# Children and Youth Behavioral Health Work Group (CYBHWG) Notes

***June 20, 2023***

| Members | | | | | |
|---|---|---|---|---|---|
| ☒ | Representative Lisa Callan, Co-Chair | ☒ | Libby Hein | ☒ | Joel Ryan |
| ☒ | Keri Waterland*, Co-Chair | ☒ | Dr. Robert Hilt | ☒ | Noah Seidel |
| ☐ | Hannah Adira* (alternate) | ☒ | Kristin Houser | ☒ | Maureen Sorenson |
| ☐ | Javiera Barria-Opitz | ☒ | Avreayl Jacobson | ☒ | Mary Stone-Smith |
| ☐ | Dr. Avanti Bergquist | ☐ | Andrew Joseph, Jr. | ☒ | Delika Steele |
| ☒ | Shelly Bogart | ☒ | Kim Justice | ☒ | Representative My-Linh Thai* (alternate) |
| ☐ | Kelli Bohanon | ☒ | Michelle Karnath | ☒ | Jim Theofelis |
| ☐ | Representative Michelle Caldier (alternate) | ☐ | Preet Kaur | ☐ | Dr. Eric Trupin |
| ☒ | Diana Cockrell* | ☒ | Judy King | ☐ | Senator Judy Warnick |
| ☒ | Lee Collyer | ☒ | Amber Leaders | ☒ | Lillian Williamson |
| ☐ | Elizabeth De La Luz | ☒ | Laurie Lippold | ☐ | Senator Claire Wilson |
| ☒ | Representative Carolyn Eslick | ☐ | Mary McGauhey | ☒ | Dr. Larry Wissow |
| ☐ | Dr. Thatcher Felt | ☐ | Cindy Myers | ☒ | Jackie Yee |
| ☒ | Summer Hammons | ☒ | Michele Roberts | | |

## Strategic Plan update

*Rachel Burke, Health Care Authority (HCA)*

*See TVW recording (5:40)*

- Interested in being part of this work, e-mail cybhwg@hca.wa.gov.

## Best Telehealth Practices for P-25 Behavioral Health: Preliminary findings

*Sarah Walker, University of Washington (UW) Co-lab, & Cara Towle, Harborview Behavioral Health Institute*

*See TVW recording (14:50), see page 6 for slides*

### Highlights

**Telehealth Report**

- Tele Behavioral Health (TeleBH) facilities increased access for some families during and after the pandemic.
- The report summarizes processes, preliminary findings, and emerging recommendations from a review of best practices for telehealth for children and youth in the prenatal stage through age 25.

## Update on children and youth boarding in hospitals

*Laura Knapp, Seattle Children's & Jamie Kautz, Mary Bridge*

*See TVW recording (46:50), see page 23 for slides*

### Highlights

**Seattle Children's**

- Seattle Children's continues to see a crisis in Emergency Department (ED) mental health; in response, it activated the Emergency command center last month.
- Seattle Children's has 45 physical exam rooms in the ED with 50% of those beds regularly occupied with patients with mental health needs.
- Around 35% of the beds are occupied routinely with patients waiting to transfer to a higher level of care or residential care.
- Another reason for boarding in hospitals is situations where the patient is ready for discharge, but the family is not ready yet, often because of safety concerns.
- Increased volume in the ED for both mental and physical health; 5000 visits in May.
- From May 2022 to May 2023 the median number of patients boarding, and the length of stay increased from 88 patients and over 19 hours to 104 patients and over 66 hours.
- Acuity of cases is going up and remaining high with a decrease in resources, including residential beds to care for these patients.

**Mary Bridge**

- Mary Bridge continues to see a large volume of kids in crisis staying for substantial amounts of time in the ED.
- Data shows:
    - Family conflict is the most common trigger for crisis; school is the second most common trigger.
    - Messaging to parents from community partners is to go to the ED.
    - Some youth coming to the ED reported that going to the ED had a negative effect on them, they did not get what they wanted, they or didn't need to be there; and that it wasn't helpful to go to the ED vs. community crisis services.
    - Opportunity to educate the community on the difference between going to the ED compared to calling crisis services.
- Kids Mental Health Pierce County is partnering with Mary Bridge to work more closely with community partners to educate and inform people of how to get the most appropriate services.
- Kids Mental Health Washington is expanding to other regions; hope is to extend statewide.

