KAUFFMAN
AND ASSOCIATES INCORPORATED

PN25 Behavioral Health Strategic Plan Advisory Group Meeting Notes

Thursday, May 4, 2023
2–5 p.m. Pacific Time

Contents

MEMBERS 2
Agenda 3
Agenda Overview 3
Review Full Value Agreement 3
Full Value Agreement Breakout Session 3
Updates 4
Subcommittee Updates 5
Update: Qualitative Behavioral Health Landscape Analysis 6
Breakout Session 1: Full Value Agreement 7
Breakout Session 7
Question 1 Responses: 7
Question 2 Responses: 8
Question 3 Responses: 8
Breakout Session 2: Qualitative Behavioral Health Landscape Analysis Questions 9
Breakout Sessions 9
Question 1 Responses: 9
Question 2 Responses: 11
Group Discussion- Future Advisory Group Meetings 17
Public Comments 17
Closing Comments/Survey 18
Chat 18
Appendix B – Power Point Slides 22

P.O. Box 21789
Spokane, WA 99201
Phone: (509) 747-4994

www.kauffmaninc.com
Minority Woman-Owned Small Business
GSA Schedule Holder

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.)	☒ Erika Boyd (Rep. Callan's Aide)
☒ Crystal Tetrick (Kauffman and Associates, Inc.)	☒ Rachel Burke (Health Care Authority)	☒ Riley Holsinger (Kauffman and Associates, Inc.)
☒ Nicole Slowman (Kauffman and Associates, Inc.)	☒ Nate Lewis (Health Care Authority)	☒ Jennifer Gillissen (Kauffman and Associates, Inc.)

TVW Recording

- TVW recording PN25 behavioral health strategic plan advisory committee

Agenda

Welcome:

- Full Value Agreement (Michelle Karnath)
- Breakout Session: Respond to questions about the agreement and meeting logistics

Project Updates:

- Advisory Group Charter Comments (Crystal Tetrick)
- Project Timeline Review (JoAnn Kauffman)
- Best Practices Research and Quantitative Behavioral Health Landscape Analysis (Nate Lewis)

Subcommittee Updates:

- Report Out: Community Engagement (Crystal Tetrick)
- Next Steps: Data (Nate Lewis)

Update: Qualitative Behavioral Health Landscape Analysis (Johnel Barcus)

- Preliminary Overview from Focus Groups
- Additional Stakeholder Engagement

Breakout Sessions: Qualitative Behavioral Health Landscape Analysis Questions (JoAnn Kauffman)

Group Discussion: Future Advisory Group Meetings (JoAnn Kauffman)

Public Comments: (JoAnn Kauffman)

Closing and Survey: (JoAnn Kauffman)

Welcome, Housekeeping Items and Agenda Walkthrough

Jo Ann Kauffman, Kauffman and Associates, Inc. (KAI)
See TVW recording (2:00)

Agenda Overview

Jo Ann Kauffman, KAI
See TVW recording (4:30)

Review Full Value Agreement

Introduction to the document: Advisory Group Co-Chairs, Keri Waterland, CYBHWG Co-Chair Representative Lisa Callan
Overview of the Full Value Agreement: Michelle Karnath
See TVW recording (6:05)

Full Value Agreement Breakout Session

Breakout Sessions: Full Advisory Group
See TVW recording (23:50)
Breakout Session Questions:

- What is missing?
- What needs to be changed?
- How do you expect breaches in this agreement to be handled?

Updates

Advisory Group Charter Feedback

Crystal Tetrick, KAI
See TVW recording (35:00)

- Feedback received on charter:
  - Last meeting voted on charter—felt rushed for people, people were not clear about what comments were included; what feedback was included in the charter.
- Feedback from charter included the following:
  - November 18, 2022, Advisory Group breakout sessions
  - March 2023 survey
  - Direct emails to HCA/KAI or to co-chairs
- All feedback and comments were collected in a table (emailed out, attached to meeting invite.)
  - Green = added to the charter
  - Brown = not included in the charter with an explanation
  - White = comments not specific to the charter language—these comments will inform the landscape analysis and or the overall function of the Advisory Group

Objections for Charter/feedback:

- Strategic plan—want to create a vision for how it should look, not how we plug holes and manage crisis, should be striving for early intervention period; screening early intervention and behavioral health conditions as they develop; wish the language would be modified

Project Timeline Review

Rachel Burke, HCA
See TVW recording (41:53)

- Moving into July–September
  - More outreach and stakeholder, parent/youth and system partner connection and engagements
  - Qualitative landscape analysis
  - Gap analysis

Best Practices Research and Quantitative Behavioral Health Landscape Analysis

Nate Lewis, HCA
See TVW recording (44:10)

- Currently in phase of *Best Practices Research* which is intended to identify practices in Washington state and elsewhere that are showing promise in improving the delivery of care to people who are in our P25 age range and their families.

