recommendation development process that was followed by a vote during which subgroup participants identified their five highest priorities. The issue of family therapy rates was one of the top three priorities identified through this process. The prioritization of this issue is consistent with clinician feedback through historical stakeholder engagement processes, including a statewide survey of mental health clinicians conducted by DCYF in 2019.

Alternative payment pathways & reimbursement for P-5 providers

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Policy **Budget [$1.25M GFS]** **☒Rule Change**	**Recommendation summary.** *This recommendation is still under development and consists of two potential pathways that could be separated or combined.* Pathway 1: Alternative-payment model for IECMH. Create a model of payment, moving from fee-for-service, which is setting-agnostic, supportive of the workforce without adding administrative burden, and provides a pathway for expanding service provision. Estimated costs to implement a pilot for FY26, not inclusive of implementation costs post-pilot: $1.25m GF-S; $1.25m Federal. Pathway 2: Non-licensed providers in home visiting and early childhood services should be reimbursed for their role in detecting and managing perinatal mental health issues.	
What is the issue?	Pathway 1: Challenges in billing for their services (Oxford & Lecheile, 2022). With these barriers to access, it may be no surprise that both national and Washington-specific data suggest that young children are less likely than older children and youth to receive needed mental health care (Ghandour et al., 2019; Health Care Authority, 2022). Although best practice is to work with the parent/caregiver and the infant/young children in treatment together, **only about 46% of licensed behavioral health agencies reported providing any**	

	amount of this type of dyadic treatment services in the 2022 Behavioral Health Provider Survey. Research shows that BH provider participation in value-based payment models support a greater return on investment in increased service quality and lower healthcare cost over time.[xvii] Pathway 2: As indicated in the Maternal Mortality Review, the largest contributor to maternal mortality postpartum is mental health. Mental health concerns may be associated with pregnancy or preexisting. However, the ability to access clinical supports is impeded by geographical location of the client, the scarcity of mental health clinicians generally, and the lack of training/expertise in medication management for pregnant or breastfeeding people. The barriers to adequate treatment are especially high for people with Medicaid insurance.
What do you recommend?	Pathway 1: Create a model of payment, moving from fee-for-service, which is setting-agnostic, supportive of the workforce without adding administrative burden, and provides a pathway for expanding service provision. Estimated costs to implement a pilot for FY26, not inclusive of implementation costs post-pilot: $1.25m GF-S; $1.25m Federal. Pathway 2: In the field, lay mental health providers in the form of parent educators, nurses, and doulas, are shouldering much of the direct support for perinatal clients. Home visitors are sensitive to the stressors of new parents, including domestic violence, poverty, and social isolation. They also are experts in early attachment and coaching parents in meeting the needs of their infants. As trusted members of the community, they are often confidants to vulnerable parents. Home visitors screen for parental mental health concerns and refer on to clinical services. However, they are often providing ongoing support and assessment while the parents wait to be connected to a mental health clinician. This may entail extra visits, longer visits, or calls which add to the cost of care. We recommend that home visitors receive reimbursement that reflects their role in early detection, monitoring, and emotional support for perinatal clients. Currently, most home visitors do not work as part of a behavioral health or healthcare organization. They may be part of a community-based organization or nonprofit without the ability to bill Medicaid for mental health services. The rules could be changed to allow them to also utilize Medicaid to support this essential work. Clinicians who are not yet licensed can bill Medicaid under the license of a supervisor, but this could also be eliminated so that more therapists and social workers could be reimbursed fully for working with this vulnerable population.
Why is taking the recommended action a smart move now?	Pathway 1: Builds off of the implementation of SHB 1325 (2021) (Mental Health Assessment for Young Children (MHAYC)), which aligned Apple Health policy and reimbursement with best practices in Infant-Early Childhood Mental Health. Pathway 2: It will take time to grow the workforce of licensed mental health clinicians able to serve more perinatal clients. In the meantime, mental health

	remains a key driver of maternal mortaility as well as interferes with secure attachment in the infant. Babies cannot wait. Their mental health trajectory for their life course depends on having attuned and responsive caregivers in the earliest years. Reimbursing for lay mental health will protect access to home visiting in the present, when the gap between State contracts for home visiting and the cost of service delivery is wider than it has ever been. Allowing non-licensed individuals to be reimbursed will increase the capacity of organizations specializing in early parenting and child development to serve clients. Clients may also be more likely to follow through with referrals to mental health services if they are co-located with their trusted home visiting hubs as opposed to community mental health organizations elsewhere.
What outreach has helped develop this recommendation?	Pathway 2: • The gap between cost of home visiting service delivery and the contracted rates is now well-documented. DCYF is conducting its own study to see how rates might be increased, but this will take time. • The results of a review of Parents as Teachers data showed that parents referred to community mental health for perinatal depression or anxiety were very unlikely to follow through and establish care. They were somewhat more likely to follow through with medical visits for medication by their primary care doctor. • Transportation is a barrier for many parents to access office-based mental health appointments. • The Maternal Mortality review bears out what we know from the field: many deaths attributed to perinatal mental health are preventable but the available of clinical help is insuficcient, particularly for people of color who are overrepresented in the Medicaid rolls.
Is there any additional collaboration needed to further develop this recommendation?	Pathway 1: Working with HCA on development. Waiting to hear about a potential HCA DP. Pathway 2: Subgroup participation would be essential in coming up with a proposed model for reimbursement or wording proposed changes to the rules. Particularly support form the HCA to see if this is even feasible in the short term, or if it is an item that would require development over a longer time frame. We might need to get a sense of what the fiscal impact would be as it would affect the budget. We would also need to coordinate with the group working on workforce development.

Sustainable funding to expand and enhance community providers supporting the parent-infant dyad following NICU stay and/or diagnosis of developmental delays

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Budget	**Recommendation Summary.** Sustainable funding to enhance behavioral health capacity among home visiting providers in supporting the parent-infant	

$500k	dyad following a Neonatal Intensive Care Unit (NICU) stay and/or diagnosis of developmental delays. This capacity building will focus on supporting the emotional well-being of parents, strengthening social-emotional skills within the dyad, and providing targeted support for medically complex infants.
What is the issue?	We are requesting sustainable funding for training programs to ensure that community providers across the state of Washington can equitably support the behavior health of the parent-infant dyad for infants who are discharging from the Neonatal Intensive Care Unit (NICU) and/or have developmental delays. The current funding structure for this workforce development relies on one-time grants, which creates instability and hinders consistent training programs. This has an impact on both the services provided to infants and their parents as well as the attrition rates of home visitors and community providers. NICU parents often face a journey that significantly diverges from their expectations of life with a new baby, profoundly impacting their emotional well-being. Perinatal mental health challenges are among the most common complications of pregnancy and birth, affecting an estimated 15% - 20% of new parents[1]. Parents of NICU infants experience particularly high rates of mental health issues, including PTSD, which ranges from 4.5% to 30%[2] and postpartum depression, which ranges from 18% to 43% of mothers and 15% to 25% of fathers[3]. In general, NICU mothers are at a 74% higher risk than non-NICU parents of experiencing postpartum depression[4]. Furthermore, anxiety rates among NICU mothers range from 18% to 43%, and 40% to 45% of NICU parents experience both depression and anxiety concurrently[5]. When a parent's emotional health is compromised, it can negatively affect their ability to establish secure attachments and respond to their infant's developmental needs, further exacerbating the mental health challenges faced by parents[6]. Community providers, such as Early Support for Infants and Toddlers (ESIT) therapists and community health workers, are typically involved with these families to support the infant's developmental needs. However, the behavioral health needs of these parents often remain unaddressed due to a lack of training and significant resource disparities throughout the state with resources concentrated in urban areas. Numerous barriers to care also

[1] Johnson Rolfes J, Paulsen M. Protecting the infant-parent relationship: special emphasis on perinatal mood and anxiety disorder screening and treatment in neonatal intensive care unit parents. J Perinatal. 2022 Jun;42(6):815-818. doi: 10.1038/s41372-021-01256-7. Epub 2021 Oct 28. PMID: 34711936; PMCID: PMC8552434.
[2] McKeown, L., Burke, K., Cobham, V., Kimball, H., Foxcroft, K., & Callaway, L. (2022). The prevalence of PTSD of mothers and fathers of high-risk infants admitted to NICU: A systematic review. Clinical Child and Family Psychology Review, 26, 33-49.
[3] Segre, L. S., McCabe, J. E., Chuffo-Siewert, R., & O'Hara, M. W. (2014). Depression and anxiety symptoms in mothers of newborns hospitalized on the neonatal intensive care unit. Nursing Research, 63(5), 320–332. https://doi.org/10.1097/NNR.0000000000000039.
[4] Rogers, C. E., Kidokor, H., Wallendorf, M., & Inder, T. E. (2013). Identifying mothers of very preterm infants at-risk for postpartum depression and anxiety before discharge. Journal of Perinatology, 33(3), 171-176. https://doi.org/10.1038/jp.2012.75.
[5] Shuman, C., Peahl, A., Pareddy, N., Morgan, M., Chiang, J., Veliz, P., & Dalton, V. (2022). Postpartum depression and associated risk factors during the Covid-19 pandemic. BMC Research Notes, 15(1), 102. https://doi.org/10.1186/s13104-022-05991-8.
[6] Als, H., Duffy, F. H., McAnulty, G. B., Rivkin, M. J., Vajapeyam, S., Mulkern, R. V., Warfield, S. K., Huppi, P. S., Butler, S. C., Conneman, N., Fischer, C., & Eichenwald, E. C. (2004). Early experience alters brain function and structure. Pediatrics, 113(4), 846–857. https://doi.org/10.1542/peds.113.4.846.

disproportionately impact marginalized communities, resulting in significant disparities in healthcare access and quality of services based on race, socio-economic status, and disability[7].

When a community provider can support the behavioral health of the parent-infant dyad in an equitable, culturally responsive way that is in tandem with support for an infant's development, outcomes can include a reduction in parental stress, improved parent-child attachment, better infant health trajectory, and a reduction in overall medical expenditures[8].

To effectively address this issue, there is a critical need for a structured, sustainable approach to training community providers. This includes ensuring that providers are equipped with the knowledge and skills to support both the developmental needs of infants and the behavioral health of their parents. Trainings are currently offered on an ad hoc basis, dependent on available funding. A consistent funding structure that supports a comprehensive training program would greatly benefit infants, parents, and the workforce. This approach would also consider the administrative burden on agencies, allowing them to send staff to trainings without compromising their ability to serve families directly. A training program that offers live and asynchronous learning opportunities, supplemented by ongoing community of practice convenings, would ensure that community providers across the state have the tools to provide consistent, high-quality care to infants and their parents.

The Hospital-to-Home Systems Change Training Team has been actively addressing the challenge of community provider confidence and competence in supporting the perinatal mental health of parents. This issue was first identified as a significant concern during a Department of Health Nutrition Contract stakeholder convening in 2015, and its importance was further underscored by the Perinatal Mental Health Task Force in 2024.

Since 2021, the Systems Change team has hosted trainings and Project ECHO groups, reaching nearly 300 diverse community providers with representation from 80% of Washington state's counties. The 3-day training program begins with a foundation in perinatal mental health followed by an intensive on infant feeding and development, and a final day focused on special topics such as how to screen parents for perinatal mental health concerns and connecting families with resources. The follow-up ECHOs (Extension for Community Healthcare Outcomes) are grounded in the idea that adults learn best through short, focused sessions, followed by case presentations and peer-to-peer discussions[9].

[7] Beck, A. F., Edwards, E. M., Horbar, J. D., Howell, E. A., McCormick, M. C., & Pursley, D. M. (2020). The color of health: How racism, segregation, and inequality affect the health and well-being of preterm infants and their families. Pediatric Research, 87(2), 227–234. https://doi.org/10.1038/s41390-019-0513-6.

[8] Hannan, K. E., Hwang, S. S., & Bourque, S. L. (2020). Readmissions among NICU graduates: Who, when and why? Seminars in Perinatology, 44(4), 151245. https://doi.org/10.1016/j.semperi.2020.151245.

[9] Agley, J., Delong, J., Janota, A., Carson, A., Roberts, J., & Maupome, G. (2021). Reflections on project ECHO: Qualitative findings from five different ECHO programs. Medical Education Online, 26(1). https://doi.org/10.1080/10872981.2021.1936435.

	Surveyed attendees have consistently reported a significant increase in their understanding of how to support the complex needs of this population, as well as an improvement in job satisfaction. To briefly summarize key efficacy data, • 85% of training participants reported their personal job satisfaction was significantly enhanced by the Hospital-to-Home (H2H) training. • 87% indicated that the quality of care that they provided to infants and parents would be improved because of the training. • 92% of participants felt that attending the 3-day training significantly improved the consistency of care for infants and families within the ESIT program. Given the high turnover among ESIT providers in Washington state, the ongoing need for training opportunities is critical to maintaining workforce competence. The Systems Change team frequently receives requests for additional trainings, though funding limitations have constrained expansion efforts. The evidence suggests that expanding these training initiatives could have a similarly positive impact on children's behavioral health across the state, particularly for those at risk due to a NICU stay or developmental delay.
What do you recommend?	To address the critical need for improved support for parent and infant behavioral health needs following NICU discharge and/or identification of developmental delays, the following comprehensive plan is recommended. The beneficiaries include the ESIT workforce and other community providers who will gain increased competence and confidence in addressing both developmental and behavioral health needs. The primary beneficiaries are the parents and infants served by these providers who will receive enhanced support for their emotional well-being and caregiving capacities. Improved parent support will directly benefit infants through better developmental outcomes and stronger parent-infant attachments. **Actions** 1. Expand and Enhance Training Programs - Conduct Live Training Sessions: Organize interactive, in-person, and virtual workshops spanning 3 days, tailored to various regions to address specific local needs and resource disparities. - Create Asynchronous Learning Modules: Develop online courses and resources that allow providers to learn at their own pace, ensuring accessibility and flexibility. - Implement Continuing Education Credits: Offer accredited training programs to incentivize participation and professional development. - Enhance Training Curriculum: Expand upon the current evidence-based curriculum focused on perinatal mental health, infant development, and family-centered care practices. 2. Establish Ongoing Consultative Support

- Launch Project ECHO Series: Facilitate regular tele-mentoring sessions with this "all teach, all learn" model, where experts provide guidance, case consultations, and support to community providers.
- Provide One-on-One Mentorship: Pair less experienced providers with seasoned mentors for personalized support and skill development.
- Develop Resource Hubs: Create centralized repositories of up-to-date research, best practices, and tools accessible to all providers.

3. Host Community of Practice Convenings

- Organize Regular Meetings: Schedule quarterly convenings for providers to share experiences, challenges, and successful strategies.
- Facilitate Interdisciplinary Collaboration: Encourage participation across various disciplines to promote holistic approaches to care.
- Gather and Analyze Feedback: Use convenings as opportunities to collect input on training effectiveness and areas for refinement and growth.

4. Address Geographic and Ethnic Disparities

- Target Underserved Areas: Prioritize training and resources for providers in rural and underserved regions, including areas identified as maternity care deserts.
- Culturally Responsive Training: Incorporate cultural competency into all training materials to ensure services are sensitive and appropriate for diverse populations.
- Collaborate with Local Organizations: Partner with community-based groups to tailor support and outreach efforts effectively.