## Celebrating Lillian Williamson

*See TVW recording (1:27)*

- Youth and Young Adult Continuum of Care (YYACC) quad-lead, Lillian Williamson, was celebrated for her accomplishments.
    - 2023 Undergraduate Dean's Medalist Award
    - 2023-24 Fulbright Scholar

*Program on the Environment » 2023 Undergraduate Dean's Medalist Award: Congratulations to Lillian Williamson, UW PoE student!*

## 2024 recommendations

*See TVW recording (1:33)*

### Highlights

- Recommendations should be targeted, detailed, and implementable.
- Consider legacy items: do we need to do more? Is a second phase needed? Are there implementation challenges that require updates or expansion?
- This is a supplemental year – the budget is set for the next 2 years so there is limited ability to make changes unless there is additional revenue; good year for policy and implementation updates.

**Ideas members shared for 2024**

- Complex needs funds - the Early Childhood Education and Assistance Plan (ECAEP) (complex needs dollars that got added were one time). How are those dollars being spent?
    - ECEAP programs are being used for one-on-one supports for kids who are experiencing a lot of trauma and challenging behaviors in the preschool age period. Future presentation to this group?
    - There is a need for more 0-3 prevention services therefore, it might be beneficial to learn about the Early Childhood Education Assistance Program (ECEAP), which offers different types of therapeutic care and learn of what other states might be doing around this topic.
- Need complete and more robust return to community plan so youth and young adults are not discharged to homelessness.
    - An appropriate setting is needed for individuals to seek services. (e.g., faith-based recovery may not be a good fit and may retraumatize; we need to make sure the service is culturally responsive and supports well-being).
- Need to continue to focus on workforce issues.
- Research administrative barriers and complexities.

## Subgroup updates 2024 work

*See TVW recording (1:58)*

**Workforce & Rates (W&R)**

- Coordinating with multiple organizations, including Workforce Training Board, Council for Behavioral Health, the Behavioral Health Institute, and others involved with workforce issues.
- The subgroup spent some time talking about the workforce initiatives passed in HB 1724 and their implementation.

***Items that have come up thus far from the subgroup***

- Conditional scholarships.
- Continue to research administrative burdens and complexities.
- Continue pilot for School-based Partnership Access Line (PAL) program and explore how to address related workforce issues.
- Continued support of Certified Community Behavioral Health Clinics (CCBHC) work and the teaching clinic rate, both legacy items.
- Workforce issues related to Wraparound with Intensive Services (WISe).
- Workforce issues related to the rapid care team for children in crisis passed in HB 1580.
- Partner with other subcommittees, including school-based subcommittee to tackle school-based workforce issues for services offered inside and outside of schools.
- Roles for non-degreed individuals.
- Psychiatric consultations in primary care settings.
- Research into forms of therapy or intervention that may be beneficial that are not currently covered by Medicaid in Washington state but may be allowable. What funding would be needed for non-traditional therapies and expanded telehealth?
- Professional licensing and credentialing processes passed in HB 1724.
- Workforce issues related to serving developmentally disabled children and youth.
- Applied Behavioral Analysis (ABA) rate and other rates that may be related to workforce shortages.
- Workforce issues related to substance use services, inpatient services, and intensive outpatient services.

*The subgroup will be sorting through the list of items to determine what recommendations to move forward.*

**Prenatal through 5 Relational Health (P5RH)**

- P5RH has supported an investment in an infant and early childhood mental health consultation program. We will be looking at the types of services and settings being offered, with possible recommendations this year or next.
- P5RH will start reviewing legacy items to determine if any policy changes or budget investments are needed.
- A big focus of the subgroup is hearing from parents, caregivers, and families to learn what is needed.

- The subgroup plans to contemplate and go deeper into some of those topics starting in July.

**School-based Behavioral Health & Suicide Prevention (SBBHSP)**

- Policy workshop scheduled for July 18th.
- Policy workshop time is used to work on recommendations with the framework structured around 5 policy buckets used to drive the discussion:
    1. Statewide leadership
    2. Workforce support
    3. System funding
    4. Programming
    5. Mental health education
- Brought on new cohort of parents and family members with lived experience.
- Currently there are 11 youth and young adults between 15-23 years old that have been participating in separate evening meetings.

**Behavioral Health Integration (BHI)**

- Working on Integration to include early childhood; researching how best to support providers.
- The subgroup is having presentations around models of care for early maternal health and early interventions.
    - HCA is supporting efforts on a four-year work plan to come up with models of care and funding.
- The subgroup is researching care coordination, which was part of the subgroup's recommendations last year, but the recommendation was not well-developed developed enough. the subgroup is trying to determine how we can best help primary care be more of a medical home for families with the hope that it would be a trusted area of space for people.
- Funding is needed for care coordination, including developing a care plan for the child/youth and coordinating with schools.
- Care coordination includes support for families, not just the person in crisis.
- We are looking at the implementation of past legislation to find out what's effective, what is not, and what may need a policy adjustment to improve integration. (e.g., Community Health Worker [CHW] grants that were awarded in past years and start-up grants).

