KAUFFMAN
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PN25 Behavioral Health Strategic Plan Advisory Group Meeting Notes

Monday, March 13, 2023
3–5 p.m. Pacific Time

Contents

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MEMBERS

Youth/Young Adults			
☐ Hannah Adira	☒ El Dolane	☐ Sol Rabinovich	☒ Lillian Williamson
☒ Darren Bosman	☒ Tracey Hernandez	☐ Casi Sepulveda	☐
☐ Xana Caillouet	☐ Bree Karger	☒ Amanda Shi	☐
☒ Sierra Camacho	☒ Kaleb Lewis	☒ Chanson Toyama	☐
☐ Sage Dews	☐ Desi Quenzer	☒ Oscar Villagomez	☐

Parent/Caregivers			
☒ Tina Barnes	☒ Amy Fumetti	☒ Niki Lovitt	☒ Sharon Shadwell
☒ Marta Bordeaux	☒ Melia Hughes	☐ Sarah McNew	☐ Lamara Shakur
☒ Melissa Brooks	☒ Rokea Jones	☒ Alexie Orr	☐ Tui Shelton
☒ Christi Cook	☒ Michelle Karnath	☐ April Palmanteer	☒ Kimberly Slattery
☐ Alyssa Cruz	☐ Karen Kelly	☐ Rosemarie Patterson	☒ Danna Summers
☒ Peggy Dolane	☐ Brandi Kingston	☒ Liz Perez	☒ Marcella Taylor
☐ Jamie Elzea	☒ Nicole Latson	☒ Jessica Russell	☐
☒ Heather Fourstar	☒ Starleen Lewis	☒ Janice Schutz	☐

Other Members		
☒ Jane Beyer (Office of the Insurance Commissioner)	☐ Byron Eagle (Developmental Disabilities Administration-Child Study Treatment Center)	☒ Amber Leaders (Governor's Office)
☒ Shelley Bogart (Department of Social and Health Services-Developmental Disabilities Administration)	☐ Carolyn Eslick (House of Representatives)	☒ Jeannie Nist *or* Katherine Seibel (School Based Behavioral Health & Suicide Prevention subgroup)
☒ Kelli Bohanon *or* Kristin Wiggins (Prenatal-5 subgroup)	☐ Hugh Ewart *or* Laurie Lippold (Workforce & Rates subgroup)	☒ Sarah Rafton *or* Kristin Houser (Behavioral Health Integration subgroup)
☐ Lisa Callan, Co-Chair (House of Representatives)	☒ Steven Grilli, Department of Children, Youth and Families	☒ Michele Roberts (Department of Health)
☐ Lee Collyer (Office of Superintendent of Public Instruction)	☐ Summer Hammons (Tulalip Tribes)	☒ Keri Waterland, Co-Chair
☒ Britni Dawson-Giles Suquamish Tribe	☐ Kim Justice (Commerce – Office of Homeless Youth)	

Staff		
☒ Jo Ann Kauffman (Kauffman and Associates, Inc.)	☒ Johnel Barcus (Kauffman and Associates, Inc.)	☐ Cindi Wiek (Health Care Authority)
☒ Crystal Tetrick (Kauffman and Associates, Inc.)	☒ Rachel Burke (Health Care Authority)	☒ Erika Boyd (Rep. Callan's Aide)
☒ Nicole Slowman (Kauffman and Associates, Inc.)	☒ Nate Lewis (Health Care Authority)	

TVW Recording

- **Link to TVW Recording**

Agenda

- Welcome
- Updates
- WA Behavioral Health Data – Vision and Opportunities, *Trevor Covington*
- Youth Behavioral Health in WA: Landscape and Recommendations, *Stephan Blanford, Children's Alliance*
- Break
- Breakout Session: Behavioral Health Care Continuum
- Public Comments
- Closing and (Optional) Survey

Welcome, Housekeeping Items and Agenda Walkthrough

Jo Ann Kauffman, Kauffman and Associates, Inc. (KAI)
See TVW recording (1:14)

Norms

Jo Ann Kauffman, KAI
See TVW recording (10:00)

- The group norms were reviewed.

Updates

Project Update and Timeline

Rachel Burke, Health Care Authority (HCA)
See TVW recording (11:15)

- Will provide an update at every meeting, going forward.
- This spring, the focus will be on building a picture of the current landscape and building a future vision.
- Focus groups are upcoming and sharing this with community and stakeholders this summer.
    - The definition of stakeholder was requested. The response was that a stakeholder is anybody who has a stake in children, youth, and families behavioral health with a broad reach in this project.
- Feedback is welcome.

Advisory Group Charter

Crystal Tetrick, KAI
See TVW recording (13:15)

- Summary of changes was provided, which includes updating the member list and incorporating feedback from the advisory group members. Primarily on the guiding principles and considerations for the project. The list of tasks at the end of the document is a succinct summary of what was included in the legislation and formatted by the timeline. We made sure that as we describe our work that it is based on trauma informed care and a trauma informed process.
- Suggestions for the future state vision will happen as we move forward in the strategic planning process.
- The decision to approve the advisory group charter was made through a show of virtual hands by members. The question was, do you approve the advisory group charter. A raised hand is a yes. Nate and Rachel conducted a manual count of raised hands.

- Question: Does approval of the charter include the timeline and statement tasks at the end?
  - Yes, but this is a living document and those may be modified as needed through the process.
- Decision: Majority vote.

Subcommittees

Crystal Tetrick, KAI
See TVW recording (20:15)

- Decisions by the advisory group are informed by the work done in standing and ad hoc subcommittees.
  - So far, we have two: steering committee and stakeholder engagement subcommittee.
  - Nate will be proposing a subcommittee today.