5. Evaluate and Sustain the Program

- Conduct Ongoing Evaluation: Utilize metrics such as provider confidence, parent satisfaction, and infant developmental outcomes to assess program impact.
- Scale and Adapt the Program: Use evaluation findings to refine and expand the program to meet evolving needs and integrate emerging best practices.

Timeline for Implementation

Phase 1: Planning and Development

- Establish partnerships with key stakeholders, particularly representatives of marginalized communities.
- Review current live comprehensive training curriculum and develop complementary asynchronous learning materials.

Phase 2: Pilot and Launch

- Conduct pilot live training sessions in select underserved regions and gather feedback.
- Launch initial asynchronous learning modules online.

	- Initiate the first series of Project ECHO sessions and establish mentorship pairings. Phase 3: Expansion and Outreach - Roll out training programs statewide, targeting additional regions and providers, particularly from maternal health deserts. - Host the first community of practice convenings and facilitate interdisciplinary collaboration. - Expand targeted efforts to address geographic and ethnic disparities through innovative tailored programs. Phase 4: Evaluation and Sustainability - Collect and analyze data on program effectiveness and impact. - Adjust training content and delivery methods based on feedback and outcomes. - Develop strategies for long-term funding and program sustainability. Ongoing - Continue to refine and expand training and support services. - Maintain regular evaluation cycles to ensure continued effectiveness and relevance. - Foster a resilient and connected network of providers dedicated to supporting parents and infants. Implementing this comprehensive plan will significantly enhance the capacity of community providers to support the behavioral health needs of infants and parents after a NICU stay or identification of developmental delays. The structured approach addresses current gaps in training and resource distribution, prioritizes culturally responsive and geographically inclusive practices, and establishes a sustainable framework for ongoing support and improvement. The anticipated outcomes include improved mental health and developmental trajectories for infants and families, increased provider satisfaction and retention, and potential long-term reductions in healthcare costs.
Why is taking the recommended action a smart move now?	Our recommendation, to establish sustainable funding for trainings to build capacity of community providers to support the perinatal mental health of parents, is a strategic and timely decision. Consistent funding will enable a regular schedule of trainings, ensuring providers can easily access information in both asynchronous and synchronous formats. Advances in medical care have led to an increase in the survival of infants born prematurely or with other health challenges. As a result, more parents are now navigating the uncertainty of bringing home a medically complex child. Delaying action could lead to increased stress and mental health challenges for these parents, which, in turn, can adversely affect infant development. In the short term, this action will ensure there are more providers able to provide equitable care to parents, helping them navigate the emotional

	challenges of caring for at-risk infants. This proactive approach can lead to healthier outcomes for children and reduce the need for more intensive interventions later in life. In the long-term, it will contribute to building a more resilient community provider workforce with home visitors better equipped to offer ongoing, effective infant mental health support reducing burnout and turnover in the profession. While the initial investment in training programs requires human and financial capital, the long-term savings are substantial. By enhancing the capacity of community providers now, we can reduce the future costs associated with untreated parental stress and mental health issues, as well as the downstream impacts on child development. This approach maximizes the efficiency of existing resources and minimizes the need for more costly interventions down the line. Taking action now will significantly enhance equity in childhood behavioral health. Parents of infants who have experienced a NICU stay or have developmental delays often face unique challenges that are not adequately addressed by current support systems. By equipping community providers with the skills to support these parents, we can ensure that all families, regardless of their circumstances, have access to the resources they need. This will help close gaps in care and create more equitable outcomes for children across diverse communities. Taking action now also would strengthen and support efforts across different groups in P5RH. Some examples of intersections: • Expanding perinatal supports per the maternal mortality review; • Sustaining community-based whole-family supports as part of the Washington Plan of Safe Care; • Emphasizing and supporting non-birthing parents' inclusion and unique needs; per the Fatherhood Council; • Strengthing connections through community-based navigators and coordinators; • Increasing number of healthcare providers integrating emotional well-being into routine care and understanding referral options per Early Childhood Comprehensive Systems (ECCS) Integration P-3; and • Expanding, diversifying, and training within the IECMH workforce with the People Powered workforce project
What outreach has helped develop this recommendation?	***What outreach has helped develop this recommendation?*** To develop the recommendation for sustainable funding for trainings, the Hospital-to-Home Systems Change Training team undertook extensive outreach efforts. The team engaged with a diverse group of stakeholders, including infant and early childhood behavioral health providers, medical providers, community organizations, and parents who have experienced the NICU journey or had an infant with a developmental delay. Their insights and experiences were crucial in shaping the recommendation, emphasizing the urgent need for specialized training to support the emotional well-being of caregivers.

	Additionally, the Systems Change Training team conducted thorough research on evidence-based best practices, reviewing existing studies and identifying gaps in current support systems. Consultations with experts in perinatal mental health, early childhood development, and NICU care ensured that the training recommendations are grounded in evidence and aligned with best practices. Outreach has included parents with lived experience, hospital-based providers, ESIT providers, other community practice settings, a range of disciplines (e.g., FRCs, SWs, MDs, RNs, RDs, SLPs/PTs/OTs, DHH/TCVI), variety of roles (e.g., direct service providers, adminstrators, managers), and extensive range of organizations (e.g., Help Me Grow/WithinReach, subgroup of WCAAP, CYSHCN, UW Infant Development Followup Clinic, Cherish, IMPACT, Barnard Center, Fussy Baby Network and more). This cross-sector outreach has clearly shown the need to build the capacity of community providers to support the emotional well-being of parents and improve infant outcomes.

Expand Maternity Support Services (MSS) regional coverage and provision of wraparound supports

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Budget **[TBD]**	**Recommendation summary.** Expand Maternity Support Services (1) provision to all counties; and (2) programming to incorporate individualized, intensive, coordinated, comprehensive, culturally competent, and trauma-informed wraparound services to better meet the needs of pregnant and post-pregnancy individuals with behavioral health conditions.	
What is the issue?	Maternal mortality remains high in our state, and disproportionately impacts birthing people of color. Most pregnancy-related deaths are in Medicaid-enrolled birthing individuals living in urban areas. Behavioral health is overwhelmingly the leading cause of pregnancy-related deaths; these deaths occur prenatal through one-year post-pregnancy. Many of the recommendations from the Maternal Mortality Review Panel center on **providing additional support to pregnant and post-pregnancy individuals.** Maternity Support Services (MSS) are preventive health and education services to help individuals have healthy pregnancies, births, and babies. Individuals can receive MSS through the First Steps Program if they are pregnant or up to 60 days postpartum and receiving Apple Health. MSS may include pregnancy and parenting information, screening for possible pregnancy risk factors, brief counseling for identified risk factors, and referral to community resources. However, only 25 counties have MSS providers. To improve care for pregnant and post-pregnancy individuals, we recommend **expanding Maternity Support Services to all counties.** MSS is only available in 25 counties after a substantial budget reduction in 2012. MSS needs to be	

	expanded to be available in all counties to provide additional support to birthing individuals on Apple Health. We also recommend **expanding the Maternity Support Services programming to incorporate individualized, intensive, coordinated, comprehensive, culturally competent, and trauma-informed wraparaound services** to better meet the needs of pregnant and post-pregnancy individuals with behavioral health conditions. MSS home visitors would be able to better identify the individuals who could benefit from more intensive wraparound services, while also helping to identify additional prentatal and post-pregnancy needs. This wraparound program should extend to one year post-pregnancy to further impact materal health outcomes.
What do you recommend?	Fund Health Care Authority to expand MSS to all counties, and fund Health Care Authority to develop and implement a model for wraparound services for pregnant or post-pregnancy individuals with documented behavioral health conditions. *Cost – TBD – We are hoping HCA can provide some historical context about cost to expand MSS to all counties (or share a prior decision package), and we may be able to mock up the cost for wraparound services based on how many pregnant Apple Health enrollees have a documented experience with mental health or substance use disorder and the experience of other programs..*
Why is taking the recommended action a smart move now?	The Maternal Mortality Review Panel reviews pregnancy-related deaths and makes recommendations every two to three years. While important progress has been made to increase access to doulas for Apple Health enrollees and addressing some needs related to birthing people who are actively using substances, Washington State can do more to provide wraparound support for pregnant Apple Health enrollees with documented histories of mental health or behavioral health needs. The mental health and behavioral health of birthing people has a direct impact on their children. The next report from the panel is expected in October 2025, which will continue to have additional recommendations related to preventable pregnancy-related deaths related to behavioral health.
What outreach has helped develop this recommendation?	We have considered the interests of the P5RH workgroup and the recommendations of the Maternal Mortality Review Panel (2023 report, #3.1, 5.1, 5.2, 5.3, 5.11).

Explore consumer tax models to create sustainable financing for P-5 initiatives

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Policy **☒Budget**	**Recommendation Summary.** The Prenatal through Five Relation Health (**P5RH**) subgroup recommends that the Legislature create a Legislative Task Force to explore consumer tax models and create a tax policy on smoking	

[Unknown – Technical assistance needed]	products (tobacco and marijuana) as a sustainable financing strategy for Prenatal through Five (**P5**) initiatives.[xviii]
What is the issue?	There is currently no sustainable funding mechanism to support P5 initiatives. The P5RH subgroup prioritizes recommendations for the Legislature to invest in under-resourced P5-related workforce and services to address unmet needs of Washington's young children, families, and providers, such as Infant and Early Childhood Mental Health Consultants ($1.75 million) and Early Childhood Education and Assistance Program ($2.226 million) (CYBHWG Annual Report, Part 1: 2024 Recommendations). Despite the growing momentum in P5 efforts to expand the Infant and Early Childhood Mental Health (IECMH) workforce and reduce treatment gaps among young children and their families (Mahomed, 2020), the lack of robust, sustainable, and equitable access to financing limits and constrains the service delivery system (Charani et al., 2022) and therefore, impedes the coordinated development of P5-related workforce and services across Washington state (Clark et al., 2018). There is a critical need to develop a Legislative Task Force to review consumer tax models and create a tax policy on smoking products (tobacco and marijuana) to ensure that the P5 funding mechanism is independent, long-term, predictable, equitable, and sufficient. To address the primary issue, it is recommended that the Legislative Task Force fulfill the following aims: (a) Gather and review information about current consumer tax models in California and Arizona states. (b) Identify additional financing strategies to supplement future decline in smoking product tax revenue. (c) Complete a statewide needs and assets assessment to discern a budget estimation of P5 initiatives. (d) Design a systematic process with supporting infrastructures across the state to (i) implement the smoking product tax, (ii) collect the smoking product tax revenue, (iii) create a portal for organizations to apply for and be awarded grants equitably, (iv) conduct outreach strategies to raise awareness of grants, and (v) disseminate funds in a timely and predictable manner. (e) Build a governing body, staff, and regional partnerships across the state to (i) designate, (ii) monitor, (iii) report progress, and (iv), when necessary, adjust P5 priority areas and goals. (Please note: implementation of this item may change the foundational structure of the P5RH subgroup). (f) Identify evidence-informed indicators to evaluate the effectiveness of implementing the smoking product tax on short- and long-term objectives of P5-related workforce and service as well as early childhood development and health outcomes. Consumer tax models in California and Arizona demonstrate robust, sustainable revenue streams that positively impact their P5 initiatives, such as IECMH prevention and treatment and quality childcare and preschool for children and

	families. First 5 California (Proposition 10) was passed in 1998 and is projected to receive approximately $348 million in tobacco tax revenue this budget year (Ibarra, 2023; State of California, 2024). First 5 funds many programs in partnership with nonprofits, local hospitals, clinics and county health, and education offices. Services vary by county, but some of the programs they fund include children's mobile immunization clinics, dental services, developmental screenings, family case management, parenting classes, and home visits from a nurse for first-time mothers. Similarly, Arizona's First Things First (**FTF**) was a voter-approved initiative that passed in 2006 that sustainably funds early childhood services with an average tobacco revenue of approximately $121 million annually (Administration for Children & Family: Office of Childcare, 2014; First Things First, 2024). The FTF initiative also created the statewide FTF Board and local regional partnership councils responsible for ensuring that these early childhood funds are spent on strategies to improve education and health outcomes for children younger than age 5.
What do you recommend?	The P5RH subgroup recommends that the Legislature: (1) Determine an estimated fiscal impact of developing a Legislative Task Force. (2) Determine a timeline for implementation. (3) Develop the Legislative Task Force. (4) Create, edit, share, and complete objectives related to exploring consumer tax models, creating a tax policy on smoking products (tobacco and marijuana), and proposing additional financing strategies to fund P5 initiatives sustainably. (Please refer to the recommended aims listed under "*What is needed to address the primary issue?*") (5) Understanding the limited resources, the P5RH subgroup also recommends that the smoking product tax revenue allocate funds to the following priority areas: (i) Childcare stipend for low and lower-middle-income families. (ii) Childcare workforce and development. (iii) IECMH workforce and development.
Why is taking the recommended action a smart move now?	Sustainable childcare for Washington's workforce: Employee turnover, absenteeism, and lost family income associated with childcare cost about $6.9 billion in Washington last year (**ECOnorthwest, 2024**). Although capital gains tax, the Fair Start for Kids Act, and the **Child Care and Development Block Grant** program have been helpful, "Washington needs to do more to make sure the families and providers are not just treading water" (Demkovich, 2024). Consumer tax on smoking products (tobacco and marijuana) can financially assist low and lower-middle-income families with childcare, bolster the workforce, and stimulate the economy as a whole. Young children's untreated mental health problems negatively affect workplace absenteeism and productivity: A study (Santisi, 2024) found there was a 2-fold increase in absenteeism among parents with a young child with mental health needs. 77% percent of parents whose child needed treatment report missing 3+

	days of work, compared to 33% of caregivers whose child did not need treatment. Also, 78% of parents whose child needed treatment reported a reduction in work performance, compared to only 22% of caregivers whose child did not need treatment. Consumer tax on smoking products (tobacco and marijuana) can financially assist in supporting the IECMH workforce development to address unmet mental health needs of young children, ultimately contributing to a healthier and more productive workforce. Supporting IECMH workforce and development: There is a current effort to explore, expand, diversify, train, and retain the IECMH workforce led by the Health Care Authority (HCA) and the University of Washington (UW) Barnard Center. Consumer tax on smoking products (tobacco and marijuana) can financially assist in implementing the recommendations proposed by the IECMH statewide tour report and the People Powered Workforce project, respectively. Equitable access to predictable funding reduces health disparities: Within-state funding is limited to **Best Starts for Kids Prenatal to Five Strategies**, Medicaid, and the Legislature's discretionary funds, thus causing significant disparities in financing to persist across the state. According to the IECMH statewide tour report (**Health Care Authority, 2024**), "funding drives their service provision, and without viable funding, they were less likely or unlikely to provide IECMH services." Consumer tax on smoking products (tobacco and marijuana) can financially assist in up-front investment in program operating expenses of community organizations and aid in building healthy communities (**Health Care Authority, 2024**). Caring for the next generation of Washingtonians: There is irrefutable proof that shows the importance of early childhood, from prenatal to age five, for sustainable development in learning, health, and behavior that impacts across the lifespan (Daelmans et al., 2017). Science clearly demonstrates that early preventive intervention will be more efficient and produce more favorable outcomes than remediation later in life (**Center on the Developing Child, 2007**). Consumer tax on smoking products (tobacco and marijuana) can financially assist in P5 initiatives that prioritize our next generation's health and well-being.
What outreach has helped develop this recommendation?	Drafters of this recommendation have engaged with five stakeholders: (1) Best Starts for Kids, a King County voter-approved initiative, and I collaborated in conducting a literature review on the predictors of childcare disruptions resulting in parents missing work. I learned that childcare instability, the cost of childcare, and children's mental health problems are leading causes of childcare disruptions and missed work. (2) A community mental health agency not included in the P5RH subgroup acknowledged an urgency to provide IECMH services to address unmet mental health needs in their community. However, they cannot finance an IECMH program due to the high up-front investment in program operating expenses and employee turnover rate.