**Youth and Young Adult Continuum of Care (YYACC)**

- The YYACC has an open application for a new youth member.
- Reviewing outstanding issues from last year.

## Public Comment

*See TVW recording (2:28)*

- *There is a huge disconnect between the leaders and the families' receiving services. I've had recent experiences where 1 child stayed for 2 weeks at Seattle Children's and another child stayed for 1 week at Mary Bridge. The way I hear the system described is not the way it is working; it is frustrating for families. We are being told by mental health agencies to call 911 when a child is in active crisis. The 988-crisis services response is not working; when you call, they say call 911. I no longer want to call the crisis line. Another concern is the lack of staff, as it leads to burnout and may create more trauma. I have also been frustrated with WISe. It seems like the program is more concerned about how long the child has been in the program vs. what services are being provided. Also, services are not culturally responsive to meet diverse needs. When you have children in active crisis, the system we have now is not acceptable. We need to include families instead of blaming them for the child's behavior; most of the time it is the behaviors of the child, not the family, that is causing the conflict. Finally, please seek voices from parents, and others with lived experience to inform systems. (Mika, Office of Education* Ombuds)

## Chat:

- Youth Regional Navigator Program website
- Interested in receiving notices of future meetings or joining a subgroup? E-mail cybhwg@hca.wa.gov

# Telebehavioral Health Best Practices: Report Out

Children and Youth Behavioral Health Workgroup
June 20th, 2023

# Team members

**Cara Towle**, MSN, RN
Associate Program Director, Behavioral Health Institute, Harborview/UW Medicine

**Melody McKee**, MS, SUDP
Program Director, Behavioral Health Institute Harborview/UW Medicine

**Sarah Cusworth Walker**, PhD, MS
Director, CoLab, UW PBSCI

**Michelle Garrison**, PhD, MPH
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**Tatiana Sarkhosh**, MPH
Doctoral Graduate Assistant,
UW School of Nursing

**Kathleen Myers**, MD, MPH
Professor Emeritus, University of Washington

**Sally Ngo**, MPH
Program Operations Specialist, CoLab, UW PBSCI

**Joane Gonzalez**, BA
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**Jeanette Hernandez**, BA
Program Assistant, CoLab, UW PBSCI

# Budget Proviso re TeleBehavioral Health Best Practices for prenatal through age 25

(Section 215, (60), beginning on page 219 of ESSB 5092, here.)

**Originated from work done by the Children and Youth Behavioral Health Work Group.**

**Background**:

TeleBH facilitates increased access for some families during and after the pandemic.
Consumers & professionals interest in:

(1) ensuring ongoing TeleBH services and
(2) examining clinically effective ways to deliver TeleBH for various consumers, diagnoses, and treatment.

**Intent:** Make recommendations regarding best practices for virtual behavioral health (TeleBH) services to children from prenatal stages through age 25

This request is supported by the Children & Youth Behavioral Health Work Group and Representatives Lisa Callan, Frank Chopp, Lauren Davis, Debra Entenman, Roger Goodman, Kirsten Harris-Talley, Mari Leavitt, Marcus Riccelli, Alicia Rule, Lillian Ortiz-Self, My-Linh Thai, and Emily Wicks.

# Timeline

**Dec 1, 2021:** Preliminary report on the 2022 work plan

**Jun 1, 2022:** Initial report with recommendations for best practices for virtual behavioral health services

**Dec 1, 2022:** Final report with:
Additional refined recommendations
A research agenda and proposed budget for fiscal year 2024 and beyond.

**Jan-June 2023:** Refinements and recommendations, including design and development of user guides

# Scope of Work

## Engage system partners and clinical experts to:

**Review current and emerging data and research, including:**

- The collection and analysis of data about clinical efficacy of behavioral health services and supports through virtual modes.
- Methods for determining and maximizing the health benefits of the different virtual modalities.

**Make recommendations regarding best practices for virtual behavioral health services to youth and young adults from prenatal stages through age 25.**

Focus on:

- Development of services & supports that deliver clinically effective outcomes for youth, young adults, and families.
- Identifying safeguards for "in-person," "audio-video," and "audio only" modes.

# Project Approach

## BEST PRACTICE RECOMMENDATIONS

- Development of services & supports that deliver clinically effective outcomes for youth, young adults, and families.
- Identifying safeguards for "in-person," "audio-video," and "audio only" modes.