Steering Committee

Keri Waterland, CYBHWG Co-chair
See TVW recording (21:04)

- A meeting between co-chairs, staff, KAI, and new steering committee members occurred to discuss this month's agenda and will continue going forward.
- This committee will also have check-in meetings in months without an advisory group meeting.
- Introduction of parent/caregiver member, Danna Summers.
  young adult member, Amanda Shie, arriving later.
- Representative Lisa Callan's Aide, Erika Boyd, provided an introduction on behalf of Lisa.

Stakeholder Engagement Subcommittee

Nate Lewis, HCA
See TVW recording (26:35)

- All the names have been gathered of people who have expressed interest. Others are still welcome to join. Send an email to cybhwg@hca.wa.gov.
- An email will be sent soon with a Doodle poll to schedule the first meeting.
- The agenda for the first meeting includes reviewing the draft stakeholder engagement plan and discussing the questions for the focus groups. The focus groups will occur in the first week of April.
- Question: Are you looking for just members or can nonmembers participate?
  - It is open to all who can speak to stakeholder engagement across the state.

Steering Committee Proposal: Data Subcommittee

Nate Lewis, HCA
See TVW recording (30:05)

- Proposing to the advisory group the formation of a data subcommittee. The landscape analysis is beginning which means looking into what things really look like across the state for behavioral health. The amount of data available will vary.
  - A role of the members will be to answer the questions: What do we do when we have too much data and what do we do when we have too little data?
  - All are welcome—members and nonmembers—including those who have experience and knowledge in data management and the information and data that is currently available in this state, or as well as those who may not have this type of background but can speak to what information is needed by their communities, whether it's currently tracked or not.
  - The focus will be on both qualitative and quantitative data.
    - Question: What's the difference between the two?

    - Quantitative is numbers and qualitative is experience.
- Contract with the new data contractor will be signed soon.
- Poll launched for advisory group members to respond to: Do you agree to establish a data subcommittee?
    - Yes or No response options.
    - Forty-six out of 83 individuals participated, resulting in 98% voting yes and 2% voting no.

Presentation: WA Behavioral Health Data – Vision and Opportunities

Trevor Covington, Western Regional Alliance for Pediatric Emergency Management
See slides (p. 18) and TVW recording (38:50)

- Rachel introduced the speaker.
- Background in emergency response and led behavioral health response for COVID-19 in Washington state with a task to build a common operating picture.
- Conceptualize behavioral health landscape from a data perspective, with disaster response orientation. Commonality is lack of resources in disaster response and behavioral health.
- Setting the stage: Vision frames everything. Develop a clear vision.
    - Objectives are how you make your vision tangible (e.g., SMART goals).
        - Information needs include data points defined by the finish line and the ability to measure now and over time.
    - Strategies are how we can achieve our vision and objectives.
        - Each strategy has information needs to make it happen, so data points are defined by how we move toward the finish line and what we need to do it. Data will need to be timely based on the strategy.
- Trevor provided an overview of one strategy including tasks to complete and the resources/information needed to support completion of the task.
- An example was provided of a behavioral health quilt, which could be used to map out a component of the behavioral health system. Essential elements of information are the key things you need to know to do the job. Trevor provided guidance on how the table could be completed.
- Encouraged the group to build a system that works on the absolute worst day possible because, unfortunately, these services are most needed when its hardest to provide them.

Presentation: Youth Behavioral Health in Washington: Landscape and Recommendations

Stephan Blanford, Children's Alliance
See slides (p. 18) and TVW recording (57:26)

- An overview of the Children's Alliance was provided by the speaker.
- The Children's Alliance commissioned a study to ask members and stakeholders across the state: what are the primary issues that they, in their families and communities, are grappling with? This was at the inception of the pandemic. Overwhelmingly the response was youth mental health.
    - As a result, Children's Alliance contracted with McKinsey & Company to conduct a landscape analysis of youth behavioral health in Washington's schools.
    - A group of stakeholders was convened to explore this topic.
    - The question was asked: What are solutions that other states that have implemented that demonstrate effectiveness that we can learn from?
- Study results were provided throughout the presentation:

  - Key statistics regarding the current youth behavioral health landscape.
  - Information on the number of youths who do not receive any form of mental health care.
  - Across the state, there is pretty equal distribution of youth reporting major depressive episodes across Washington. The demographics of kids reporting is different, there is variation.
    - ESD is Educational School District.
  - Breakdown of mental health providers and youth by race/ethnicity.
  - Barriers to behavioral health care in Washington schools, which includes seeking care, provider availability, affordability of care, and effectiveness of care.
- The steering committee compiled a list of 24 initiatives to address barriers to receiving behavioral health care. Then, the steering committee identified a set of prioritized programs/solutions to advance in the near term.
- Next steps include observing legislative sessions and reassess what has been done then make recommendations on what could be done.

Breakout Sessions: Continuum of Behavioral Health Care in Washington State

Background

Continuum of Behavioral Health Care in Washington State

Keri Waterland, CYBHWG Co-Chair
See TVW recording (1:25:00)

- Think of this as a fishhook. This is not the only way to do this, but rather a model of the continuum of care that we know of today. There is more work to do. The model was developed to map out a high-level mental health and substance use disorder services for people of all ages provided by the state (Health Care Authority, Department of Health, Department of Children, Youth, and Families, and Department of Social and Health Services). It was not developed with the lens of caring for children, youth, young adults, and families.
- The models were presented to start a conversation around what the behavioral health landscape should look like for this group, how should this group present it, and what does it look like to really paint a picture of BH services for children, youth, and families in Washington state.