	(3) Representative Debra Entenman, 47th Legislative District, provided information on Washington's current political and fiscal environment. I learned from Rep. Entenman not to pursue a consumer tax on vaping products because there is a growing movement to prohibit flavored vaping products to prevent youth smoking. (4) Dr. Barbara Stroud, a founding organizer and the inaugural president (2017-2019) of the California Association for Infant Mental Health, described the process by which First 5 California was passed. I learned from Dr. Stroud not to pursue a consumer tax on alcohol because of the alcohol industry's strong lobbying efforts. (5) Janet Fraatz, Director of Infant and Early Childhood Mental Health Consultation at Child Care Aware of Washington, shared her experience of working in Washington compared to Arizona and how Arizona's FTF funds childcare programs.
Is there any additional collaboration needed to further develop this recommendation?	• Engage in more stakeholder outreach, including the P5RH subgroup, DCYF, HCA, UW Barnard Center, and community leaders. • Technical assistance is needed to identify the process to get this recommendation into a budget, whether it is the Governor's or an agency's budget.

School-Based Behavioral Health & Suicide Prevention (SBBHSP)

Continue funding for Mental Health Literacy Coordinator

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Budget **[$300,000 per biennium]**	**Recommendation Summary.** Maintain OSPI budget allocation, originally allocated in the 2024 supplemental budget, funding mental health instruction implementation coordinator charged with facilitating the addition of mental health education in schools. Expand the role to include national collaboration with other state education agencies and the US Department of Education. 5950-S.SL.pdf (wa.gov) – pg. 660, Sec. 501 (1)(m), $150,000 for FY24	
What is the issue?	Washington schools need to provide strong prevention support for students, and the foundation of prevention support is dedicated instruction to students on mental health literacy and suicide prevention. Mental health education is more proactive and cost-effective than waiting for needs to arise to the level of concern where treatment is required. Education on Social Emotional Learning	

	and Mental Health Literacy helps create newly informed students who know how to understand and respond to concerns they notice in themselves and in their peers. It is foundational to school multi-tiered systems of support as an critical piece of Tier 1 (universal) supports. When schools do choose to provide mental health literacy and suicide prevention instruction to students, there is no state oversight to ensure that the curriculum they use is culturally-responsive and research-informed and that those tasked with teaching it have the competency to do so effectively. Schools need more support in connecting with appropriate curriculum. Data from the 2019-21 Behavioral Health Navigator Survey indicated that only 68% of district surveyed were proving any form of student instruction on mental health or substance use at the time they were surveyed. Only a portion of those were evidence-based. Overall, there are many evidence-based options for schools to refer to & use for mental health curriculum already available; however, many schools don't know about them.
What do you recommend?	The legislature should re-allocate $300,000 per biennium to the Office of Superintendent of Public Instruction (OSPI) to continue funding an FTE staff position to serve as a mental health curriculum lead responsible for aiding in the implementation of Mental Health Education instructional curriculum for the P-12 education system. The staff member in this state lead position should work to connect and support, the ongoing the work of the Mental Health Instruction Library, and act as a proactive liaison providing implementation support to education service districts (ESDs) and school districts looking to provide effective curriculum for students. The staff member should leverage state and national collaborators already connected to, and ensure K-12 Learning standards in Mental Health align with best practices nationally. 5950-S.SL.pdf (wa.gov) – pg. 660, Sec. 501 (1)(m), $150,000 for FY24
Why is taking the recommended action a smart move now?	It is widly recognized that this leadership position is the critical piece to leveraging existing resources and partnering with ESD's, Districts and schools. It is the final piece create to a system of schools using Tier 1 education to prevent more expensive needs in Tier 2 and especially Tier 3 efforts. The onboarding for this role, subject to renewal, just began in mid-August (2024) and the new coordinator is already embedded with state and national resources and partners with tremendous promise. That said, the implementation support for schools will continue ramping up in the coming months and just fully developed at the end of this current cycle. This position should be a permanent position within OSPI, as It will be a long-term benefit to school-age youth and the work should be a long term investment in Tier 1 supports as well. At the very least, it should be renewed for the 2025-27 biennium to evaluate and confirm efficacy once systemically established by the end of this current cycle. It should also be noted, this leadership position is now being modeled in other states, whith Delaware, as an example.

	MHL education is key to eliminating stigma, empowering peers to support each other, and reducing the behavioral health services burden on schools, allowing the school to focus on all aspects of a well-rounded education. The Mental Health Curriculum Library effectively summarizes the importance of strong student instruction on mental health literacy: *Studies show including Mental Health Literacy (MHL) in an education program leads to decreased stigma and a stronger mental health knowledge base. In turn, that leads to robust peer support amongst youth, decreased delays to care, improved student productivity and more effective interventions for students at risk of suicide (Kutcher et. al, 2016). Regardless of the availability of SEL programs, MHL is likely a key support for addressing today's youth mental health crisis and eliminating mental illness stigma for a generation.*
What outreach has helped develop this recommendation?	The original reccomendation for this position by the SBBHSP Subcommittee in 2023 consisted of 37 members, including family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations, and a Youth Advisory Committee consisting of 11 youth and young adults with lived experience interacting with behavioral health supports in WA K12 schools. The Subcommittee developed recommendations across five Zoom workshops and three Zoom Youth Advisory Committee meetings. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here is a combination of the group's fourth and seventh ranked priorities in the survey. ESD Behavioral Health Navigators collected the data reference above through interviews with school district staff from 2019-2021i . The dataset includes 219 districts, representing all 9 ESDs, and 37 of 39 counties in the state. The interview protocol included questions covering behavioral health services in schools, community referrals, behavioral health screening, Medicaid, and more. The SBBHSP Subcommittee is bringing this items forward again for the 2025 legislaative session as a legacy item.

Funding for School Districts

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Budget **$300,000 per biennium**	**Recommendation Summary.** Provide funding directly to local education agencies (LEAs) to plan, coordinate, and/or provide school-based supports that address the emergent mental health crises in their student populations and meet the requirements of RCW 28A.320.127.	
What is the issue?	OSPI conducted a survey of all 321 Local Education Agencies (LEAs) in the state between March 2022 and February 2023 to gauge compliance with the RCW 28A.320.127. Data collected from the survey found that only 172 LEAs (54%)	

	reported that they had an EBD plan in place. **149 LEAs reported they did not have an EBD plan in place**. School districts currently lack the funding necessary to coordinate comprehensive supports across the behavioral health continuum for their students. RCW 28A.320.127 requires each school district in Washington to adopt a plan for recognition, initial screening, and response to emotional or behavioral distress (EBD) in students, including but not limited to indicators of possible substance abuse, violence, youth suicide, and sexual abuse. The RCW requires EBD plans to include a list of components - including identifying training opportunities, developing partnerships with community-based organizations, and creating protocols for responding to crisis situations – all of which require significant staff time and resources to complete effectively. However, the state does not provide funding to LEAs, outside of funding allocations for school nurses, social workers, counselors, and psychologists, to do this crucial work. As such, many LEAs lack adequate funding for implementing foundational evidence-based preventative supports, especially those in collaboration with community-based providers, while coordination of intervention supports often relies on navigating challenges with billing student insurance. When community providers are available to support students, schools have difficulty engaging community providers because of access, scheduling, and funding issues, making it difficult to integrate services into school support teams. The OSPI survey on compliance with RCW 28A.320.127 asked LEAs about barriers they encountered in developing an EBD plan. Lack of time or adequate staff was the most mentioned barrier, cited by 84 LEAs in the survey. Lack of funding and/or resources were the second most commonly cited barrier. Many LEAs mentioned that they needed more funding to ensure proper training and professional development, both to create the plan and train their staff to support the plan once it was created. Several LEAs also mentioned that they would need funding for an additional staff member to create the plan, since they felt their current staff didn't have the time or the proper expertise. Similarly, some LEAs said that they would need money to hire behavioral health staff to support the plan once it was created. Other LEAs pointed to a lack of behavioral health resources in their community as a barrier to putting this plan in place and/or emphasized, in general, that the EBD RCW, as it stands, is "another unfunded mandate."
What do you recommend?	The legislature should provide funding to all school districts to create and implement a plan for screening, recognition, and response to emotional and behavioral distress in students, as required by RCW 28A.320.127. In the absence of funding for all school districts, and to pilot direct funding support for compliance with RCW 21A.320.127 paired with state-level and regional support for training and technical assistance, the legislature should

	allocate $5 million to establish a statewide grant for school districts, prioritizing the following activities: • Technical assistance, training, resources and/or staff support to adequately meet the behavioral health needs of all students, including creating and/or strengthening a plan for recognition, screening, and response to emotional or behavioral distress in students • Creating a tiered approach to suicide prevention inclusive of prevention, intervention, and postvention The grant program should pair grantees with a state-level and regional support/accountability structure to guide LEA planning, connect LEA staff to effective training and technical assistance, and ensure community-centered implementation. This recommendation seeks to further invest in local capacity to achieve the functions of high-quality school mental health supports that improve student well-being.
Why is taking the recommended action a smart move now?	OSPI survey data from the last 19 months shows a clear picture of where LEAs need support with planning and coordinating for effective screening, recognition and response to emotional and behavioral distress in students. 149 LEAs (46% of those across the state) self-reported that they did not have an EBD plan in place. Within that context, we know that WA students are experiencing a mental health crisis. 19% of 8th graders, 20% of 10th graders, and 20% of 12th graders said they considered suicide in the past year. 9% of 8th graders, 8% of 10th graders, and 7% of 12th graders said they attempted suicide in the past year. Among 12th grade students, 74% said they felt nervous or anxious in the past two weeks, 63% said they were unable to stop or control their worrying in the past two weeks, 48% reported feeling sad or hopeless in the past year, and 15% felt they had no adult to turn to for support when feeling sad or hopeless.2 The data on these mental health indicators show significant disproportionality by race, sexuality, and disability status. In one tragic example, the 2022 COVID-19 Student Survey found that 20% of students that identify as transgender, 10% of students that identify as Questioning or unsure of their gender, and 12% of students that marked “Something else fits better” when asked their gender, said they attempted suicide in the past year, compared to 3% and 5% of their peers that identified as male or female, respectively. It is imperative that we address the mental health crisis that WA students are facing by providing crucial funding support for LEAs to use to create and strengthen their EBD plans and mental health support systems. We acknowledge that the State Legislature made a significant investment in the funding allocations for physical, social, and emotional (PSES) support staff through House Bill 1664 (2022). This funding will move our system towards a longer-term "righting" of the school staff capacity we need for prevention/education. However, schools need dedicated funding right now to address the mental health crisis WA students are facing.
What outreach has helped develop this recommendation?	The original reccomendation for this position by the SBBHSP Subcommittee in 2023. That year, the subcommitteee consisted of 37 members, including family members with lived experience, school district staff, school-based behavioral health providers, and staff from advocacy and technical support organizations,

	and a Youth Advisory Committee consisting of 11 youth and young adults with lived experience interacting with behavioral health supports in WA K12 schools. The Subcommittee developed recommendations across five Zoom workshops and three Zoom Youth Advisory Committee meetings. Staff encouraged members to propose recommendation ideas, which members ranked through a survey. The recommendation detailed here is a combination of the group's fourth and seventh ranked priorities in the survey. ESD Behavioral Health Navigators collected the data reference above through interviews with school district staff from 2019-2021i . The dataset includes 219 districts, representing all 9 ESDs, and 37 of 39 counties in the state. The interview protocol included questions covering behavioral health services in schools, community referrals, behavioral health screening, Medicaid, and more. The SBBHSP Subcommittee is bringing this items forward again for the 2025 legislaative session as a legacy item.

Growing the behavioral health workforce in schools

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Policy **☒Budget** **TBD]**	**Recommendation Summary.** Pass legislation that will increase the number, skills and diversity of physical, emotional, support (PSES) staff in school buildings. This legislation will: 1. define school social work and their role as school mental health professionals in alignment with the the national model for school social work 2. conduct a landscape analysis of legislature's investment in PSES staff in 2022 (House Bill 1664) 3. develop an advanced behavioral health skills certificate for PSES staff 4. train school adminstrators on the roles of PSES staff and the importance of each type of professional 5. provide matching grants to high need, rural school districts to hire school social workers that don't currently have the resources to do so 6. provide conditional scholarships for 30 news students in UW's Workforce for Student Well-being program along with skills-building– Also submitted as a recommendation to Workforce and Rates subcommittee	
What is the issue?	The issue: • There are inadequate staff to address the social, emotional and behavioral health needs of students in K-12 public and tribal schools despite the legislature's investments in 2022. • Existing staff in schools are often not trained in the evidence-based systems and clinical practices necessary to deliver effective school-based behavioral health services. • School social workers, the discipline that is the most likely to support the behavioral health needs of students in schools across multiple tiers of	

	support and in conjunction with family/ community, are the most limited in their numbers in schools. The Workforce for Student Well-being (WSW), funded by the U.S. Department of Education is a consortium of higher education institutions schools of social work statewide who are working to increase the number, diversity, and skills of well-trained social workers in schools. It is challenging for recent graduates of the WSW to find positions due to the limited supply of school social work jobs available in our state especially in rural, high need school districts. What is needed: • Provide education to school administrators of what school social workers are uniquely trained to do and what all PSES staff do. • Target for support school districts that want to hire school social workers, but don't have the resources to do so. • Offer an advanced training certificate for PSES staff that builds on the initial ESA Certification. • Conduct a landscape analysis of current school PSES staffing levels following up on the legislature's 2022 investment reporting back to the legislature about what additional investments may be needed. • Expand the WSW to recruit more diverse school social workers using conditional scholarships paired with skills training. (Also under consideration in the workforce and rates subcommittee). Evidence: • Data shows there are few social workers working in Washington state schools relatvie to other PSES staff. • Data shows the gaps in meeting students' needs in schools that could be filled by having more school social workers in schools. • Data shows the positive impact of the WSW in training future school social workers through a collaborative approach among all schools of social work across the state.
What do you recommend?	Beneficiaries: *__High need school districts in rural areas__ receive matching grants to hire school social workers with grants distributed in time to be used for the 2026-2027 school year. • Run a competitive grant process in two cycles 2025-2026, 2027-2028 • Select targeted high need schools in rural areas eligible for matching grant funding to hire additional school social workers • Assist awarded grantees with finding school social workers • Monitor compliance with grant award as well as evaluate what happens post grant award with retaining hired school social workers *__School PSES staff__ receive additional skills training in evidence-based school mental health systems and clinical practices.