## ADVISORY GROUP

Members from key partners and groups interested in youth telebehavioral health services

## CLINICAL EXPERT TEAM

Experts, both locally and nationally, to help provide feedback on the literature review

## DESIGN TEAM

Behavioral Health Institute, CoLab for Community and Behavioral Health Policy, Center for Health Innovation & Policy Science, and Dr. Kathleen Myers

## KEY INFORMANTS

Individuals identified to provide feedback on specific practice issues, where there are gaps in the literature, and other remaining considerations

# Key Collaborators & Partners

## POLICY and ADVOCACY

Broad system and community perspective

Knowledge of state policy

## PROVIDER ORGANIZATIONS

Understand the service delivery environment

## CLINICAL SYNTHESIS EXPERTS

Knowledgeable about the wider clinical field

## FUNDER ORGANIZATIONS

Knowledgeable about payment, quality and access

## CONSUMER EXPERTS

Knowledgeable about what is helpful therapeutic practice

# Core Advisory Group

**Sharon Brown,** Senator 8th Leg District

**Christine Cole**, HCA

**Ken Dorais**, Yakima Valley Farm Workers

**Bradford Felker**, UW PBSCI, VAMC

**Marissa Ingalls**, Coordinated Care

**Bridget Lecheile**, WA Assn of Infant MH

**Lucy Mendoza**, HCA

**Julia O'Connor**, WA Council for BH

**Monica Oxford**, UW Sch of Nursing

**Mary Stone-Smith,** Catholic Cmty Svcs & WA Council for BH

**Elizabeth Tinker,** HCA

**Kristin Wiggins,** Consultant

# Subject Matter/Clinical Experts

**Kathleen Myers**, MD, UW PBSCI/Seattle Children's Hospital (ret) - Lead

**Amritha Bhat**, MBBS MD, MPH, UW PBSCI

**Don Hilty**, MD, UC Davis

**David Brieger**, PhD, UW PBSCI & Psychology

**Jonathan Comer**, PhD, Florida International University

**Bradford Felker**, MD, UW PBSCI, VAMC

**Johanna Folk**, PhD, UC San Francisco

**Joyce Harrison**, MD, Johns Hopkins

**Alissa Hemke**, MD, UW/Seattle Children's Hospital

**Monica Oxford**, MSW, PhD, UW Sch. of Nursing

**Bonnie Zima MD**, MPH, UC Los Angeles

# Literature Review Approach

| Clinical Practice Guidelines | Systematic Reviews | Individual Articles |
|---|---|---|
| - First priority<br>- Published or promoted by professional practice organizations<br>- Focus on specific treatments and/or tele BH strategies | - Second priority<br>- Search terms<br>  - Age terms<br>  - Tele BH terms<br>  - BH/MH terms<br>  - Review terms<br>  - Diagnosis-specific terms “or” field | - Third priority<br>- Address gaps not addressed through clinical practice guidelines or systematic reviews |
| **12 guidelines identified** | **PubMed - 169 articles**<br>**Web of Science - 233 articles**<br>**CINAHL - 150 articles** | **After analysis, remaining gaps will considered for expert interviews** |

# Literature Review Findings

- Infant, dyadic, and early childhood guidelines are lacking
- Only one potential population where teleBH might not be as effective
  - Systematic review and meta analysis by Nair et al. (2018) identified two studies with poorer outcomes in in the treatment group, who received psychoeducation and CBT online.
- Potential considerations (clinical not empirical)
  - Trauma experiences involving technology (cameras, recordings)
- Guidelines were general, mainly operational, and did not offer the level of specificity desired or needed by teleBH providers.