Focus Groups

Timeline

Dr. Johnel Barcus, KAI
See TVW recording (1:28:50)

- Around May, share the preliminary findings.
- Mid to late May, share a draft report to obtain feedback before finalizing the report.

Breakout Sessions

Total number of breakout sessions: 10
Total number of notes received via email: 6
Time in breakout session: 20 minutes

Breakout Session Questions

1. Icebreaker: What is one thing you do to take care of yourself?

2. Discussion: How would you describe the current landscape of mental health and drug and alcohol treatment services for children, young adults, and their families?

Breakout Session Notes

Question 1 Responses:

- Lots of gaps in care reported. Attendee serves every region of Kitsap County, Child mental health services, have a WISE team, integrated into public schools. Working to bring evidence-based practices into social emotional services into the classroom. Inpatient due to reopen the end of March. Early March they started mobile crisis unit.
- Kitsap uses tele behavioral health—they do it themselves rather than subcontracting it.
- Kitsap Mental Health has contract with school districts to provide intensive services to a given number of children in a classroom. They don't know how long the list of kids is that they are not seeing. School districts are triaging and managing which children with IEPs are being served in their allotment of purchased seats.
- Asked if there is any interface between what the schools are providing and Medicaid. Answer: No, the IEP get services irrelevant of insurance and to her knowledge there is no communication with the insurance company.
- Notetaker K Cross – personal thoughts … my sense is schools may be more able to keep personal information personal when the information is not in the healthcare system. Can school records be obtained in court cases? What are the impacts on stigma reduction? Why are duplicate services provided or one student's needs being counted more than once?
- People with insurance can find providers sometimes. Wealthy people don't have to worry about insurance and have more access. KMH Kitsap Mental Health is available in her community. Staff turnover is very high and affects the quality of care provide. It doesn't matter what care is provided.
- Spokane County – Two kids ADHD/ OT/ST services—easy to get insurance, has state assistance, can get kids into care no problem. People of color have difficulty. People with addiction have trouble getting in to see providers.
- Pierce County – Medicaid … hard to find resources for children for mental health (autism dual dx with severe anxiety). Provider expertise isn't there—not enough providers available who will take Medicaid. Wraparound services haven't been available either. Doctors not sure what to do. Personal mental health therapist (parent) was let go at 6 months because they didn't want patients to become "dependent on therapy." Medicaid is possibly influencing that.
- My experience is that no matter the insurance you carry, it's difficult to find providers in a timely fashion for mental health care. Another problem facing providers is that Medicaid payments are so slow (and it appears they deny the first bill automatically for care like ABA therapy). Our provider SOAR just went under because of the slowness of payments, they shuttered their doors.
- They were one of the best and highest-rated providers of ABA therapy in Spokane. Hundreds of families lost vital care for their kids.
    - There are insufficient levels of care for the most challenging mental health cases among youth with significant personality or mental health. Many of them come from the foster system and have been adopted into families that do not have the tools for all of the challenges those youth are facing.
    - There isn't enough education in schools about both mental wellness and substance use. Kids are accessing vaping and marijuana edibles in elementary schools and there definitely needs to be a partnership with schools/education as a part of primary prevention practices.
- Reflections on the continuum of care:

  - Thoughts about the continuum of care … easy to break down the services into smaller steps. Found it helpful.
  - Everything is based on your reflections and your lens (a youth with PTSD).
  - Workforce is still such as big issue.
  - Access is so difficult.
  - We have a fail-first system in WA state.
  - Would like to see more WISE practitioners.
- Reflections on the presentation:
  - Need to focus on the root causes of mental health and poor mental health of youth.
  - Phone calls and focus groups are going to be very important.
  - Would like to have seen a category for people with disabilities.
- Fragmented, episodic, acute, in crisis, taking baby steps toward coordination and collaboration, giant steps in finding someone they trust: teacher, doctor, family member, etc.
- See it through my own behavioral health and experiences. The way I deal with a lot of things I went through with my ADHD, foster care, CPS—it always starts as home. BH not seen as serious as physical things that are going on. We go talk to the parents, go to their door. Should be implemented: Bring it up as a family first. Yes, social media and other things have an impact, but it always starts at home.
- I'd describe the current landscape of mental health and drug/alcohol treatment services as something that is either very costly for most people to afford or services are too far for most people in remote or suburban areas (most programs seem to be in cities from what I have seen) to access or be able to use services frequently. Most people also don't know where to find these services if they need them, so they are unable to access them.
- Parent and someone who works in the system—impacts on BH workforce make it quite difficult to provide all the services that are needed for the communities involved. The shrinking workforce makes for shrinking services. So, access to services is stunted. Impact of workforce shortage on making effective, accessible services available for our families.
- Exist but hard to find—heard of it, but don't know how to get into contact.
- For population size, through the cracks on resources, support, money to get support, behind times.
- This is a non-system, a broken system, an underfunded and underserving system.
- This is a system that is crisis focused and therefore leads to crises instead of preventing crises.
- Patchy, gappy system with most resources committed to crisis end of the continuum with almost nothing focused on recovery and maintenance.
- Ablest system—children who are not verbal have almost no services available to them.
- Children who are I/DD are bounced between the DD system and the BH system and often left with nothing from either one.
- Power within the system is in large agencies. Practitioners who can provide long-term relational healthcare are not reimbursed in a way that makes their services accessible.
- Insurance companies have far too much control and disincentivize a broad array of practitioners from supporting a more robust and diverse service system.
- Immigrant parents (even those with excellent resources and language skills) find that the system is impossible to navigate, full of loopholes and barriers.
- Everyone gets a lower level of care than what they need.
- Drug and alcohol problems are pervasive with a tremendous lack of help. Young people are dying of overdoses and there isn't any help.