	• PESB and contracted training & technical assistance organization collaborate to develop certificate program in 2025-2026 • Certificate is available to all PSES staff in 2026-2027 providing • Clock hours/ CEUs and/ or an incentive payment for school staff who complete the certificate should be offered. *__School administrators__ receive training on the role of PES staff including school social workers. • Two-hour mandatory training offered by XXXX during the 2025-2026 and 2026-2027 school years *__Social work students__ receive conditional scholarships for participating in the Workforce for Student Well-being providing service in high need school districts for 3 years post-graduation. (Under consideration in the workforce and rates subcommittee) • Recruit an additional 30 conditional scholarships per year to participate in the WSW across the schools of social work statewide
Why is taking the recommended action a smart move now?	The WSW has created great momentum to recruit and train a diverse new cohort of school mental health professionals. The underrepresentation of school social worker as PSES staff relative to other PSES staff has been uncovered by this inititative. Children/ youth need behavioral health services available in schools now more than ever due to the dire statistics about their mental health and well-being and the impact on their academic achievement.
What outreach has helped develop this recommendation?	Conversations with current WSW participants (graduates and practicum instructors), current school social workers including the Washington Association of School Social Worker Association, and with the schools of social work across the state. Data has also been collected on PSES staff shortages. WSW has been rigorously evaluated. A video about the WSW has been created. https://vimeo.com/955059092/9ea34c7a3b?share=copy
Is there any additional collaboration needed to further develop this recommendation?	We will work with key legislator(S) to develop a stakeholder group that can help to shape, advocate for, and implement the legislation. SBBHSP may need help to identify key stakeholders and perhaps co-chair this stakeholder group with a legislative champion.

Expansion of behavioral health student assistant professionals (SAP) program

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**

☐**Policy** ☒**Budget** **[Fiscal Impact]**	**Recommendation summary.** Request for additional funding for the state-funded AESD Behavioral Health Student Assistance Professional (SAP)s program. The program currently deploys embedded SAP to provide behavioral and mental health and substance abuse prevention and intervention services in small, rural and areas with low access to behavioral and mental health services across our state.
What is the issue?	*More details to come.* In 2024, the legislature allocated $10 million to maintain one-time state investments in the AESD Network to continue these school-based services across 68 districts (96 schools) statewide; and supports expansion to at least 30 additional sites in the 2024/25 school year. SEE: *Budget* - ESSB 5950, Sec 510 (15), pg. 711 Funding for: *OSPI to continue behavioral health regional service grants to support school districts with the least access to behavioral health services through June 2025; and* *Conduct an evaluation of the investments in behavioral health supports and report those findings by December 31, 2024.* *This was a support item of the SBBHSP subgroup in 2024. The 2025 request will build off the 2024 legislation.*

Develop and publish a School Health Hub playbook

Type of Recommendation	☐ **Legacy* CYBHWG Recommendation**	☒**New Recommendation** ☐**Previous Subgroup Priority**
☒**Budget** **~$250,000 (one-time)**	**Recommendation Summary.** Develop and publish a playbook to help Washington schools, behavioral health agencies, and local/state governments build and sustain coordinated, school-based behavioral heath programs/services/systems of care (SBIRT, MTSS, ISF) during the 2025-2026 school year. Request funding for 2 FTE (~$250K) to support the development and publication of the playbook.	
What is the issue?	Research indicates that coordinated, school-based behavioral health programs/services/systems of care (SBIRT, MTSS, ISF) are an effective way to engage students/families and improve heath outcomes and academic performance. Unfortuntately, schools, behavioral health agencies, and local/state governments face significant challenges/barriers to impelmening coordinated, school-based behavioral health programs/services/systems of care. Here is a breakdown of the major challenges/barriers: **Fragmentation of Services** • **Multiple Providers**: Students often receive care from different providers—school counselors, private therapists, pediatricians, and specialists. These providers may not communicate effectively, leading to gaps in care. • **Different Systems**: Schools, healthcare systems, and community organizations often operate in silos with different goals, funding sources, and regulations, making coordination difficult.	

Resource Limitations

- **Insufficient Funding:** Behavioral health services are often underfunded, especially in schools, leading to inadequate staffing, limited access to care, and long wait times.
- **Staff Shortages:** There is a national shortage of mental health professionals, especially those trained to work with children and adolescents. This limits the availability of care and places additional strain on existing providers.

Complexity of Student Needs

- **Diverse Mental Health Issues**: Students may present with a wide range of issues, from anxiety and depression to trauma and behavioral disorders. Coordinating care for these diverse needs requires specialized knowledge and resources.
- **Co-occurring Issues**: Many students face multiple challenges simultaneously, such as mental health issues combined with learning disabilities, family instability, or substance abuse. Addressing these co-occurring issues requires integrated care plans.

Stigma and Privacy Concerns

- **Stigma**: Stigma around mental health can prevent students and families from seeking help or fully engaging with the services available.
- **Privacy Laws**: Laws like FERPA and HIPAA protect student privacy but can also hinder the sharing of important information between schools, healthcare providers, and families, complicating coordination efforts.

Cultural and Socioeconomic Barriers

- **Cultural Sensitivity**: Behavioral health care needs to be culturally sensitive, but providers may lack the training to effectively address the needs of students from diverse backgrounds.
- **Socioeconomic Disparities**: Students from low-income families may face additional barriers, such as lack of transportation, unstable housing, or limited access to technology, which can complicate care coordination.

Systemic Challenges

- **Bureaucracy and Red Tape**: Navigating the bureaucratic requirements of schools, healthcare systems, and insurance providers can be time-consuming and confusing, delaying or disrupting care.
- **Inconsistent Policies**: Policies regarding student behavioral health vary widely between states, districts, and schools, leading to inconsistencies in how care is coordinated and provided.

Parental Involvement and Advocacy

- **Varied Levels of Involvement**: The level of parental involvement in a student's care can vary significantly, impacting the effectiveness of care coordination. Some parents may be highly engaged, while others may be less able to advocate for their child due to their own challenges.
- **Misalignment of Expectations**: There can be a disconnect between what parents expect and what schools or providers can realistically deliver, leading to frustration and strained communication.

	Technology and Data Management • **Lack of Integrated Systems**: Many schools and healthcare providers use different systems for managing student records, which are often not interoperable, making it difficult to track and share information. • **Data Security**: Ensuring the security of sensitive student health data while facilitating effective coordination is a major challenge. These factors contribute to the complexity of buildng and sustaining coordinated, school-based beahvioral health programs/services/systems of care.
What do you recommend?	Overcoming these challenges/barriers requires a collaborative, multi-faceted approach. The good news is that all the solutions/best practices we need to build and sustain coordinated, school-based behavioral health programs/services/systems of care already exist. Now, we just to build a detailed guide, plan, or 'playbook' to make it easier for schools, behavioral health agencies, local/state governments to implement these solutions/best practices. Here are the key areas/domains that will be included in the playbook: **Policies and Programs** • **Statewide Behavioral Health Frameworks**: Schools and state governments have already developed and adopted several statewide frameworks for school-based behavioral health, including Multi-Tiered Systems of Support (MTSS) and Integrated Systems Framework (ISF). • **Statewide Policies**: School and state governments have already adopted several policies, guidelines, and protocols for school-based for screening, referral, treatment, and follow-up. • **Evidence-Based Programs**: To comply with statewide policies, schools and regional governments have already adopted and started implementing evidence-based programs, such as Screening, Brief intervention, and Referral to Treatment (SBIRT). **Funding and Resource Allocation** • **Braided Funding Streams**: Schools can secure funding from a variety of local and state governments, philanthropies, insurers, and corporate/individual sponsors to build and sustain school-based behavioral health programs. This funding can be used to hire more school counselors, psychologists, and social workers, partner with behavioral health agencies, and setup care coordination systems/infrastructure. • **Grants and Financial Support**: State and local governments provide grants or financial incentives to schools that adopt innovative or effective behavioral health programs. **Building Collaborative Networks** • **Student Health Hubs**: Work with the state to establish or expand student health hubs that offer integrated behavioral health services. These centers

can serve as a critical resource for coordinating care between schools, healthcare providers, and community organizations.
- **Regional Consortia**: Establish regional consortia or partnerships that bring together schools, state agencies, healthcare providers, and community organizations to coordinate care and share resources. These consortia can facilitate regular communication and collaborative problem-solving.

Data Sharing and Technology Integration
- **Interoperable Systems**: Collaborate on the development of interoperable data systems that allow for secure sharing of student health information between schools and state agencies. This can improve coordination of care by ensuring all parties have access to the same information.
- **Statewide Data Portals**: Develop or enhance statewide data portals that track student behavioral health trends, service utilization, and outcomes. This data can be used to inform policy decisions and identify areas in need of additional resources or support.

Training and Professional Development
- **Joint Training Initiatives**: State governments can support schools by funding and organizing professional development programs focused on behavioral health. This training can be provided to teachers, administrators, and school-based mental health professionals, ensuring they have the skills to identify and address behavioral health issues effectively.
- **Cross-Sector Training**: Encourage cross-sector training that includes school staff, healthcare providers, and state agency personnel. This helps build a shared understanding of the behavioral health challenges facing students and fosters a collaborative approach to addressing them.

Legislative Advocacy and Support
- **Legislative Changes:** Schools can work with state governments to advocate for legislative changes that support better coordination of student behavioral health care. This might include laws that require or incentivize schools to partner with local health agencies or that streamline the process for students to access mental health services.
- **Mandated Reporting and Follow-Up**: Create laws or regulations that mandate schools to report on the behavioral health services they provide and the outcomes of these services. This reporting can help identify gaps in care and areas where additional support is needed.

Community and Family Engagement
- Statewide Awareness Campaigns: Partner with state governments to launch public awareness campaigns that reduce the stigma around mental health and promote the availability of school-based services. These campaigns can also educate families about the signs of behavioral health issues and how to seek help.
- Family Support Programs: Collaborate on the development of state-supported programs that provide resources and support to families dealing

with behavioral health issues, such as parent training, counseling, and crisis intervention services.

Crisis Response Coordination

- **Statewide Crisis Intervention Teams**: Schools and state governments can work together to establish or enhance crisis intervention teams that are available to respond to behavioral health emergencies. These teams can provide immediate support and help coordinate follow-up care.
- **Emergency Protocols**: Develop standardized emergency response protocols that are implemented across the state, ensuring that schools have clear guidelines on how to handle behavioral health crises and connect students to appropriate care.

Here are the benefits of developing/publishing a playbook to help Washington schools, beahvioral health agencies, and local/state governments build and sustain coordinated, school-based behavioral heath programs/services/systems of care:

Benefits for Students

- **Improved Mental Health Outcomes**: Better coordination ensures that students receive timely and appropriate care, leading to improved mental health, reduced symptoms of anxiety, depression, and other behavioral issues, and overall well-being.
- **Enhanced Academic Performance**: When behavioral health needs are met, students are better able to focus, engage, and succeed academically. This can lead to higher grades, improved attendance, and increased graduation rates.
- **Early Intervention**: Coordinated care allows for early identification and intervention for behavioral health issues, preventing problems from escalating and helping students develop coping skills and resilience.
- **Holistic Support**: Students benefit from a more comprehensive approach to their well-being, where their mental, emotional, and physical health are all addressed in a coordinated manner.

Benefits for Parents

- **Peace of Mind**: Parents gain confidence knowing that their child's behavioral health needs are being addressed in a coordinated and professional manner, both in and outside of school.
- **Streamlined Communication**: Better coordination means parents are kept informed and involved in their child's care, with clear communication between the school, healthcare providers, and themselves.
- **Access to Resources**: Parents can more easily access the resources and support they need, such as counseling, education, and crisis intervention services, without having to navigate a complex and fragmented system.
- **Reduced Stigma**: As schools and states work to integrate mental health services and raise awareness, the stigma surrounding mental health issues may diminish, making it easier for parents to seek help for their children.

Benefits for Schools

- **Enhanced Learning Environment**: With better-coordinated behavioral health services, schools can create a safer, more supportive environment where all students can thrive academically and socially.
- **Reduced Behavioral Issues**: Addressing behavioral health needs leads to fewer behavioral disruptions, reduced incidents of bullying, and a more positive school climate.
- **Efficient Resource Use**: Schools can more effectively use their resources when behavioral health services are coordinated, reducing redundancy and ensuring that students receive the most appropriate care.
- **Improved Staff Capacity**: Teachers and school staff benefit from training and support, enabling them to better manage behavioral health issues in the classroom and focus more on teaching. School Counselors and Social Workers will have an efficient way of referring and coordinating student services which gives more capacity to provide direct services/supports.

Benefits for State Leaders

- **Better Public Health Outcomes**: By addressing student behavioral health comprehensively, state leaders contribute to improved public health outcomes, reducing long-term costs associated with untreated mental health issues.
- **Economic Benefits**: Healthier, well-educated students are more likely to succeed in their careers, contributing positively to the state's economy. Improved coordination can also lead to cost savings in healthcare and education by preventing crises and reducing the need for more intensive interventions.
- **Educational Success**: State leaders can take pride in higher academic achievement and graduation rates, which reflect positively on the state's education system and attract families and businesses to the area.
- **Social Stability**: Effective behavioral health care contributes to a more stable and productive society, with lower rates of juvenile delinquency, substance abuse, and other social problems.

Collaborative Benefits

- **Stronger Communities**: When students, parents, schools, and state leaders work together to coordinate behavioral health care, it fosters a sense of community and shared responsibility. This collaboration strengthens the social fabric and creates a more supportive environment for all students.
- **Equity and Access**: Improved coordination ensures that all students, regardless of socioeconomic background, have access to the behavioral health services they need. This promotes equity in education and health outcomes across the state.

In sum, building and sustaining coordinated, school-based behavioral health programs/services benefits everyone involved by creating a more efficient, responsive, and supportive system. It leads to better outcomes for students,

	peace of mind for parents, more effective schools, and healthier, more prosperous communities.
Why is taking the recommended action a smart move now?	Developing a playbook to help schools, behavioral health agencies, and local/state governments build and sustain coordinated, school-based heath programs/services/system of care is a smart move now for the following reasons: **Rising Rates of Mental Health Issues:** There is a significant increase in mental health disorders among young people, including anxiety, depression, and suicidal ideation. Early intervention is crucial to prevent these issues from worsening. Given that young people spend approximately 1000 hours per year at school each year, the schoool setting is an improtant access point to engage, screen, and connect youth to services. **Long Term Impact:** Mental health issues in youth can lead to long-term consequences such as lower education atttainment, unemployment, substance abuse, incrased risk of physical health problems. Addressing these issues can prevent a lifetime of challenges. **Education and Development:** Mental health directly impacts a young person's ability to learn, devlop social skills, and achieve their potential. Unaddressed mental health issues can hinder academic performance and overal development, effecting/impacting their future propsects. **Strain on Healthcare and Social Systems:** If not addressed, youth mental health issues can lead to higher healthcare costs, increased use of emergency services, and greater demand for social services. Early intervention can reduce these long-term costs and strain on public systems. **Equity and Access:** Marganlized group, incuding racial minorities and those from low-income families, often face greater barrier to accessing mental health care. Schools provide a trusted, low-barrier access point for many of these groups. Investing in school-based behavioral health program/services can help close equity gaps and ensure that all young people have the support they need. **Cultural and Social Stability:** Young people are the future of society. Ensuring their mental well-being is essential for fostering a stable, healthy, and productive population. Mental health crisis can lead to broader societal issues, incuding increased crime rates and social unrest. By investing in coordinated, school-based behavioral health programs/services/systems of care now, states can create a healthier and more resilient generation, reduce future costs, and contribute to the overall well-being and stability of society.