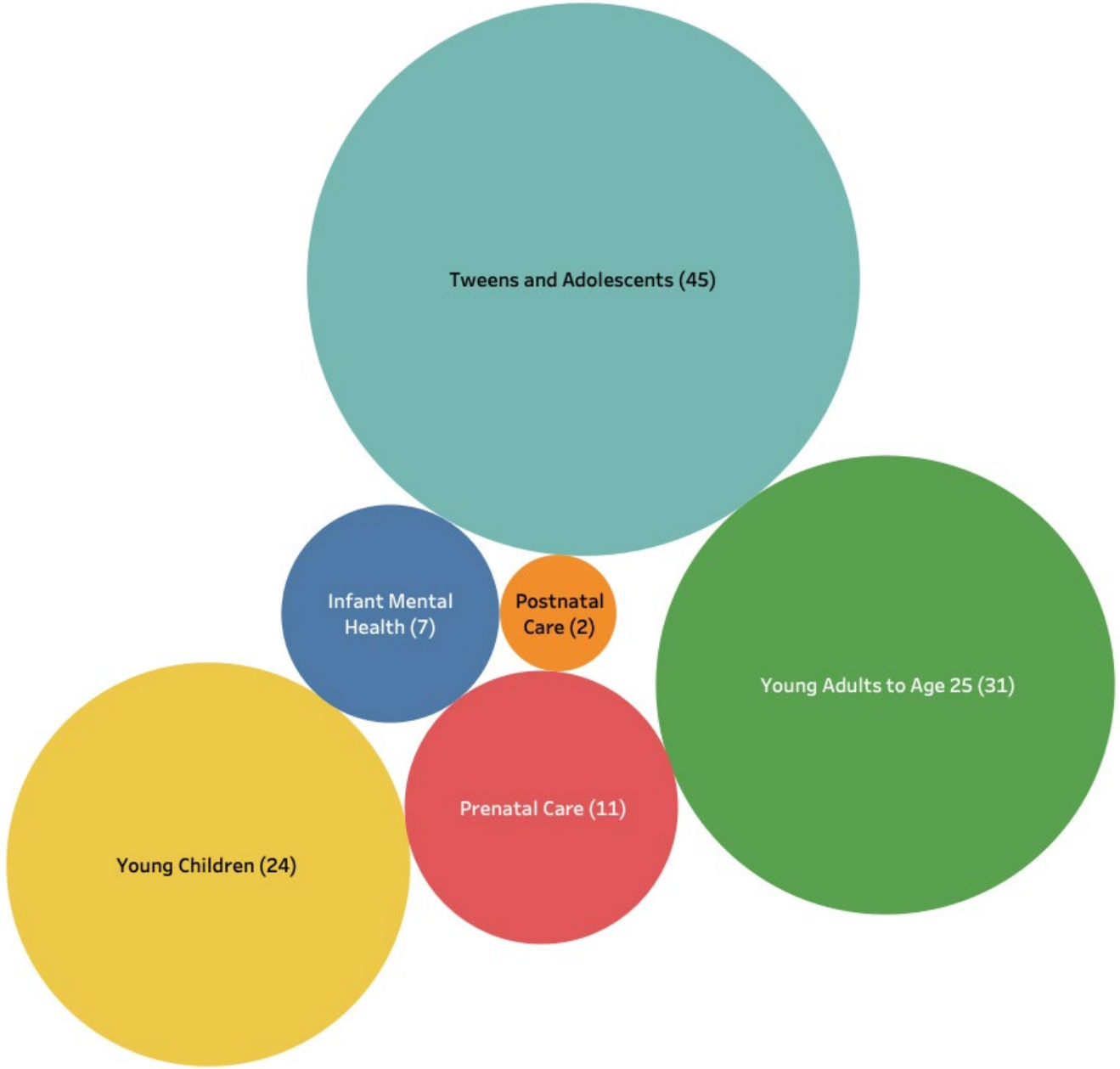
# Coverage in the literature for developmental stage by quality pillars

| | Perinatal | Infant | Young child | Teen | Young adult |
|---|---|---|---|---|---|
| Access | | | | | |
| Equity | | | | | |
| Workforce | | | | | |
| Quality | | | | | |
| Safety | | | | | |
| Treatment | | | | | |
| Diagnosis/ Assessment/ Evaluation | | | | | |
| Best practice / guidance | | | | | |

| Key | None to limited literature | Somewhat robust literature | Substantial literature |
|---|---|---|---|

# Provider Survey

| | |
|---|---|
| Community clinic | 14 |
| Crisis services | 3 |
| Federally qualified health center | 0 |
| General outpatient behavioral health services | 13 |
| Hospital: academic hospital | 3 |
| Hospital: critical access hospital | 1 |
| Inpatient behavioral health/psychiatric services | 0 |
| Multispecialty clinic | 1 |
| Other | 13 |
| Peer services | 1 |
| Primary care | 3 |
| Residential care | 0 |
| Serious mental illness (SMI) care | 0 |
| Specialty behavioral health | 6 |
| Specialty substance use disorder (SUD) treatment | 1 |
| Trauma services | 0 |
| Tribal and/or Indian Health Services | 0 |



# Guide for Elementary-School Children

### DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1ST- 5TH)

Elementary-school youth vary greatly by gender in their pubertal development and cognitive maturity. For example, a 1st grade boy may still be learning to control impulses and cooperate in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Elementary-school children readily engage regarding the technology, especially seeing themselves on the "TV." Assessing their interest in the technology may contribute to assessing their mental status.