- Family-oriented interventions are rare—most services are individualistic, causing trauma and not establishing a basis for integrating recovery in the home and community.
- Need for belonging isn't a priority in this individualistic system.
- Parents don't get training or help to know how to support their children long term. Parent: "Nobody spoke with me as a human being." No family-centered care.
- The ER as a way of responding to crises is problematic, traumatizing, and perpetuates misinformation. (ER staff told parent that a mental health counselor could write a prescription/incorrect).
- Dire lack of treatment options for the most severe and disabling mental illness conditions is causing families to fall apart (give up custody, for example) and contributing directly to the school-to-prison pipeline. We need a residential school for behavioral health!!! (Says a parent whose child is currently being served out of state and was absolutely unsafe to stay in the home and community.)
- Need for adult services for pregnant parents and parents B-3 as part of early intervention. Parenting support to keep families together with skills they need for developmentally appropriate dyadic services.

Question 2 Responses:

- After – 5
- Before – 0
- No preference – 1

Public Comments

See TVW recording (1:34:17)

- Time for individuals who are not on the advisory committee to share comments. The discussion was opened up to advisory group members after public comments.
- Comments:
    - I am a mom who lost a son to suicide at the age 23 after falling through every crack in the nonexistent system. I am going to work for a national nonprofit treatment advocacy center which is strategically focused on population of individuals with the most severe and disabling mental health conditions. I am showing up in this space to ensure that severe mental illness is not shafted in this process. It is very popular in meeting spaces like this that are cordial and professional to talk about services for this population in a very politically correct way, which cannot happen. Severe mental illness is horrific and causes trauma in families. We are not going to be able to fix this broken system if we don't serve the sickest youth and young adults. That is going to involve some conversation around the continuum of care where involuntary treatment is the only treatment. Because for individuals who do not have insight into their illness, voluntary only systems will never be accessible.
    - I think we need to take on the behavioral health system, not public health doing population-based supports. We should not rely on public health because they don't do the work of making the services and building community, community kinds of supports that need to happen. A lot of kids and families who may not meet the diagnostic criteria in terms of how health care is paid for but need the behavioral health supports. We could be addressing a whole lot of those needs and could be working upstream in responses. Additionally, we need to plan for health. If we're trying to maximize health in our populations and families, what kinds of supports and services do we put in place to make that happen? That's a part of the picture.

  - I commend the person that made the fishhook diagram. I'd like to see the fishhook diagram overlaid over the multitiered system of supports that the public school system uses and perhaps we can make some sense of collaboration and communication with clinical health care on the outpatient and school-based behavioral health on the outpatient system.
  - I've foreseen some of these events on COVID. Government entities focus on side effects of COVID, neglecting the behavioral and mental health which can create a ripple effect. I've written to the government to bring attention to the ripple effect of COVID, especially in teens and mental health. I've seen a lot of homelessness in Tacoma. I've seen individuals who are mentally challenged and no facilities. Proactive measures, instead of taking measures after the effect. Collaboration is necessary to combat what is already here.
- Additional comments can be sent to the Children and Youth Behavioral Health Workgroup email: cybhwg@hca.wa.gov

Closing Comments

Jo Ann Kauffman, KAI
See TVW recording (1:42:32)

- A list of advisory committee meetings was provided:
  - The next meeting is May 4.
  - Thereafter, July 6, September 7, and November 2.
  - Next steps include the landscape analysis and developing a vision.
- An optional short survey link was provided at the end of the Zoom meeting to gather feedback about how to improve the meetings going forward.
  - The survey was open until the end of the day to complete.

Chat

- **Introductions**
  - Attendees introduced themselves in the chat with name and organization.
  - Are we writing M for member again?
    - The M in names indicates they are a member of the committee.
    - Please add the M if you are a member of the advisory group.
  - Also want to introduce a new state agency representative: Bridget Underdahl, from OSPI, replacing Lee Collyer.
- **General Questions and Comments**
  - We support early intervention BEFORE a crisis situation. Additionally, I am concerned that two months for research on best practices, including for delivery systems, is insufficient.
  - Please define stakeholder.
    - That's good to know, often stakeholders don't include parents and youth.
    - Youth includes young adults to age 25, correct?
      - That's correct.
      - That's exactly who we really want to make sure is included and has an opportunity to be part of this.
  - What is the KAI team?
    - KAI is Kauffman and Associates, Inc.
    - The KAI team is Crystal, Jo Ann, Nicole, and Johnel—our partners with Kauffman and Associates, who are facilitating the strategic plan work.
  - Can we get the slides emailed to us?