What outreach has helped develop this recommendation?	This recommendation is informed by the development/publication of a statewide playbook for COVID-19 testing in Washington State schools (https://doh.wa.gov/sites/default/files/legacy/Documents/1600/coronavirus/421-018-LearnToReturnPlaybook.pdf) that supported the impelmentation COVID-19 testing services in almost every public, private, and tribal school in Washington State(https://storymaps.arcgis.com/stories/375107d48f5441699fac33ffc86436b1). This recommnedation is also informed by the development/implementation of Student Health Hub (https://studenthealthhub.org/) - - a coordinated, school-based service/program/system of care that has been co-developed and pilot tested in Renton, Washington in collaboration with schools, city government, behavioral health agencies, philanthropies, corporate sponsors, education service districts, county government, and state government agencies. The Student Health Hub model is now being expanded in Renton and pilot tested in Seattle and Enumclaw.

Designate and fund a lead agency for school-based behavioral health

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☒Previous Subgroup Priority**
☒Policy **☒Budget** **[$10M]**	**Recommendation Summary.** Designate a statewide leadership authority for student behavioral health and wellbeing, with a mandate to ensure student access to a continuum of effective behavioral health services in school and interconnected community settings. Provide funding to the leadership authority to act on that mandate.	
What is the issue?	Behavioral health and wellness supports for K-12 students in Washington are fragmented and uncoordinated. The Office of the WA State Auditor's 2021 Performance Audit on K-12 Student Behavioral Health in WA provided the basis for this recommendation1. Their audit found that: *The state's current approach [to school-based behavioral health] is fragmented, with roles and responsibilities assigned across several local and state agencies. Washington's decentralized approach has relied on school districts to develop behavioral health plans without oversight. Furthermore, educational service districts can only provide limited support to school districts as they develop those plans. Gaps in the current oversight and guidance structure requires improved state-level coordination to help schools better identify and connect students to behavioral health supports. Insufficient state-level direction and oversight results in students having uneven access to behavioral health supports. Leading practices suggest greater state-level direction and coordination can help schools and districts better address students' needs.* The SBBHSP Subcommittee spent significant time discussing these issues over the last two years. Members emphasized that the state does not have a comprehensive, unified working plan for school-based behavioral health with corresponding organizational oversight. No state agency is accountable or	

	responsible for ensuring, facilitating, or supporting student access to school-based behavioral health services. As a result, WA youth are being left underserved in a critical time of their development. Behavioral health prevention, intervention, and treatment services offered in the state are siloed. Students encounter barriers to access that need to be coordinated across billing and provision systems to increase access and sustain efforts (i.e. Medicaid, insurance, grants, and federal dollars). Members noted that the state lacks a dedicated financial infrastructure to support school-based behavioral health. Grants and time-bound funding are not a viable solution. Effective and equitable statewide coordination for student behavioral health services requires a behavioral health lead agency with resources, knowledge, and capacity to connect state, regional, and local stakeholders related to school-based services.
What do you recommend?	The legislature should designate a statewide leadership authority for student behavioral health and wellbeing, with a mandate to ensure student access to a continuum of effective behavioral health services in school and interconnected community settings. Upon doing so, the legislature should allocate $10 million to the lead authority with requirements to: a) Establish and maintain an advisory council with representatives from HCA, OSPI, educational service districts, school districts, and other key partners such as managed care organizations and community providers. The council's responsibilities should include: a. Developing a Washington State framework for comprehensive, interconnected school-based behavioral health (SBBH) based on evidence for effective systems, programs, and data systems b) Developing recommendations for a statewide SBBH training and technical assistance (TA) entity that can aid districts to design, fund, and implement comprehensive, interconnected SBBH based on the Washington State SBBH framework and train relevant leaders and practitioners on effective SBBH systems, practices, and data systems. c) Creating an accountability system for SBBH based on the Washington State SBBH framework that includes outcome and quality/fidelity measures at the state, district, and school levels. Establish strategic direction and goals for programming around the full continuum of SBBH services funded under this legislation Develop a comprehensive workforce development strategy addressing needs across the SBBH continuum, and align with the CYBHWG's Prenatal-25 Strategic Plan Advisory Committee's work in this area. a. Create resource(s) to provide clear definitions for Education Staff Associate (ESA) roles and provide guidance for coordination between ESA roles to meet comprehensive SBBH needs in schools. Create and make available and accessible comprehensive information on well-supported Tier 1 (including mental health literacy), Tier 2, and Tier 3 programs/curricula that are relevant to districts as they develop their comprehensive SBBH strategy and for which training and implementation

	support can be readily provided by the Washington SBBH training and TA Center (WSTTAC). Establish an initial grant program to aid districts to develop comprehensive SBBH systems based on assessment of their strengths and needs for development using the Washington State SBBH framework and TA from the statewide SBBH training and TA entity. Report results from the Washington State SBBH accountability system to the Legislature annually.
Why is taking the recommended action a smart move now?	The 2021 Performance Audit on K-12 Student Behavioral Health in WA provides further impetus for pursuing this recommendation now: *Addressing the broader issue of behavioral health disorders goes beyond what schools can reasonably solve. Nonetheless, because schools are a hub for the vast majority of children who might begin to exhibit symptoms, schools are a natural setting for prevention and early intervention efforts.* The National Assembly on School-Based Health Care emphasizes the role state leadership can play in it's *10 Critical Factors to Advancing School Mental Health* brief2 as such – "State leaders across child-serving public sectors must establish a cohesive and compelling vision and shared agenda for school mental health that can inspire localities to act." The Subcommittee is hopeful that this recommendation will be prioritized given the Governor's directive to take action to address the behavioral health crisis so many children and youth are facing. 2021 Washington Healthy Youth Survey data underlines the need for bold action to improve school-based behavioral health supports. 19% of 8th graders, 20% of 10th graders, and 20% of 12th graders said they **considered** suicide in the past year. 16% of 8th graders and 10th graders and 15% of 12th graders said they **made a suicide plan** in the past year. 9% of 8th graders, 8% of 10th graders, and 7% of 12th graders said they **attempted** suicide in the past year. Other mental health indicators tell a similarly dire story. Among students in 12th grade, 74% said they felt nervous of anxious in the past two weeks, 63% said they were unable to stop or control their worrying in the past two weeks, 48% reported feeling sad or hopeless in the past year, and 15% felt they had **no** adult to turn to for support when feeling sad or hopeless.
What outreach has helped develop this recommendation?	This recommendation is an item previously pursued by SBBHSP in 2024. We received a lot of feedback this cycle about how to strengthen this recommendation and split it out into components that offer more of a path forward for the most impactful pieces of the recommendation. SBBHSP is looking to update the recommendation to better emphasize the need to establish a formal network charged with statewide coordination on SBBH, providing more robust state-level guidance on what schools should do to support behavioral health, providing an inventory of options for resources

	available to support each tier in the SBBH continuum, providing more support for schools after they experience a crisis, and providing a roadmap for training staff. The new* 'School Health Hub playbook' recommendation may be incorporated into this recommendation.

Workforce & Rates (W&R)

Ensure viable and appropriate implementation of the CCBHC model

CCBHC = Certified Community Behavioral Health Clinic

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Policy **☒Budget** **[TBD]**	**Recommendation Summary.** The Legislature should take necessary steps to provide legislative and budgetary support to ensure implementation of the CCBHC model by FY2027, including participation in the federal demonstration and/or executing a State Plan Amendment.	
What is the issue?	Certified community behavioral health clinics (CCBHCs) provide critical care for people with mental health and substance use disorder (SUD) challenges. Launced in 2017, the CCBHC model is now operating in 46 states, while 17 CCBHC expansion grant sites have operated in Washington (of those, 12 grants are currently active). CCBHCs dramatically increase access to mental health and SUD treatment, diverting individuals in crisis from already-burdened systems such as hospitals and jails. The CCBHC model also helps to alleviate the impact of the ongoing crisis-level workforce shortage we face in community behavioral by enabling participating agencies to increase hiring; on average, 41 new jobs per clinic are created. As a conduit for integrated behavioral and physical health, CCBHCs are responsible for engaging in care coordination and developing partnerships with primary care providers to ensure clients' access to services that meet their full range of health care needs. CCBHCs are funded either through the federal Medicaid demonstration program or via two-year SAMHSA grants. In Washington, all of our CCBHCs are funded via these SAMHSA grants, including initial two-year expansion grants and subsequent two-year extension grants. CCBHCs in the Medicaid demonstration are paid using a prospective payment system (PPS), which supports the actual cost of care, including expanding services and increasing the number of clients served, while improving flexibility to delivery client-centered care. A growing number of states are moving to implement the model independently, including via a state plan amendment (SPA) or a Medicaid waiver, including Washington. In 2022, the Legislature funded a CCBHC budget proviso to support the Health Care Authority (HCA) in planning for this statewide	

	implementation process. That same year, the Legislature also appropriated $5 million for CCBHC bridge funding to help sustain CCBHC grantees while the state began this planning process. HCA applied for, but did not receive, a $1 million CCBHC planning grant from SAMHSA; this planning grant is a prerequisite to be able to apply to become a demonstration state. In 2023, the Legislature appropriated $1 million to replace the assumed federal funding that would have resulted from receiving a SAMHSA planning grant; this work will culminate in a report to the Legislature by December 2024. In 2024, the Legislature again appropriated $5 million for CCBHC bridge funding to support CCBHC grantees while the state continues its planning and implementation process, and **directed HCA to implemented the model statewide by FY2027,** either via participation in the federal demonstration or through a SPA. In September 2024, HCA will submit a new application for a $1 million SAMHSA planning grant; the outcome of this application is anticipated in early 2025.
What do you recommend?	Specific recommended action will depend on two factors: the report issued by HCA to the Legislature as part of its current $1 million planning proviso and the outcome of the new application for a SAMHSA-issued CCBHC planning grant. As we await these steps, the Workforce & Rates subgroup and the Children & Youth Behavioral Health Workgroup (CYBHWG) as a whole should continue to strongly encourage Washington to join the federal demonstration when able and should recommend the Legislature take necessary action to ensure HCA's adherence to the FY2027 implementation timeline.
Why is taking the recommended action a smart move now?	For the past three sessions, the Legislature has made investments to develop and implement the CCBHC model statewide, including both fiscal support for existing CCBHC expansion grantees and programmatic planning efforts at the sate level. The Legislature's most recent action, directing HCA to implement the model statewide by FY2027, is a clear statement of support for this model and its role in the future of Washington's community behavioral health system and workforce. Depending upon the outcome of the upcoming planning grant application, the Legislature should take steps to ensure HCA is able to comply with this directed timeline and that providers are supported throughout this implementation process. The CYBHWG has been a strong supporter of expanding the CCBHC model in Washington for the past several years, with the Workforce & Rates Subcommittee frequently and consistently identifying CCBHCs as a priority item. Not only does the CCBHC model allow for greater recruitment and retention of a well-qualified workforce, it provides significant value to the broader behavioral health system by relieving strain on other systems, like law enforcement and emergency departments.
What outreach has helped develop this recommendation?	The Washington Council for Behavioral Health (the Council) is a consistent presence in both subgroup meetings and at the full workgroup level and has shared regular updates at subgroup meetings throughout the interim and for several past years. Additionally, the Council is a core member of HCA's CCBHC Technical Provider Workgroup, which is currently engaged in a stakeholder process including:

	• Designing Washington's CCBHC model • Conducting actuarial analysis to model budget impact • Providing cost information from prospective CCBHCs This workgroup's efforts will inform a legislative report submitted in December 2024. Any relevant action stemming from that report will likely be considered for incorporation into this recommendation. Additional outreach may be necessary depending upon the outcome of HCA's upcoming application and forthcoming legislative report.
Is there any additional collaboration needed to further develop this recommendation?	Additional collaboration should be considered following the submission of HCA's newest application for a SAMHSA planning grant, as well as following the publication of the legislative report related to its current $1 million state planning proviso. Council policy staff are working closely with HCA and its actuarial partner, Milliman, as part of the CCBHC Technical Provider Workgroup (the $1 million state planning proviso work). Council staff will continue to share updates with subgroup members, as well as meet with subgroup leads as needed to develop any further recommendation/advocacy strategies. We anticipate this will remain part of the Council's legislative advocacy for the upcoming 2025 session, but do not feel this should negate the need for support and advocacy from both the subgroup and the full workgroup**.**

Behavioral Health Teaching Clinic designation & enhancement rate

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Policy **☒Budget** **[TBD]**	**Recommendation Summary.** The Legislature should enact legislation codifying the Behavioral Health Teaching Clinic Designation & Enhancement Rate into law; appropriate funds necessary to enact and adequately fund the enhancement rate; and direct the Health Care Authority (HCA), during the FY26-27 biennium, to take necessary steps to submit the Behavioral Health Teaching Clinic Designation & Enhancement Rate for approval by the Centers for Medicare and Medicaid Services (CMS).	
What is the issue?	Community behavioral health agencies (BHAs) are the essential safety net providers for adults, children, youth, and families experiencing mental health and/or substance use disorders (SUD) in Washington State. Decades of underinvestment, including chronically low Medicaid rates, have left BHAs unable to offer competitive compensation packages to their employees. In addition to providing clinical services and care coordination, BHAs are the training ground for students and new graduates pursuing behavioral health careers across sectors and settings, bearing the cost for the essential training and supervision infrastructure that sustains this crucial workforce development pipeline. This role, however, is an unofficial and uncompensated one. A	