## ENGAGEMENT

- **Explain technology:** Provide an explanation of the technology and, if possible, a demonstration, such as showing the child his/her image on the screen, or giving a virtual tour of the clinician's office.
- **Test solo capability:** Determine the youth's ability to be interviewed alone in the videoconferencing room, according to impulse control, cooperation, and verbal abilities. This is usually possible for those with well-developed self-regulation. Test by doing a short task and screen share while parent/guardian is present.
- **Curate toys and tasks** to engage the child and to facilitate a developmentally-relevant mental status examination over the monitor, e.g., the child's drawings, demonstration of selected academic skills, Pokemon cards or puppets (younger children), a favorite toy with symbolic implications (such as dolls or cars/trucks, a puzzle), a website (older elementary-school children). Use the screen share to develop ideas or a "plan"

## FAMILY INVOLVEMENT

Family involvement in the child's treatment varies according to usual clinical guidelines.

- For medication sessions, the parent/guardian will be present for most, perhaps all, of the session, depending on clinical presentation and need. For example, children with autism, psychosis, separation anxiety, social anxiety, and severe depression will likely need the parent/guardian present for most/all of the session due to the difficulty the youth may experience in interacting through the technology. This issue may abate after the first or second session.
- For Disruptive Behavior Disorders (DBD), evidence-based guidelines indicate Behavior Management Training (BMT) that predominantly involves the parent/guardian. The child may not be present for all sessions.
- For individual psychotherapy interventions for Mood Disorders, Anxiety Disorders, and Adjustment Disorders, family involvement should follow usual in-person guidelines. Exceptions include issues involving the technology, e.g., reluctance to speak up or engage over the video, or frustrations with the technology.

Tip!

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## DIAGNOSTIC CONSIDERATIONS

Some children with mental health disorders may be challenged to engage in treatment provided through TBH. With some tolerance and creativity, successful treatment can be achieved.

- Children with DBDs or ASD may be unable to sustain their engagement. Clinicians must be ready to allow these children to entertain themselves, but while maintaining visual observation on the screen. In general, do not allow them to use electronics as they will never re-engage.
- If children refuse to stay within the camera's range, the clinician must unite with the parent/guardian to calmly monitor the child to ensure the child's safety as well as the integrity of the examination room.
- Children with ASD may be distressed by seeing themselves on the screen. The clinician should determine this issue with the parent and turn off their on-screen image.
- Children with Social Anxiety Disorder and Selective Mutism may not speak during the session, especially the first session. The clinician should be creative in allowing the child to just listen, to engage in a quiet activity while "actively listening," telling them to indicate if they want to write a comment on the "chat" or "whiteboard" instead of speaking.

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## SAFETY AND PRIVACY

The ability to establish safety and privacy depends on the site at which the youth is receiving TBH services. If services are being received at a clinic, such as a mental health clinic or a pediatrics clinic, safety and privacy will be ensured by clinical practices at those sites. If services are received at non-clinical sites such as the school or home, careful planning to ensure safety and privacy is needed.

- **Virtual tour:** The clinician should give the youth a virtual tour of his/her office to demonstrate that no one else is observing the session.
- **Non-traditional settings:** To endure safety and privacy, sessions may be conducted in non-traditional settings such as a porch or backyard, a bathroom, or an automobile.
- **Plan ahead:** Children with DBDs may stray from the interview. Steps to ensure the child's safety while out of the clinician's view and influence must be established.
- **Two+ adults:** Children with DBDs who may elope during the session will need a second adult present to manage the child while the clinician completes the interview with the parent/guardian.

Tip!

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### CASE EXAMPLE

TJ was a 10 y/o boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and his falling behind academically. The Mother noted similar difficulties in the home. Both parents worked and lived in a neighborhood with poor transportation options. Thus, they agreed to home-based TBH after school and work. The family used their smartphone for the sessions. They had adequate, but not optimal, cell reception. So, sessions were held in the parent's bedroom where there was a landline in case the videoconferencing system failed. The bedroom also provided the greatest privacy in the home. The siblings were watched by the older sister in another room and/or taken for a walk.

### RESOURCES AND LINKS

- Link
- Link
- Link

TJ was readily engaged over the smartphone and told of his favorite videogame, his love of legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Through these discussions, the clinician appreciated TJ's good verbal skills and intellect, as well as a mild mid-facial and guttural tic even with the spotty connectivity. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, TJ was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly again ran to the smartphone to show his artwork which showed no bearing on the topic, but he enthusiastically told of its meaning demonstrating his creativity and knowledge.