        - Yes, we will email the slides to everyone.
        - Just curious, do only the actual members get the slides emailed to them?
            - We will email the slides to everyone on the mailing list.
    - Why are we still saying MENTAL HEALTH!!!!
    - What is the email for us to send our notes?
        - Send notes to: nicole.slowman@kauffmaninc.com
- **Charter**
    - Did we receive a new copy with the changes? Or show us the wording you changed?
        - Yes, changes were sent out last week.
    - Does approval of the charter include the timeline and statement tasks at the end?
        - Yes.
    - Sixty-four-point-seven percent of the vote, specifically.
    - Next time we have a perfunctory vote like this it might be helpful to hear why people did not vote yes.
    - I have significant concerns about lack of reference to access to care through integrated primary care settings, and early intervention in NON-crisis setting. That's why I abstained.
    - I also agree that we didn't discuss the feedback that you received on the charter. I'm wondering why I spent my time sending it to you. I also abstained for that reason.
        - Crystal (KAI): The language in the grid is a summary of the language in the bill—not the vision for the future. This group will be leading the vision—it has not been decided by anyone. I hope this helps provide clarification.
- **Subcommittees**
    - Which email do we send our interest to?
        - Send interest in committees or anything else to: cybhwg@hca.wa.gov.
        - Subcommittees are open to anyone who wants to join.
    - Seattle Children's and Hope Sparks in Pierce County are collecting data from their pediatric BH programs. They've come up against some challenges that you may want to be aware of. They also have some very helpful data.
    - Agree with the qualitative data comments.
    - It will be wonderful to have folks with lived experience help us understand what the quantitative data means as well.
    - Quantitative = numbers; Qualitative = stories and words.
    - Also, when the behavioral health integration subgroup started meeting in 2021, HCA pulled a lot of data on the current landscape that you may want to get as a starting point.
- **Presentations**
    - Please note that all questions will be sent to the presenters after the meeting and answers will be provided later.
    - **First Presentation: WA Behavioral Health Data – Vision and Opportunities**
        - I hope we can move away from talking about mental health and instead behavioral health. Even in these examples that are hypothetical it narrows our thinking.
        - Missing from this baseline: You need to understand the target population ... (see previous comment).
        - What does "an update tempo" mean in this context?
            - Update tempo means how frequently you need to update the data. For example, weekly, quarterly, yearly.
        - Surge management assumes there is even a baseline of services. Without that understanding, the problem won't be well understood.

- How do you measure negative impact on family when you are only measuring individuals?
- The "not served" numbers need to include denials by the DCRs.
- We have a system designed to keep people out (ex. CLIP), so we need to really think hard about what we measure and how we measure it?
- Do the EEIS all use the same time frame? AKA queue data for six months, acuity data for the same six months, etc.?
- This is an ongoing disaster predating COVID.
- There have been both types of supports/services requested which don't currently exist and there are types of BH supports that are not currently being provided by our Medicaid and or private funded systems. How would those aspects be 'counted'? How does the model proposed include an equity lens, increase diversity population focused supports and or center BIPOC communities?
- There are some gaps that are so significant that we don't even have data that would alert us to them. Perhaps this is where the focus groups and other strategies for gathering qualitative data will help us understand what may not even be on our radar.
- I appreciate the presentation and understand that Trevor was giving us support on process and framing, not providing "answers" at this stage. I also realize that his background is in emergency response. My concern is that our focus not be on things like triage and surge management, i.e., assuming that the state's BH services will continue to operate largely as an emergency response system as it does now. For one thing, no improved operational systems will make BH services adequate in this state; there simply aren't currently enough resources to provide timely and effective care using delivery systems we have now. Instead, I believe that we need to reimagine BH services, integrate them into whole person care, add community health workers who can help with navigation and coaching for families. There are many more possibilities but IMO we need to figure out how to deliver BH care in new ways, with some new funding as well.

- **Second Presentation:** Y**outh Behavioral Health in WA: Landscape and Recommendations**
  - Were parents included in the stakeholder group?
  - Define "adolescent" does it include 18 and 19 year olds?
  - Where is the data about children ending up in jail during the pandemic?
  - Also need to look at comparative levels of children entering foster care or homelessness or drop out from school.
  - When we only look at "mental health" we exclude the most vulnerable children—those with emotional regulation issues.
  - Most people with severe behavioral health conditions do not seek care because their brain-based symptoms block their capacity to recognize their own impairment or understand why treatment would be helpful. This is not self-stigma—it's symptomatic.
  - Do we know if any of the children are CPS involved?
  - We need to make sure to include an analysis of whether care is accessible. For example, a voluntary only system of care is not accessible to someone without insight into their condition.
  - I wonder, has data looked at high turnover of clinicians?

    - I would be interested to see how many clinicians' clients are assigned within a defined period of time (e.g., a year) as a way of looking at the impact of turnover on quality of care within agency settings.
- How many families tried to access WISE but were turned away because it is a voluntary service?
- What percent of children who are being boarded in hospitals have the type of anxiety and depression that the Children's Alliance looked at? My guess it is only a fraction ... the rest are children with disabilities, serious mental illness and trauma.
- We should also look at how long services are offered, and what happens to youth that drop out? Are they just abandoned? (hint: yes)
- We need to stop looking at race as a primary lens when disability is completely ignored.
- Can the link to the WA health workforce survey be shared?
- I suspect that no matter how "evidence-based" services are, they are going to have limited impact if provided outside of the context of a consistent, predictable, attuned therapeutic relationship.
- We need more BIPOC providers.
- For example, last I heard, children with IEPs can't access MTSS
    - MTSS?
        - MTSS is a multi-tiered system of support for intervening with behavioral health problems seen at school.
    - More information is on OSPI's (our state's education department) MTSS webpage.
- I have to admit it's really difficult to find a provider who understands "neurodiversity" (the unique ways a person's brain work) and intersectionality of disability and race.
- Stigma as a barrier to care is only a small part of the problem. A bigger problem is lack of insight because mental illness is a brain-based condition and the brain cannot perceive its own impairment with clarity. Requiring so much information via self-report is going to elicit skewed data.
- One important way to destigmatize using BH care is to integrate assessments and brief interventions into primary care. This normalizes BH issues and treatment from an early age as part of whole-person care.
- Group based settings are designed for neurotypical children ... and they will not address the school to prison pipeline.
- Restorative circles are AMAZING!!
- Correct—no government oversight. Critically needed. There is no other area of medicine that would allow these appalling outcomes.
- Reminder ... this was a CRISIS BEFORE COVID!!!!!
- I think the Children's Alliance needs to work with special education parents. (I was PTA special ed advocacy chair at Seattle public schools.)
- Wonderful presentation Stephan, I appreciate the recommendations provided by your committee and would be curious to learn more about the methods used.
- I would love to read the full report if it's available.
- What about the intersection with substances? As an advocate for youth living with SUD and mental health concerns almost always go together. One rarely exists without the other. I also realize I have a different lens working with youth with SUD, but it has not even been mentioned.