	Behavioral Health Teaching Clinic Designation & Enhancement Rate is an innovative solution to recognize and compensate our BHAs for training the broader behaiovral health workforce in cutting-edge, critical behavioral health treatment modalities.
What do you recommend?	To sustain our community BHAs and to incentivize providers to remain in the field, both of which are critical to the mental health of Washingtonians, the Legislature should invest in enacting and funding a Behavioral Health Teaching Clinic Designation & Enhancement Rate, with the ultimate goal of receiving a federal Medicaid match to sustain the model in perpetuity. This solution will be achieved through a partnership between the Washington State Legislature (to codify and fund the model), the Department of Health (as the certifying body) the Health Care Authority (as the contracting body), and a wide array of community behavioral health providers and advocates who are dedicated to improving the lives of people living with serious mental illness and/or addictions disorder. In the 2024 legislative session, three crucial steps should be taken: 1. The Legislature should enact the Behavioral Health Teaching Clinic Designation & Enhancement Rate into law in Washington State. 2. The Legislature should appropriate funds necessary to enact the enhancement rate. ▪ This should include amounts adequate to fund the payment of a Behavioral Health Teaching Clinic Enhancement Rate to qualifying BHAs throughout the state, as well as amounts necessary to fund the administration and oversight conducted by DOH and HCA. 3. The Legislature should direct the Health Care Authority, during the FY2026-2027 biennium, to take the necessary steps to submit the Behavioral Health Teaching Clinic Designation & Enhancement Rate for approval by the Centers for Medicare and Medicaid Services (CMS) in order to secure federal investment and matching necessary for long-term sustainability. ▪ HCA should seek CMS approval for direct payments and amend MCO contracts to include language that requires MCOs to pass the enhanced rate funding through to approved teaching clinics.
Why is taking the recommended action a smart move now?	The Workforce & Rates subgroup, and the CYBHWG as a whole, has included the teaching clinic concept as among its priorities for multiple years now, throughout the development process. Each successive year has built upon existing work to culminate in the final demonstration project report and the development of a formal Behavioral Health Teaching Clinic Designation & Enhancement Rate. The findings of the data collection conducted during the demonstration were conclusive: BHAs expend resources to train and supervise behavioral health workers that are not sufficiently recouped through current reimbursement rates. This one-way investment continues to put a strain on our community behavioral healthcare system and will continue to increase as our population's needs grow. The Behavioral Health Teaching Clinic Designation & Enhancement Rate offers a solution, one that should be enacted now in order to further reverse decades of

	underinvestment in our community system. Codifying this model and funding the enhnacement rate offers an opportunity for thousands of new therapists, counselors, substance use disorder professionals, and more to join the workforce in the coming years, with strong incentives to remain and serve our most vulnerable populations.
What outreach has helped develop this recommendation?	The Washington Council for Behavioral Health (WA Council) developed this concept with the intent to formally identify and compensate BHAs for the true cost of this teaching role. A multi-part process was developed to recognize, describe, and test the concept, which utilized a public-private resource development path, including legislative appropriations and philanthropic grant funding. • In 2021, the Legislature funded a workgroup led by HCA to develop preliminary standards and rate estimates for the concept, which resulted in a preliminary report that the WA Council demonstration project utilized as a starting point. • In 2022, the WA Council formally launched the demonstration project, funed via a $1.1 million grant from the Ballmer Group, with six participating volunteer BHAs from across Washington State, representing a wide array of populations and communities served, as well as service provision and workforce types. • In 2023, the Legislature funded a 0.5 FTE at HCA to ensure the agency would participate in these efforts to ensure BHAs are compensated for their role as teaching clinics for students seeking professional education in behavioral health disciplines and for new graduates working toward clinical licensure and certification. Data was collected from participating BHAs, analyzed to accurately capture the true cost of the hours of investment put into supervising, training, and preparing clinicians to administer behavioral healthcare across the spectrum of patient needs. Teaching clinic standards and billing eligibility requirements, as well as a calculated projected enhancement rate were developed from this data. In addition, the WA Council has been an active and consistent participant in the Workforce & Rates subgroup, providing presentations and regular progress updates on the teaching clinic development process since 2020. The subgroup's support, as well as that of the full CYBHWG, has been instrumental in achieving the legislative successes to date.

Fund the supervisor stipend program

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Budget **[Fiscal Impact]**	**Recommendation Summary.** Fund the supervisor stipend program at the DOH that was included in HB2247 from 2024.	

What is the issue?	As identified by individuals and organizations over multiple years, significant barriers to moving from receiving a degree in one of the behavioral health professions and working in the field is the cost associated with the requirement that most professions have for a certain number of supervised hours post graduation. This is true for social workers, licensed mental health counselors, and others. Unless the individual is working in a CBHA, payment to the supervisor is likely coming from the supervisee. The number of hours typiclly required, coupled with the cost per hour for supervision, along with the student loans many are having to pay off, AND the reality that wages for behavioral health professionals tend to be on the lower side, can make the prosepct of having to pay for supervision financially overwhelming. In order to help address the barrier, HB1724, passed in 2023, directed the DOH to establish a stipend program. While well intended, the model included in the legislation raised questions and concerns about implementation (e.g. who would actually benefit from the stipend) and therefore, in 2024 a new model for the stipend program was included in HB2247.
What do you recommend?	The recommendation is to include funds in the '25-'27 biennial budget to implement the supervisor stipend program as established by the legislature in HB2247 (2024). At this point the exact amount needed is TBD as we are awaiting information from DOH about a possible DP. The legislature has a choice in 2025 to fund what they have required DOH to develop or not. Our recommendation is to fund!
Why is taking the recommended action a smart move now?	It is essential that indivduals who have completed their degree and are working toward certification/licensure are retained. Financial obligations can be significant and we must do what we can to address them. Offsetting the cost of supervision is a strategy that has been identified by those impacted and others who are deeply connected to and knowlegable about behavioral health professionals. Additionally, the past 2 legislative sessions has focused on the issues of having to payi for supervision. Advancing this request now takes advantage of the momentum, interest, and commitment the legislature has to addressing the behavioral health workforce challenges.
What outreach has helped develop this recommendation?	The DOH has done considerable outreach and has consistently held community meetings to get input on implementation of HB1763 and HB2247 – including the components of both regarding the supervisor stipend program. Additionally, this topic has come up repeatedly in the Workforce/Rates subcommittee meetings and we have had DOH presenting at those meetings about the issue/model. Impacted individuals have weighed in, including those who are providing (or could provide) supervision.
Is there any additional collaboration	At this time we are waiting to find out from DOH if there will be a DP or if there are funds available in the budget to begin the stipend program on July 1, 2025. If there is a DP, the proposal advanced to the CYBHWG will need to be adjusted

needed to further develop this recommendation?	to reflect the information provided therein. If there isn't a DP, we will need to work closely with DOH when finalizing the proposal in order to accurately identify the cost. And if there are funds available and no ask is needed for the 25-27 biennium, then the proposal could be withdrawn. The stipend program/model should be very familiar to the CYBHWG as a whole, as well as the subcommittees ,since the creation of it was a priority for the WG last session! That said, it will be important to continue to get input from the other subcommittees about specific proviso language and discuss the proposal with other advocates, the professional associations, and impacted individuals. It will also be essential to talk with and stay connected to folks who are or could be supervisors. Rep. Bateman (likely becoming a Senator) is committed to taking this issue on in 2025. If funding is included in the Governor's budget DOH will be able to be actively involved. Coordination between advocates and DOH would be key. If there is a DP and it is not included in the Governor's budget, advocates will be mobilized both within the CYBHWG and outside of it. There is capacity to be a lead on this issue.

Conditional Scholarships

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Policy **☒Budget** **[Fiscal Impact]**	**Recommendation Summary.** A policy change is needed to direct WSAC to work with a UW-led consortium of 13 institutions of higher education statewide to recruit a diverse cohort of master's level candidates. Funding is needed for: 1) conditional scholarships ($50k/student; 180 students); 2) three concentration areas to provide skills training to candidates in alignment with employers' needs ($10k/student); and 3) continuing program evaluation beyond one-year of funding ($150K).	
What is the issue?	A shortage of qualified behavioral health professionals persists in many communities and among critical service providers in Washington state. To address this issue, Master's candidates are needed to serve children and adults with behavioral health challenges in the public mental health system, in community mental health centers, in crisis care settings, and within and in partnership with K-12 public and tribal schools. The range of high-need public behavioral health settings could be expanded in the future. With the philanthropic support of Ballmer Group, the University of Washington School of Social Work has partnered with 12 universities across the state to address the workforce shortage. Launched in 2021, more than 250 graduate students have received Ballmer Behavioral Health Scholarships; an additional 13	

	MSW students have participated in UW's initiative to train K-12 school social workers.
What do you recommend?	We recommend funding for: 1) conditional scholarships ($50k/student; 180 students); 2) three concentration areas to provide skills training to candidates in alignment with employers' needs ($10k/student); and 3) continuing program evaluation beyond one-year of funding ($150K).
Why is taking the recommended action a smart move now?	In addition to private funding and federal funds, UW School of Social Work and its partners have successfully implemented a statewide behavioral health workforce development initiative. Building upon the momentum created by universities; the implementation of HB1946 – Creating the Washington Behavioral Health Corps; and ongoing learning sessions with public policy makers makes this a smart move now. There is a great need across our state.
What outreach has helped develop this recommendation?	In addition to the 13 universities that have receive and distributed private funds to their Master's candidates, discussions have taken place with Washington state legislators representing Eastern and Western Washington.
Is there any additional collaboration needed to further develop this recommendation?	Additional collaboration is needed with Washington Student Achievement Council to share lessons-learned and to manage the financial transactions for conditional scholarships. There are also public entities, such as Washington Employment Security Department to map the Washington state workforce including the impact of this initiative relative to the existing workforce and monitor Washington state utilization of behavioral health services in these three specialization areas (behavioral health, school mental health, and crisis response). Continued affiliation with the Children & Youth Behavioral Health Work Group via the Workforce & Rates Subgroup and the School-based Behavioral Health and Suicide Prevention Subgroup, as well as statewide and national organizations and professional associations, remain important.

Maintenance funding expansion for Partnership Access Line (PAL) & Referral Service

Type of Recommendation	**☒ Legacy* CYBHWG Recommendation**	**☐New Recommendation** **☐Previous Subgroup Priority**
☒Budget **$2.211M [370k GF-S] [biennium]**	**Recommendation Summary.** Maintenance Funding Expansion for Partnership Access Line (PAL) and Washington's Mental Health Referral Service for Children and Teens	
What is the issue?	PAL and the Mental Health Referral Service are funded by the state based on the cost of service positions set at 2018 salary levels. However due to cumulative inflation and mandatory cost of living adjustments to salaries over the past 6 years, these programs now operate in a significant deficit. Without a funding level expansion for these service's operating budgets in the next biennium, significant service delivery cutbacks in staffing will be forced to occur. For instance, the Referral Service would no longer be able to maintain the current 7-9 day turnaround on making matched available referral	

	recommendations for parents (when the service was understaffed in the past, this would take a month), and the timeliness of PAL consults will also suffer for primary care.
What do you recommend?	To keep PAL and Referral Service both operating at full capacity with no service cuts over the upcoming biennium, we request budget increase for those two programs together to be a total of $2.211 million dollars over the biennium. Because HCA receives large contributions of funding for PAL and the Referral Service from the state's commercial insurers (due to previous legislation) and from Federal matching dollars, we understand that the state commitment component of that amount would be on the order of ~$370,000 state general funds over the biennium (subject to HCA's final confirmation)
Why is taking the recommended action a smart move now?	If this is not passed now, the Referral Service staffing will drop and parents can end up waiting a month or longer again for assistance. Primary care providers would no longer be able to reliably expect to reach a child psychiatrist on demand when calling PAL.
What outreach has helped develop this recommendation?	Seattle Childeren's, HCA, and the PAL Team have all consulted together on this, with PAL and Children's advancing this as a recommendation to the committee.

Well-being Specialist designation

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☐New Recommendation ☒Previous Subgroup Priority**
☒Policy **☒Budget** **[Fiscal Impact]**	**Recommendation Summary.** State adopts a plan to incentivize referral to wellness services from primary care, details forthcoming.	
What is the issue?	Purpose of continuing to pursue and support the Wellbeing Specialist designation: • It is an effort that will increase the numbers of individuals in the behavioral health workforce through focused recruitment, on the job training, and support through licensure for one of at least four DOH designations (Reg AAC, CPC, CHW, Btech) and an additional wellness certificate. • The wellbeing specialists will be trained and supervised to provide direct therapeutic support and pull down living wage billing rates, while maintaining a focus on delivering culturally grounded care in line with the definition of Wellness Services • Wellness services can be developed and supported across the range of clinical need and care and aligns with and can support many other workforce priorities (IECMH, integration, perinatal, youth mental health…).	
What do you recommend?	End goal (5 year goal): Sustainable state grant program that provides scholarships for On the Job training (OJT) in core competencies across licensure	

	types for non-MA providers across the state. Wellbeing specialists have licensure in an existing workforce type (primary focus on registered AAC/MHCP) PLUS an additional wellness certificate. Wellness services are part of state/local grant programs that provide agencies additional incentives for training and employing wellness specialists. What we have funding for now/is already in the works: I. Creating the blueprint including curriculum pathway with a) core competency track across Reg AAC, Peers, B Techs, SUDPs, CHWs b) licensure track for multiple licenses c) additional wellness certification d) eligible/ideal OJT sites e) for already licensed workforce, pathway for additional wellness certification II. Beginning wellness services in agencies pre-identified for also taking up the OJT recruitment track in 2025. What we need funding for in FY2024/25 ($780,000): I. Scholarships to support OJT pathways subsidized by the state for 50 WBS.$100,000 II. Clinic incentives to participate in wellness specialist training program that help pay for step increases in pay, supervision and ongoing training costs for 10 participating agencies. $300,000 (if the agency rates vary in cost, we will look to expand the number of participating agencies) III. Continued funding for agency culturally responsive and leadership training for 10 agencies.$130,000 IV. Administration, evaluation and technical assistance. $250,000 Placements/OJT for wellness specialist track starts early fall 2025. Regulation policy ask (no money) State adopts a plan to incentivize referral to wellness services from primary care, details forthcoming.
Why is taking the recommended action a smart move now?	1) We need strategies to increase the immediate availability of mental health therapeutic services 2) We need strategies that increase the cultural diversity of the public mental health workforce 3) We need strategies that increase the availability of holistic, culturally grounded services in mental/behavioral health Wellness services are supported by a large and growing literature to directly improve mental and behavioral health - these are services that can be delivered

	with high quality by individuals with natural therapeutic competencies. Higher education credentials are not necessary for the delivery of effective therapeutic services as an adjunct to a program of treatment in specialty behavioral health and as a standalone intervention for prevention services and mild and moderate mental health needs. Recruitment, screening and on the job training will focus on recruiting individuals with natural therapeutic competencies and training will focus on the delivery of group-based programs for their therapeutic benefit and benefits to expanded system capacity.
What outreach has helped develop this recommendation?	Since CARE was first funded, the effort has engaged over 1,000 community sounding board members, statewide, over 40 project amplifier organizations, and a core wellness coalition of 20 multisector leaders of diverse backgrounds and professional experiences. We also completed a comprehensive literature review of the non-MA workforce and the capacity to deliver therapeutic interventions, which we sent back to our community sounding board for reflection – this was recently published in a high impact peer reviewed journal: Frontiers | Translating research evidence into youth behavioral health policy and action: using a community-engaged storyboard approach (frontiersin.org) We have **ready partners** for pilot implementation for both implementing wellness services (agencies) and to recruit, train and manage placements for OJT training including the Health Training Fund, Workforce Central Pierce County, UW faculty and clinical experts, SPARK peer organization, King County Behavioral Health and Recovery Division, and others. Our advisory group spans multiple sectors including payors, parents, youth, providers, health equity experts, among others. This project is already rolling and ready to implement, and simply needs continued funding.
Is there any additional collaboration needed to further develop this recommendation?	We are still waiting to consult with HCA to confirm that wellbeing specialists could bill under our hoped for SERI codes, and that they will adopt ownership over a state program.