To get more time with his mother, the clinician asked TJ to play with some of his legos on the coffee table in front of his mother so that she could see him while she and his Mother talked. He did so, fairly quietly for a while, then started to get louder and louder, more disruptive. The Mother quietly switched the camera on the smartphone so that the clinician could naturalistically observe TJ's play without his knowledge.

Then, the clinician then sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room. She also logged into the school's website to check the child's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician had individual time with TJ, observing his play and discussing the relevant themes.

The clinician made a diagnosis of ADHD with a concern about a learning disability. They made a treatment plan that included the clinician requesting rating scales from selected teachers, making the child a "Focus of Concern" under Public Law 94-142, and developing a structured plan for homework including turning it in reliably. The clinician emailed the mother some selected readings about ADHD and treatment, including information about a behavior chart. As the family did not have a printer, the clinician also send a hard copy of the readings. They made a plan for the Mother to meet alone with the clinician in a week to set up a behavior program, consistent with evidence-based treatment for ADHD.

Country, City, Zip
example@example.com
www.example.com

*Last updated xxx*

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UW Medicine Department of Psychiatry and Behavioral Sciences | Harborview Behavioral Health Institute | CoLab | PURDUE UNIVERSITY

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# Next Steps

- Review quick guides with Advisory team
- Release quick guides
- Panel webinar to roll out the guides with Subject Matter Experts one of these dates:
  - Oct 20th, Nov 15th, Dec 15th
- Evidence review under consideration for publication

# Recommendations

- Maintain funding for telebehavioral health
- Leverage out of state providers and ensure they have access to WA telebehavioral health guidance
- Evaluate the quick guides
- Portal for video demonstrations of online games, digital tools
- Update review for more recent literature (e.g. audio only)

# SCH Youth Mental Health

***Laura Knapp,*** *VP of Mental and Behavioral Health*

CYBHWG 6.20.2023


Seattle Children's

# ED Mental Health Crisis

## Emergency Operations Center activated May 22, 2023

Seattle Children's is seeing significant volumes of:

- Patients needing inpatient admission (to PBMU or other facility) and experiencing long waits to access them
- Patients whose families do not feel safe taking them home, but they don't need hospitalization (aka "stuck kids")
- Generally high volumes of patients presenting in mental health crisis and in need of physical health care (over 5,000 total patient visits to the ED last month)

SCH ED has 45 physical rooms:

- Routinely over 50% of them are being used to treat patients with mental health needs
- Routinely **between 35%-50% of the rooms are routinely being used for patients with mental health needs awaiting disposition planning**.

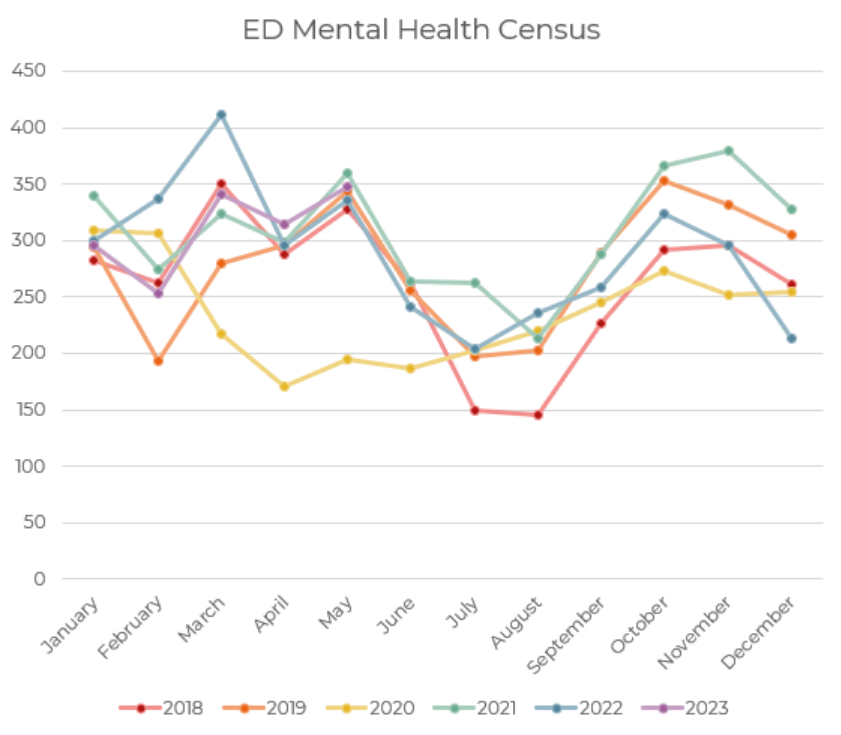
Statewide there are routinely 30 or more pediatric patients boarding in need of inpatient psychiatric beds.