    - They included SUD as well. For children B–5, behavioral health isn't an appropriate term.
- To clarify, I know we need to do crisis management right now, but I think there is a desperate need to move beyond that to new, innovative approaches to care, that are tiered, integrated into whole-person care, and coordinated among systems (e.g., schools, primary care, specialty care, intensive outpatient, ED's, inpatient care). As Stephan mentioned, groups and telehealth are two of the new approaches we need to consider.
- In thinking about the continuum of BH care in WA state slide, for children, youth and family's applicability, I think it is important to overlay all the systems that also are touch points and at times provide BH supports, e.g., schools, child welfare, juvenile justice.
- That's not an accurate reflection of the law, but that's part of the issue. Health Care Authority and DCYF aren't supportive of family-initiated treatment.
- The impact on future adult mental health issues is going to be profound for the children who were in high school during shut down.

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Appendix A – Charter

PN25 Behavioral Health Strategic Plan Advisory Group Charter

February 10, 2023

Purpose

During the 2022 legislative session, the Children and Youth Behavioral Health Work Group (CYBHWG) recommended the development of a statewide Prenatal through 25 (PN25) Behavioral Health Strategic Plan. This recommendation was passed by the Washington State legislature in Second Substitute House Bill 1890 (HB 1890).

The purpose of the PN25 Behavioral Health Strategic Plan Advisory Group is to oversee the development of longer-term, system-wide strategies to ensure access to high-quality equitable care and supports in behavioral health education and promotion, prevention, early intervention through crisis response, intensive treatment, postintervention and recovery, and ongoing well-being for families in the perinatal stage (pregnancy through the first year of life), children, young people transitioning to adulthood, and their caregivers. The development of these new system-wide strategies will be through a trauma-informed lens to reduce incidents of harm or trauma that may be experienced by families and instead, promote healing, recovery, and resiliency throughout the behavioral health system.

The Strategic Plan Advisory Group will provide guidance and oversight of the following activities:

- Strategic plan schedule and project scoping decisions
- Community engagement strategies
- Strategic plan development
- Submission of the strategic plan to the CYBHWG by August 15, 2024, and the Governor and legislature by November 1, 2024.

The Strategic Plan Advisory Group will report their progress and recommendations to the CYBHWG and its subgroups as needed. Similarly, the PN25 Advisory Group may engage the other CYBHWG subgroups to help fulfill the objectives of the strategic planning process.

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Objectives

- Fulfill the requirements of HB 1890
- Use a strategy and approach that centers racial equity and elevates the voices of young people and family members with experience receiving behavioral health services in meetings and the statewide stakeholder process
- Develop a landscape analysis of the behavioral health system and services available to families
- Complete a gap analysis for the full continuum of care
- Complete best-practices research, including an analysis of peer-reviewed publications, and evidence-based practices addressing the delivery of behavioral health services to families
- Develop a behavioral health future state vision
- Complete a comparison of the current behavioral health system for the identified population with the Behavioral health future vision
- Develop the strategic plan to be approved by the CYBHWG and delivered to the Governor legislature
- Oversee a state-wide stakeholder engagement process.
- Engage tribes as sovereign nations as part of the stakeholder engagement process.
- Address gaps and barriers related to lack of coordination and integration between systems and between types of providers

Guiding Principles

The following principles will guide the work of the Advisory Group: As individuals and a collective we:

- Are community-centered
- Engage in respectful engagement - we listen to the voices of children, youth, parents, and family support systems
- Foster trust, safety, and inclusivity for all members
- Commit to transparency in decision-making
- Embrace diversity
- Foster ideas and intentions to make innovative changes
- Embrace radical ideas and thinking
- Speak on personal experience, not for the group of people/population

Governance Structure

Children Youth Behavioral Health Workgroup (CYBHWG)

The CYBHWG provides recommendations to the Legislature to improve behavioral health services and strategies for children, youth, young adults, and their families. The group includes representatives from the Legislature, state agencies, health care providers, tribal governments,

community health services, and other organizations, as well as parents and family support systems of children and youth who have received services.

Strategic Planning Advisory Group Co-Chairs

- Representative Lisa Callan
- Dr. Keri Waterland, Washington State Health Care Authority (HCA)

The PN25 Behavioral Health Advisory Group is one of 6 advisory groups to the CYBHWG (Figure 1). There is cross-cutting collaboration across the 6 groups. The co-chairs of the CYBHWG also serve as the co-chairs of the Strategic Plan Advisory Group. The advisory groups work will be informed by its own subcommittees both standing and ad hoc, which will be established as needed. The Advisory Group will also be informed by the 5 CYBHWG standing subgroups.