Fund youth-focused curriculum for Behavioral Health Support Specialists (BHSS)

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Budget	**Recommendation summary.** A Behavioral Health Support Specialist will be a new bachelor level provider type with a scope of practice that includes mental	

[TBD]	and behavioral health interventions delivered under clinical supervision. UW Seattle is a catalyst for this workforce project and received funding from Ballmer Group to develop an adult curriculum. The BHSS program is seeking funding for a youth focused curriculum that will be disseminated by colleges and universities across Washington State.
What is the issue?	In concert with CYBHWG recommendations in 2023, the issues are behavioral health workforce shortages for youth and families; services for young people transitioning to adulthood; need for school based behavioral health services and supports; an wait lists that create a barrier to care when youth need it. One solution of many is to increase the mental and behavioral health workforce pool. This work has begun for the adult population through SSB 5189 to establish a BHSS in Washington State. There is a need to identify funding to develop youth focused curriculum and on-going support of this centralized curriculum. The UW BHSS Clinical Training Program has engaged seven active partners in delivering BHSS curriculum. Five additional colleges and universities are engaging in a self-study to prepare to integrate BHSS training into their psychology or social work programs. It is anticipated that these programs will graduate approximately 100 students per year in the first two years and that the number will increase signficantly as more higher education programs join in this workforce development effort.
What do you recommend?	The University of Washington Department of Psychiatry and Behavioral Sciences believes that state support will help fund the inclusion of subject matter experts in youth mental and behavioral health to develop appropriate curriculum for the bachelor level programs. Previous legislation has helped create the structure for credentialing. The cost estimates for this effort are currently under development.
Why is taking the recommended action a smart move now?	Washington State has moved forward with developing a bachelor level provider type working under supervision with a scope of practice that includes behavioral health. The BHSS will be able to work across settings helping to create a network of providers in school based mental health, integrated primary care, community social services for youth and specialty mental health care. These providers will be training in public and private institutions with a common core of competencies. One expectation is that the broadening of higher institutions and pathways into the profession will help diversify the workforce.
What outreach has helped develop this recommendation?	Since 2022, the UW BHSS project team has been engaging with both adult and youth advocacy groups representing providers, payors, community leaders, client/patient populations and higher education programs. Feedback has been to work on educational pathways for the delivery of youth-based services. To prepare this recommendation for legislative action, we need to engage a legislative sponsor.

Youth & Young Adult Continuum of Care

Expand access to peer support services

Type of Recommendation	☐ Legacy* CYBHWG Recommendation	☐New Recommendation ☒Previous Subgroup Priority
☒Policy	**Recommendation Summary.** Expand access to peer services (especially youth and family peer services) by creating and enforcing network adequacy standards, lowering barriers to insurance billing, maximizing billing for current programs to expand services and ensure sustainability, and investing in wellness programs and professional development for the peer workforce.	
What is the issue?	Peers are the only profession within the behavioral health workfroce where we have not a shortage, but a surplus of willing workers. Access to peer services significantly increases treatment engagement, adherence to treatment plans, and longevity in treatment. Furthermore, peers play a crucial role in conducitng outreach to bring people into treatment and services who would otherwise not receive care. Peer services are enormously effective. Given the massive behavioral health challenges our youth and young adults are facing, we cannot afford to have peer services underutilized and to have inadequate access to peer services.	
What do you recommend?	• Create nework adequacy standards for youth peers, family peers, and adult peers across Medicaid and commercial insurance carriers and a mechanism to enforce these standards. • Create a low barrier way for non-behavioral health agencies to bill for the provision of peer services. • Ensure insurance is being maximally billed for existing peer services programs. • Increase funding for the Washington Peer Network and the Washington Peer Jobs database.	
Why is taking the recommended action a smart move now?	The peer landscape will change radically in July 2025 with the implementation of SB 5555, the creation of the new certified peer specialist, and the ability for individuals with commercial insurance to access peer services for the first time. Any legislation passed in the 2025 session would have an effect date that coincides with SB 5555 implementation.	
What outreach has helped develop this recommendation?	This recommendation builds on prior successful YYACC efforts to expand access to youth and family peer services. The need for increased access to peer services was raised again during YYACC meetings in the 2024 interim.	

Is there any additional collaboration needed to further develop this recommendation?	Yes, there will be engagement with HCA, OIC, the MCOs, and other vested parties to further the development of this recommendation.

Support expansion of recovery high schools

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation ☐Previous Subgroup Priority**
☒Policy **☒Budget** **[Fiscal Impact]**	**Recommendation summary.** Convene an advisory committee to establish a statewide network of recovery high schools.	
What is the issue?	Currently, Washington has few resources to support adolescents and young adults in returning to the community after they complete substance use disorder treatment. Early recovery supports are essential for young people to sustain the gains they made in treatment and build recovery within the four dimensions of health, home, purpose, and community (SAMHSA, 2012). Recovery high schools are an opportunity for Washington to fill this gap. Recovery high schools are an evidence-based strategy, with national and Washington data documenting their effectiveness. One federally funded study from Finch, Tanner-Smith, Hennessy, & Moberg (2017) found that, compared to students in non-recovery high schools who received substance use treatment, students in recovery high schools: (a) have higher graduation rates, (b) report significantly lower absenteeism, (c) have significantly lower odds of dropping out, (d) are more likely to abstain from using substances, and (e) have significantly fewer days using drugs and alcohol. In 2014, King County Behavioral Health and Recovery Division (BHRD) and Seattle Public Schools partnered to open the only public recovery high school in Washington. It was prompted by a 2013 DSHS report which found only 25% of adolescents in publicly funded SUD treatment graduated from high school. This number dropped to 17% for adolescents with co-occurring disorders (Behavioral Health Needs and School Success, 2013).). Puget Sound Educational Service District and King County BHRD described the demographics and characteristics of students who attended the Interagency Recovery Campus for more than 90 days between Fall 2015 and Spring 2022: 1. An average of 38 students enrolled for at least 90 days annually.	

	2. 63% of students have either earned, or were working toward, a HS Diploma, with another 18% transferring to continue schooling elsewhere. 3. More than half of students had more than one year of recovery following initial enrollment. 4. Compared to the school district, more students receive Individualized Educational Plan (IEP) and McKinney-Vento services. Recovery high schools are effective nationally and locally in promoting recovery and guiding youth toward the vital milestone of graduating from high school.
What do you recommend?	Assemble an advisory committee whose work may include reviewing strategies used by other states, reading the Association of Recovery Schools Toolkit for starting a school, conducting outreach and needs assessments, identifying potential long-term funding sources, and developing a structure for evaluation and communication of student characteristics and outcomes. As Oregon demonstrated, the first step to opening state-sponsored recovery high schools is convening a committee tasked with designing a strategic plan outlining a path forward. Locally, the committee could engage King County BHRD and the Interagency Recovery Campus staff in keys to success. The exact budget is unknown. Initial investments would likely include a portion of an FTE to staff the proposed advisory committee and stipends for some committee members.
Why is taking the recommended action a smart move now?	Washington State youth had a mortality rate from drug overdoses nearly twice the national average in 2020-2022 (New England Journal of Medicine article, pp. 99-100). In the 2022-2023 school year, Narcan was used to reverse overdoses 42 times across Washington's schools (Byran, C. The Seattle Times, 2023). Washington's public schools are facing significant budget deficits, limiting their ability to meet student needs. Primary objectives for the advisory committee would include (a) identifying funding sources for recovery high schools that will not negatively impact Washington's public schools; (b) prioritizing historically marginalized communities and groups with a focus on eliminating racial, ethnic, geographic, linguistic, and socio-economic behavioral health inequities; and (c) developing an evaluation plan to measure success.
What outreach has helped develop this recommendation?	The primary source of outreach has been studying the Interagency Recovery Campus implementation. Additional outreach may include consultation with (a) the state of Oregon regarding their process for establishing a statewide network of recovery high schools; (b) Dr Andrew Finch, co-founder of the Association of Recovery Schools and Professor of the Practice at Vanderbilt University's Peabody College who has published extensive research on recovery high schools; and (c) specific communities in which schools may be started.

Fund administration of CAPS and streamline the pathway to First-Episode Psychosis care

CAPS = Central Assessment of Psychosis Services

Type of Recommendation	☒ Legacy* CYBHWG Recommendation	☒New Recommendation ☐Previous Subgroup Priority
☒Budget **$1.1M [one-time]**	**Recommendation summary.** Despite the increased availability of First Episode Psychosis services across our state, pathways to FEP care remain difficult for families to navigate and teams are often under-equipped to meet the need. The Central Assessment of Psychosis Service (CAPS) seeks to streamline the pathway to FEP care in Washington State and address obstacles to early detection of psychosis by creating one front door for young people as well as their families and practitioners who have a psychosis-related concern; a stable source of funding is needed to launch and sustain this statewide service in SFY2026.	
What is the issue?	Significant progress has been made in increasing access to First Episode Psychosis (FEP) Coordinated Specialty Care services across the state. Although the availability of this evidence-based model has contributed to reductions in Duration of Untreated Psychosis (DUP)—a leading predictor of schizophrenia spectrum disorder prognosis—the DUP in Washington State remains higher than the maximum DUP recommended by the World Health Organization. Furthermore, recent analyses by the Department of Social and Health Services Research Data and Analysis Unit suggest that many young people who meet criteria for FEP are not accessing New Journeys' FEP services (DSHS, 2021). Currently, each New Journeys team handles their own referrals, has their own screening processes to determine admission eligibility, and has their own processes and timelines for onboarding new clients. This system creates inefficiencies and is vulnerable to staffing volatility, training deficits, implicit biases, and differential access to screening, assessment, and treatment services across the New Journeys Network. Moreover, rural and racially marginalized youth are disproportionately impacted by circuitous pathways to care, diversions from the care pathway to the criminal justice system, and misdiagnosis. In short, existing entryways to the New Journeys Network are difficult to navigate and continue to disadvantage underserved and marginalized communities.	
What do you recommend?	The Central Assessment of Psychosis Service (CAPS) seeks to streamline the pathway to FEP care in Washington State and address obstacles to early detection of psychosis by creating *one front door* for young people as well as their families and practitioners who have a psychosis-related concern. CAPS currently operates as a limited-capacity UW Medicine telehealth service that provides psychodiagnostic assessments for diagnostically complex referrals to the New Journey Network. In 2023, the Health Care Authority invested in the conceptual and operational development of an enhanced assessment service, which would work to expand equitable and efficient access to FEP screening and care across the State of Washington through the following activities:	

	(1) Develop, launch, and operate a health communication campaign to support awareness of psychosis signs and symptoms, the New Journeys Network, and CAPS services. (2) Develop the clinical operational, quality management, and data management systems to support a statewide psychosis screening and assessment service. (3) Develop and maintain a Health Information Technology system for case level tracking. (4) Develop and maintain a referral database to ensure that all families receive timely referrals to right fit care. A cost analysis projects that the annual operational costs associated with these activities is $1.1 million, inclusive of 10% indirects, beginning SFY2026 (July 2025—June 2026). If funded, a stagewise rollout of the health campaign and corresponding services will be feasible for a SFY26 launch due to readiness activities that were funded by the 1115 IMD Waiver and MHBG Bipartisan Safer Communities Act (BSCA) in SFY2024-25.
Why is taking the recommended action a smart move now?	Expanding CAPS is squarely in line with state and federal efforts to support early and periodic screening, diagnostics, and treatment for high-risk and high-impact health conditions. The activities outlined above are responsive to best practices in early identification, measurement-based care, and public health campaigns, all of which are associated with a reduced Duration of Untreated Psychosis, cost savings, and evidence-based coordinated care at the population level. Furthermore, the statewide CAPS expansion would further the state's mission to enhance equitable access to mental health care by facilitating timely, culturally-sensitive, and psychometrically validated screening and assessment processes. By making CAPS a "front door" through which all individuals would be screened for New Journeys admission, the state can reduce lag times for referrals, and enhance efficient, appropriate, and equitable access to First Episode Psychosis care. Furthermore, CAPS is poised to develop a central registry for New Journeys referents. A central registry enables more accurate estimates of First Episode Psychosis and Clinical High Risk for Psychosis incidence rates, geographic distribution, and service use data across the state, all of which are sorely needed to inform future program and policy decisions for this high-risk population.
What outreach has helped develop this recommendation?	The conceptual and operational development of the enhanced service has been informed by an extensive stakeholdering process. The UW CAPS team, led by Dr. Sarah Kopelovich in coordination with New Journeys Implementation Lead and Director of the Washington State Center of Excellence in Early Psychosis, Dr. Maria Monroe-DeVita, has co-produced the enhanced model with input from New Journeys program directors, agency administrators, families and service users, the Health Care Authority, DSHS Research and Data Analysis administrators, and UW Medicine administrators. In addition, the CAPS team has presented the model to community members, behavioral health agency peer and clinical staff, and policymakers to ascertain perceptions of the acceptability and feasibility of the statewide service. Anonymous data obtained

from the CYBHWG Youth & Young Adult Continuum of Care (YYACC) subgroup committee following a presentation on the proposed expansion of CAPS are presented in Figures 1 and 2, below.