# EDMH Census

## 5-Years of Patient Visit Volumes

Key Takeaways:

- Consistent seasonal peaks in Spring and Fall (except for 2020 due to COVID)
- Consistent seasonal “lull” in Summer – less significant decrease in 2021 and 2022
- We were experiencing crisis level visit volumes and needs pre-COVID




*Note that this has not yet been reviewed by SC Clinical Data Analysts. While individual data points may change slightly, the trends are accurate.

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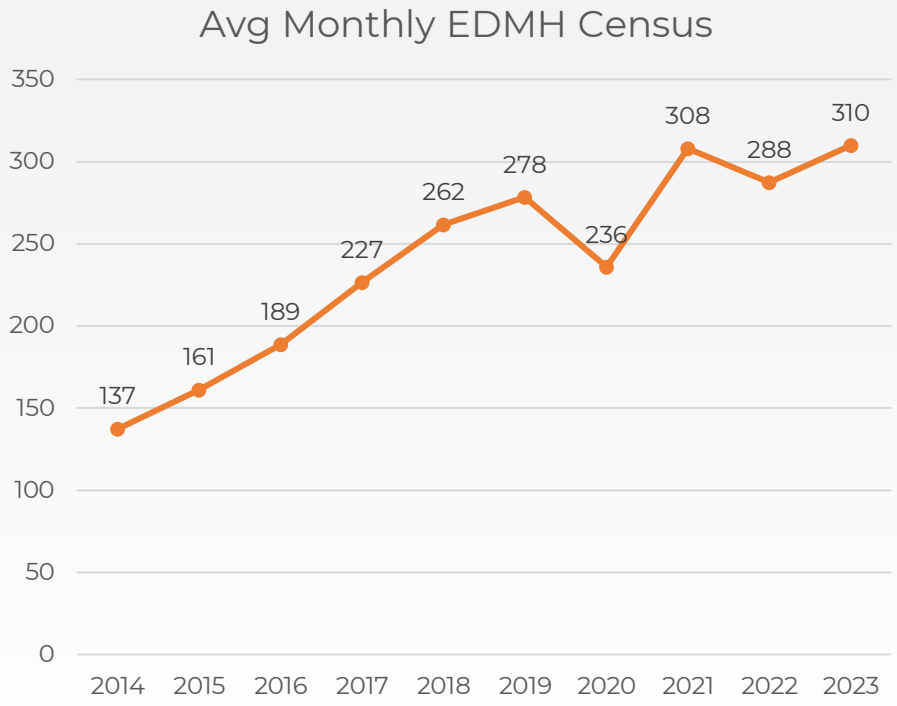
# EDMH Census

## A different perspective

This is the average # of visits per month to SCH ED for mental health, year over year 2014-2023.

Key Takeaways:

- A steady increase in need
- 2020 was an unusual year, due to COVID
- 2023 is the average monthly EDMH census year-to-date through end of May, this number will change throughout the year.




*Note that this has not yet been reviewed by SC Clinical Data Analysts. While individual data points may change slightly, the trends are accurate.

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# EDMH Census

## Extended Stay Patients (24h+)

In 2021, **we had between 35-60 patients** per month with a length of stay greater than 24 hours

In 2022, that range moved up to between **48-72 patients** per month

In 2023, so far we've had between **65-100+ patients** per month who stay in the ED 24hours+

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## May 2022

*Kashi presented this data to CYBHWG in June 2022*

2022 was characterized **by high overall volumes** of pediatric patients presenting to the ED in MH crisis

- **335 EDMH** visits
- **88 boarding patients** (at the time, this was a record-breaking number of patients)
- Median boarding length of stay: **over 19 hours**

## May 2023

In 2023, **volumes have remained steadily high** and a slight increase from 2022

The significant difference is in **boarding** or extended stay patients.

- **347 EDMH** visits
- **104 boarding patients** (nearly record-breaking; 108 is record, set in March 2023)
- Median boarding length of stay: **over 66 hours**

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# Continuum Challenges

## Acuity remains high; Resources remain limited

Behavioral acuity of patients continues to be high, even as volumes look more stable

Community resource landscape – options are decreasing, impacting ability to discharge patients from the ED

- Reduction in residential beds (recent facility closure)
- SCH PBMU currently has limited capacity due to ongoing facility improvements for patient safety.

Ongoing state- and nation-wide challenges regarding behavioral health workforce.

Consideration for CYBHWG:

While we await the proposals and recommendations from the P-25 Strategic Plan,

**what is the short-term plan to increase youth behavioral health service capacity?**

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# Thank you!