Decision Making

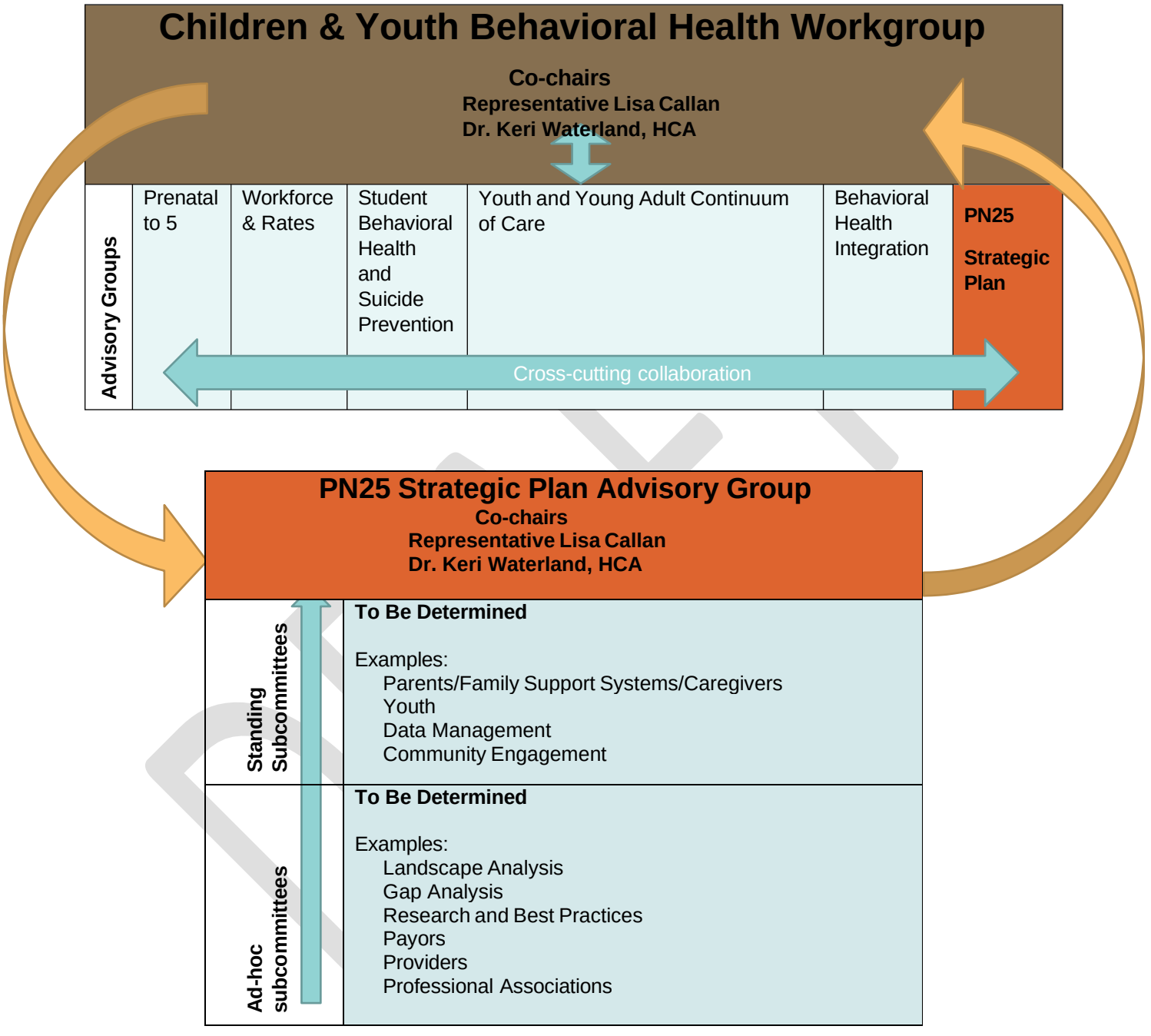
Decision making is done at the Advisory Group level. Decisions are informed by work done in standing subcommittees and ad hoc subcommittees. Decisions will be made by vote using electronic polling of the entire Strategic Planning Advisory group membership. We expect that any member who has a potential conflict of interest on a particular decision will abstain from voting.

Communication

All Advisory Group meetings are documented in meeting minutes which are distributed to Advisory Group members and posted on the CYBHWG website. In addition, all meetings are recorded on TVW.

Additional communication vehicles (email newsletters, social media, etc) will be used to announce project updates and stakeholder engagement opportunities.

Figure 1


Children & Youth Behavioral Health Workgroup
Co-chairs
Representative Lisa Callan
Dr. Keri Waterland, HCA
Advisory Groups
Prenatal to 5
Workforce & Rates
Student Behavioral Health and Suicide Prevention
Youth and Young Adult Continuum of Care
Behavioral Health Integration
PN25 Strategic Plan
Cross-cutting collaboration
PN25 Strategic Plan Advisory Group
Co-chairs
Representative Lisa Callan
Dr. Keri Waterland, HCA
Standing Subcommittees
To Be Determined
Examples:
Parents/Family Support Systems/Caregivers
Youth
Data Management
Community Engagement
Ad-hoc subcommittees
To Be Determined
Examples:
Landscape Analysis
Gap Analysis
Research and Best Practices
Payors
Providers
Professional Associations

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List of Advisory Committee Members

Appointees

Representative Lisa Callan, Co-Chair
Keri Waterland, Co-Chair (HCA) *or* Diana Cockrell (HCA)
Shelley Bogart (DSHS-DDA)
Lee Collyer (OSPI)
Byron Eagle (DSHS-Child Study Treatment Center)
Representative Carolyn Eslick
Steven Grilli (DCYF)
Kim Justice *or* Matt Davis (Commerce – Office of Homeless Youth)
Amber Leaders (Governor's Office)
Jane Beyer (OIC)
Michele Roberts (DOH)