Figure 1: YYACC Subgroup Survey Respondents by Profession

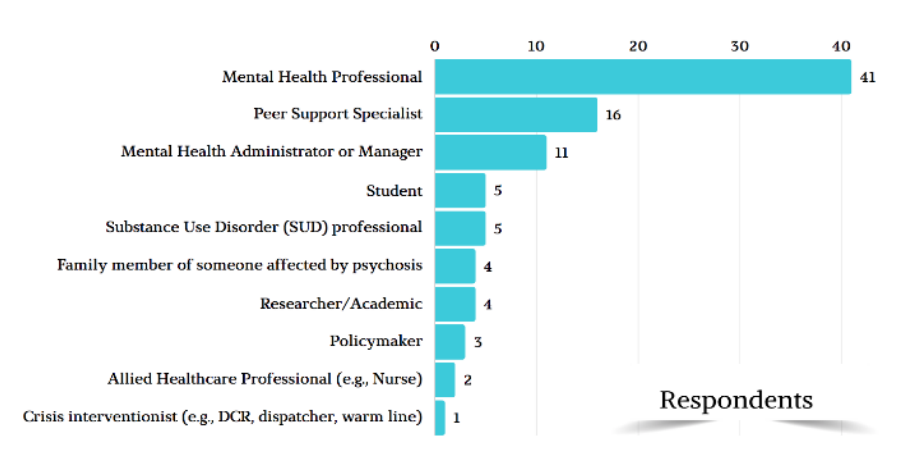
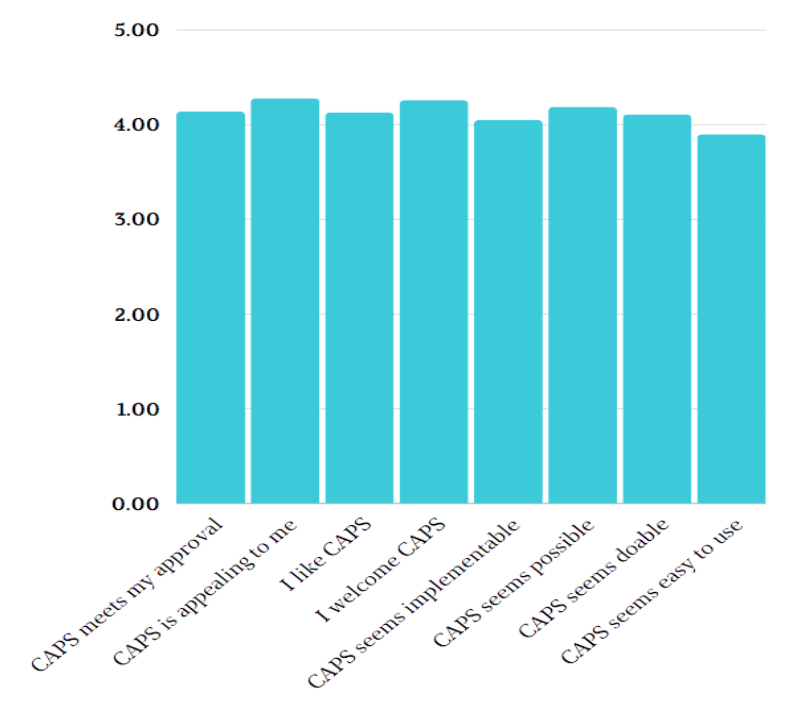


Figure 2: YYACC Subgroup Perceptions of CAPS Acceptability and Feasibility (1—5 Likert Scale)



Aggregated data across three large community and professional events is currently in the process of being analyzed. Results will be submitted for peer-review publication in FFY25.

Is there any additional collaboration needed to further develop this recommendation?	Considerable coordination across programs is needed to support a successful psychosis awareness campaign effort and the statewide screening, assessment, and referral service. The educational, marketing, and promotional materials developed for the campaign will be supplied to New Journeys teams, who can develop adaptations that are indicated for their catchment area (e.g., translations). Furthermore, the UW CAPS team will conduct analytics of campaign activities to detect whether the campaign is having equitable impacts across the state. This data will be triangulated with data from referrents about their pathways to CAPS; these analytics can then be used to develop more targeted outreach and social marketing strategies that are indicated in different regions. For instance, a health education effort among clergy, teachers, pediatricians, and family medicine practitioners may be more fruitful in a rural region, whereas targeting law enforcement and correctional staff may be a more fruitful strategy in a larger metropolitan area. The funding request outlined above would enable both public-facing activities and the continuous quality improvement efforts that are needed to maximize the efficacy of the health campaign. As is the case with complimentary resources such as the Mental Health Referral Service and the Behavioral Health Toolkit, once launched, families and practitioners will come to rely on CAPS services. A state proviso will help to ensure the stability of the service and enable it to meet its stated objectives. Moreover, the population-level data that will be obtained through this statewide service will complement RDA's efforts to track clinical outcomes and estimate the incidence of FEP and Clinical High Risk for Psychosis, thereby informing future program and policy decisions related to this vulnerable population.

Expand the Bridge Residential housing program

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation ☐Previous Subgroup Priority**
☒Policy **☒Budget** **$1.5M [annual] [*per* additional House]**	**Recommendation Summary.** Expand the number of Bridge Housing programs that serve young people exiting inpateient behavioral treatment. The Bridge Housing are 6-10 bed, 90 day, residential programs that provide mental health and substance use disorder support onsite and in the community.	
What is the issue?	This is an issue that was a Support Item for the most recent CYBHWG agenda and is related to Young Adults 18-24. The request is to add 2-6 more Bride Housing programs across the state. The current situation is according to DSHS data that those most likely to be homeless within 3-12 months of exiting a state system are the 18-24 year old's coming from inpatient behavioral health treatment. This is mainly due to them being discharged from the inpatient treatment facility to destinations that are not long term safe housing with	

	community supports. Instead they are discharged to emergency shelters, drop-in centers that have no beds or worse.
What do you recommend?	We want to expand the successful SHB 1929 and add more Bridge Housing. It is estimated to be a $1.5 annual cost for each House and we would implement them as soon as the HCA could release the RFP and the funding was active. Likely July 2025.
Why is taking the recommended action a smart move now?	This is both a fiscal cost saver and a critical strategy to prevent and end young adult homelessness and the behavioral health crisis. When a young person agrees to get treatment that is an opportunity to be an offramp from homelessness and return to the table of community. Because young people of color and LGBYQ+ young people are homeless at a higher rate this is an equity strategy. Many young people can return to their community and family but given history their families and community support's often require them to be on their meds and/or without substance use for a period of time. The Bridge Housing supports young people in a safe, miliue to get healthy and identify their Return To Comminity Plan.
What outreach has helped develop this recommendation?	NorthStar Advocates and young people with lived experience have had several focus groups with young people who have had behaviroal health inpatient treatment experience. We did this for the SHB 1929 and over the past several months to get input on the design of the 1929 RFP and design of the programs. We heard over and again from young people how they were discharged into unhealthy and unstable living environments which led to immediate relapse and return to homelessness.
Is there any additional collaboration needed to further develop this recommendation?	NorthStar Advocates will take responsibility and the lead for advocating for expansion. It is not clear if we need a bill or if a budget proviso will suffice given the passage of SHB 1929. We are talking with legislators and others but it does look like a budget proviso will suffice. We will continue to welcome the support of the YYACC and the CYBHWG for any ideas or support. The main need at this point is to be on either the Priority or Support agenda for the 2025 legislative session. The impact is to leverage both the motivation from young people who entered inpatient treatment and the funding the state already expended by authorizing payment for the inpatient treatment epidsode.

Increase and sustain funding for Youth Wellness Zones

Type of Recommendation	**☐ Legacy* CYBHWG Recommendation**	**☒New Recommendation** **☐Previous Subgroup Priority**
☒Budget **$550k [one-time]**	**Recommendation summary.** Support four model Youth Wellness Zones in Washington state to give time for these sites to demonstrate proof of concept and build political momentum: NE Spokane Zone, Renton Innovation Zone Partnership, Parkland Youth Wellness Zone, Yakima Valley Partners for Education. Each site is requesting $100,000 ($400,000 combined), with additional funds going to a convening organization ($50,000) and ongoing	

	evaluation and technical assistance ($100,000). The Youth Wellness Zones effort will seek additional matching funds to extend and sustain the work moving forward. Each site is informed by a youth team, which also aligns with Washington state's efforts to have policies guided by youth voice in matters affecting their well-being.
What is the issue?	Youth mental and behavioral health (wellness) is influenced more by social and environmental conditions than genetic and personal factors. Current approaches to addressing youth wellness are too heavily weighted towards clinical approaches that become easily backlogged and difficult to access. As a complement to other workforce and investment strategies, Youth Wellness Zones, address youth wellness at the source, through community-wide strategies that build social connection, youth and family mobilization, prevention services and built environment strategies (parks, transportation).
What do you recommend?	We request that the YYACC continue support for four model Youth Wellness Zones in Washington state to give time for these sites to demonstrate proof of concept and build political momentum: NE Spokane Zone, Renton Innovation Zone Partnership, Parkland Youth Wellness Zone, Yakima Valley Partners for Education. Each site is requesting $100,000 ($400,000 combined), with additional funds going to a convening organization ($50,000) and ongoing evaluation and technical assistance ($100,000). The Youth Wellness Zones effort will seek additional matching funds to extend and sustain the work moving forward. Each site is informed by a youth team, which also aligns with Washington state's efforts to have policies guided by youth voice in matters affecting their well-being.
Why is taking the recommended action a smart move now?	Washington state is currently in the bottom fourth of U.S states in measured youth mental health and wellness. We need bold and strong investments to re-imagine policy and funding solutions that will get at the core conditions that support youth thriving. The recommendation can easily build on the 2024 proviso, to be reinstated for the new fiscal year with the requested adjusted amounts.
What outreach has helped develop this recommendation?	The Youth Wellness Zones effort was cocreated with four existing collective impact organizations in Washington state with extensive history of community informed planning to support educational outcomes. The approach to the planning and implementing strategies in the Zones are informed by national best practices, and the convener, Shine Strategies, has years of experience working in collective impact initiatives locally and nationally. The approach to evaluation and the framework for studying the Zones is informed by a comprehensive review of the literature on place-based, collective impact efforts focused specifically on youth mental health and wellness. The specific Zone strategies are being informed by hundred of citizens living in the Zone areas.

Extend the timeline of House Bill 1580 (2023)

Type of Recommendation	☒ Legacy* CYBHWG Recommendation	☐New Recommendation ☐Previous Subgroup Priority
☒Policy	**Recommendation summary.** Extend the timeline of House Bill 1580 (2023 State Session, sponsored by Rep. Callan) to ensure the team can fully build a process to support children who remain hospitalized unnecessarily due to barriers to discharge.	
What is the issue?	In 2023, the Washington State Legislature passed House Bill 1580 to codify a new approach to addressing the issue of patients remaining hospitalized unnecessarily. This was a top recommendation of CYBHWG during the 2023 session. HB 1580 created a position in the Governor's Office to lead a multi-disciplinary team as well as dedicated positions at the child-serving state agencies (DCYF, DDA, and HCA). The team was intended to be ready to receive referrals of patients "stuck" in hospitals as of Jan 1, 2024; however the Governor's Office did not hire their lead until May 2024 and as of August 2024 the 1580 Team is working to establish permanent processes. The biggest issue is: we still have children facing these dire situations and we have not yet seen this bill serve its intended purpose. The 1580 Team has immense promise to revitalize how we as a system support children and families who remain hospitalized without medical necessity and we need to give them the time to implement it thoroughly.	
What do you recommend?	HB1580 was passed with a timeline that ran only for the 2023-2025 biennium and will expire in June 2025 if not extended – recommend extending both the positions and flexible funding elements of the bill for at least another biennium.	
Why is taking the recommended action a smart move now?	This remains an urgent issue facing our most vulnerable youth and families – there are still too many children who are stuck boarding in hospital emergency departments and inpatient units who are ready for discharge but whose families cannot acces the services/supports they need to feel safe/confident in taking them home. Taking action now to extend 1580 prevents the team from sunsetting before it can build permanent processes that improve the lives of children, youth, and families.	
What outreach has helped develop this recommendation?	There was extensive stakeholdering conducted in preparation for the original ask in the 2023 State Legislative Session. Since the bill's implementation, Seattle Children's has discussed this issue with other hospitals, with the 1580 team and other state agencies, with frontline workforce at SCH, and with parents who have lived experience. There is broad agreement that we cannot continue in status quo and that a new approach – like the one possible through 1580 – is a dire necessity.	
Is there any additional collaboration needed to further	Seattle Children's has already communicated to Reps. Lisa Callan and Tana Senn that the timeline for 1580 sunsets at the end of the biennium and that an extension feels critical. I (Kashi Arora with SCH) suspect this will need to be a bill rather than just a budget item and will flag that it does not have a prime	

develop this recommendation?	sponsor yet – happy to work with YYACC and/or CYBHWG leads. Kashi is very willing to collaborate on advocacy here and SCH will have this be one of its focus areas for the 2025 State Legislative Session.

Support the ASD/IDD workforce servicing youth and young adults

Type of Recommendation	☐ **Legacy* Recommendation**	☒**New Recommendation** ☐**Previous Subgroup Priority**
☒**Budget** **[Fiscal Impact]**	**Recommendation summary.** Fund a one-year pilot program to enhance program coordination and system navigation by non-licensed professions, and expand training for licensed professionals assisting with diagnosis. **This recommendation requires additional input.*	
What is the issue?	1. Trends impacting pediatric autism programs: a. Centers for Disease Control and Prevention (CDC) estimates an average of 1 in 88 children have autism. b. ASD has a dramatic impact on health care costs, in the following ways: i. Significantly more comorbid psychiatric and medical conditions, ii. Greater likelihood of hospitalization, iii. More Emergency Department (ED) visits. c. ASD programs focused on the integration of medical, psychiatric and community services with an emphasis on care coordination have the potential to reduce costly high-acuity services and center care in the family's community. 2. ASD Clinical Alignment and Resource Effectiveness (CARE) model: a. Mary Bridge is thinking about autism within a system of CARE, which allows them to: i. Identify gaps in access and opportunities for integration, and ii. Think about the strategic improvement of care across the continuum of services. 3. Mary Bridge has identified a fair number of roadblocks along the pathway of care. a. At Mary Bridge, there is currently a 1-year waitlist for children under 3 who are seeking an ASD diagnosis, and a 2-year waitlist for children older than 3. b. Additionally, there are older children who have never received a diagnosis and have thus missed out on significant support services. c. Due to a high volume of patients and limited resources to help with care navigation, Mary Bridge is experimenting with using a risk stratification tool for patients with a diagnosis, via their lone nurse navigator. i. Using this model, Mary Bridge has been able to connect children to care beyond Applied Behavior Analysis (ABA) to find community services that are a good fit for the child and family. d. Mary Bridge is hoping to increase their capacity to have staff helping families navigate systems of care, creating a more personal connection to	

	understand needs surrounding health literacy, rural care, transition of care, need for interpreters, multi-system involvement, and beyond.
What do you recommend?	4. Mary Bridge has proposed a one-year pilot to do the following: a. Program coordination that involves: i. Convening community summits, ii. Forming workgroups, iii. Mapping services, iv. Overseeing navigation and collecting metrics, and v. Liaisoning to the Mary Bridge steering committee. b. Increase navigation capabilities by: i. Continuing to use the registered nurse (RN) navigator for medical advocacy and care coordination, ii. Adding a social worker (SW) for community advocacy and care coordination, and iii. Testing a tiered intervention approach that allows for more personal and consistent care for crisis and subsequent connection. c. Expand training for professionals that could assist with diagnostics, by: i. Providing Autism Diagnostic Observation Schedule (ADOS) kits for nurse practitioners (NPs) in the Neontatal Follow-Up Clinic, and ii. Providing ADOS training for mid-level practioners. 5. Funding options for the one-year pilot: a. Option A ($525,000) = 1 program coordinator, 1 RN navigator, 2 SW navigators, 7 ADOS kits/training b. B ($350,000) = 1 program coordinator, 1 RN navigator (MultiCare expense), 2, SW navigators, 7 ADOS kits/training c. C ($225,000) = 0 program coordinators, 1 RN navigator (MultiCare expense), 2 SW navigators, 7 ADOS kits/training 6. If Mary Bridge can accomplish everything in the proposed pilot, there could be a model that is scalable to other systems with similar infrastructure across the state.
Why is taking the recommended action a smart move now?	
What outreach has helped develop this recommendation?	
Is there any additional collaboration needed to further develop this recommendation?	**This recommendation requires additional input from subgroup members and leadership, and other stakeholders.*

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FINANCING INFANT AND EARLY CHILDHOOD MENTAL HEALTH SUPPORTS AND SERVICES
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