Other Representatives

Hugh Ewart *or* Laurie Lippold (Workforce & Rates)
Summer Hammons (Tulalip Tribes)
Kristin Houser *or* Sarah Rafton (Behavioral Health Integration)
Kristin Wiggins *or* Kelli Bohanon (Prenatal through 5)
Jeannie Nist *or* Katherine Seibel (School Based BH and Suicide Prevention Subgroup)
Britni Dawson-Giles

Youth/Young Adults

Hannah Adira	Sage Dews	Desi Quenzer	Lillian Williamson
Darren Bosman	Eli Dolane	Sol Rabinovich	
Xana Caillouet	Tracey Hernandez	Casi Sepulveda	
Sierra Camacho	Bree Karger	Amanda Shi	
Amy Fumetti	Kaleb Lewis	Oscar Villagomez	

Parent/Caregivers

Tina Barnes	Melia Hughes	Sarah McNew	Lamara Shakur
Marta Bordeaux	Rokea Jones	Alexie Orr	Tui Shelton
Melissa Brooks	Michelle Karnath	April Palmanteer	Kimberly Slattery
Christi Cook	Karen Kelly	Rosemarie Patterson	Danna Summers
Alyssa Cruz	Brandi Kingston	Liz Perez	Marcella Taylor
Peggy Dolane	Nicole Latson	Jessica Russell	
Jamie Elzea	Starleen Lewis	Janice Schutz	
Heather Fourstar	Niki Lovitt	Sharon Shadwell	

Staff

Jo Ann Kauffman (Kauffman & Associates)
Lisa Guzman (Kauffman & Associates)
Nicole Slowman (Kauffman & Associates)
Crystal Tetrick (Kauffman & Associates)
Nate Lewis (HCA)
Rachel Burke (HCA)
Erika Boyd (Rep. Callan's Aide)

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2023 Meeting Schedule

Date	Time (PST)
January 12, 2023	4 to 6:30 p.m.
February 16, 2023	1 to 3 p.m.
March 13, 2023	3 to 5 p.m.
May 04, 2023	3 to 5 p.m.
July 06, 2023	3 to 5 p.m.
September 07, 2023	3 to 5 p.m.
November 02, 2023	3 to 5 p.m.

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Note: The timeframe column will be updated and finalized by the end of March.

Lead (Individual, Core Project Team, Committee or Subcommittee)	Task	Time Frame
Core Team	**Engage Advisory Committee Members** Identify and engage Advisory Committee Members -Identify experts or stakeholders no identified in the legislation. - Develop and implement a recruitment strategy that ensures diversity - Develop application, selection, and appointment process	9/1/22 – 11/30/22
	Stakeholder Engagement Develop strategy to gather information from a diversity of stakeholders statewide including providers and system partners, family support systems, parents and family members and youth and young adults (up to age 25).	10/20/22- 4/7/23
	Behavioral Health Landscape Analysis A description of the current service continuum, cost of care, what access looks like, gaps in services, barriers to accessing preventive care, the current behavioral health oversight and management of systems.	1/2/23-5/15/23
	Gap Analysis A description of the full continuum of care estimating the prevalence of needs for Washington state behavioral health services for the identified population served by Medicaid and private insurance.	1/15/23 – 6/30/23
	Best Practices Research Report An analysis of peer-reviewed publications, evidence-based practices, and other existing practices (including best practices from other states) and guidelines with preferred outcomes regarding the delivery of behavioral health services to families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth across multiple settings that includes: - Approaches to increasing access and quality of care for underserved populations and communities; - Approaches to providing developmentally appropriate care; - The integration of culturally responsive care with effective clinical care practices and guidelines;	1/15/23-6/30/23

	- Strategies to maximize federal reinvestment and resources from any alternative funding sources; and - Workforce development strategies that ensure a sustained, representative, and diverse workforce.	
	Future State Vision (informed by stakeholder engagement) A vision for behavioral health services for the identified population in which services are: - Accessible, affordable, effective, timely, and engaging; - Culturally, linguistically, and developmentally relevant; - Supportive and affirming of gender orientation; - Supported by evidence; - Incorporating tailored interventions, as needed; - Coordinated across sectors, and tailored and aligned with communities' strengths and needs' - Integrated, whole-person care; - Sustainable, with robust capacity and funding; - Hold the promise of measurably improving health and outcomes; and - Amply resourced for all children, youth, and young adults. The vision shall include: - A complete continuum of services statewide from education, promotion, prevention, early intervention through crisis response, intensive treatment, postintervention, and recovery, as well as supports that sustain wellness in the behavioral health spectrum; - How access can be provided to high quality, equitable care and supports in behavioral health education, promotion, prevention, intervention, recovery, and ongoing well-being when and where they are needed; - How the children and youth behavioral health system can successfully pair with the 988 behavioral health crisis response described under chapter 82.86 RCW;	10/1/22-6/30/23

	- The incremental steps needed to achieve the vision for the behavioral health service delivery system based on the current gaps and barriers for accessing behavioral health services, with estimated dates for these steps; and - The oversight and management needed to ensure effective behavioral health care including forecasting need; developing, monitoring, and evaluating system performance in providing access to quality behavioral health services and supports, and on outcomes for children, youth, and families who receive services.	
	Comparison and Cost Benefit Analysis A comparison of the current behavioral health system for the identified population with the Behavioral Health Future State Vision created by the Strategic Planning process through a cost-benefit analysis.	7/1/23- 8/30/23
	Strategic Plan Goals and Strategies Preliminary strategic plan to share with public	7/1/24
	Revised Draft Strategic Plan Incorporates public comments, and deliver to CYBHWG	10/1/24
	Final Strategic Plan - Delivered to the Legislature and the Governor by October 20, 2024.	10/20/24