- Intend to do a deeper dive into the items that look especially promising so that we can implement those or take away some lessons to improve the quality of services in Washington.
- Second phase is *Gap Analysis*, which is intended to identify the gaps in both the current state which is the landscape of services in Washington and the future vision but also as a component of that, the gap between the capacity, the need and what's actually available. That means not only having providers have direct access but also direct needs for demographic, culture, language, and diagnosis. Making sure all those items are considered and met. That is the core of the gap analysis.
- *Landscape Analysis* is the current state of the behavioral health system in Washington, this is the quantitative analysis, looking at the data this piece compensates the qualitative analysis, which is more of what's the experience, what's the expectation.
- This work is planned to be done by the end of the year, end of November or early December.

Subcommittee Updates

Report Out: Community Engagement

Crystal Tetrick, KAI

See TVW recording (47:40)

- Purpose: Make sure we are following the requirements of the legislation for this project.
- Role: Oversee the development and implementation of a community engagement plan. Identify stakeholders, help reach out to stakeholders, and assist with engaging them in the strategic planning process.
- Meetings: March—reviewed and revised draft community engagement plan. April 20, strategized identifying stakeholders. Continue meeting every third Thursday of every month.
- Identified co-chairs who will be finalized at the end of this week.
- Next Steps: Identify community partners and grouping for seven engagement sessions in July.

Community and Stakeholder Engagement Timeline

Three Phases:

Phase 1: Engagement on Current Landscape and Shared Future Vision
  - July 2023 > Aug > Sept

Phase 2: Engagement on Goals and Strategic Directions
  - Jan 2024 > Feb > March > April

Phase 3: Engagement on Draft Strategic Plan
  - June 2024 > July > Aug

- Conduct seven stakeholder engagement sessions on current landscape and the shared future vision (July 1–Sept. 1, 2023)

Next Steps: Data

Nate Lewis, HCA

See TVW recording (51:50)

- Nate sent out an email Wednesday, April 3, who expressed interest.

Purpose: Provide recommendations around data needs and to provide guidance on behavioral health landscape analysis.
Next Steps: Schedule the first meeting.

- Intend to send out a poll Monday, April 8, to schedule the first meeting of the data subcommittee. The function of that data subcommittee is going to be reviewing the work being done within the quantitative analysis, answering questions, or helping to refine exactly what we are looking for.
- Expect to meet each month for an hour or two depending on how the flow of work goes.

Update: Qualitative Behavioral Health Landscape Analysis

Preliminary Overview from Focus Groups and Additional Stakeholder Engagement

Johnel Barcus, KAI
TVW recording (56:30)
Focus Groups: Timeline

- April 19–26, conducted six focus groups with 20 participants. Two youth and three parent groups with working group members. One provider group.
    - Questions comprised of member experiences with behavioral health services.
- May 4, preliminary finding shared in May Advisory Group meeting.
    - Additional data collected during breakout session.
- Mid to end of May, draft report of qualitative landscape analysis.
    - After obtaining feedback, finalize the report.

Preliminary Findings from Focus Groups

- What does behavioral health mean to you?
    - The term behavioral health is too broad, overused, and misapplied. Implies that there is a choice in your behavior.
    - Focus not just on the individual, but on the family and community.
    - Super reactive, instead of being preventive.
- Behavioral health services
    - Emergency/crisis services used most
    - Not enough prevention services available
    - Not enough providers available—none serving specific needs
    - Punishment for having a behavior health illness
    - Insurance dictates services
    - No in-patient residential treatment in state
    - Less services available to adolescents and young adults

Breakout Session 1: Full Value Agreement

Breakout Session

Total number of notes received via email: eight
Time in breakout sessions: 10 minutes
Jo Ann Kauffman, KAI
TVW recording (1:03)

Breakout Session Questions

1. What is missing?
2. What needs to be changed?
3. How do you expect breaches in this agreement to be handled?

Breakout Session 1 Notes

Question 1 Responses:

1. *What is missing?*
    - Nothing, seem like good rules.
    - Call out it is a living document and how often we make time to ask for feedback about how it is working and make adjustments as needed.
    - Share agreements in the beginning of every meeting.
    - Not missing, but really like the part about using plain language.
    - Create space for teaching moments when appropriate language is not used v. attacking or accusing.
    - Acknowledge that everyone is coming to the place with positive intent and a shared commitment to this work.
    - Listen to understand.
    - Speak your truth—speak from your lived experience.
    - Use person-first language—e.g., A person with----------; a person who died by suicide.
    - Keep an open mind—we are all in different places of growth.
    - Inclusive about folks recognizing their bias.
    - No categorizing or grouping individuals.
    - Two people may disagree, but both may also be right. Attendees were concerned if they did anything wrong in the last meeting and that's why we have an agreement right now.
    - About sharing your experiences, there is something beyond that. We want your experience and knowledge that provides for our plan. We each have stories to share, but there is expertise from those stories.
    - Parent (POC): Being able to center, staying center to an abundance, not scarcity. Making eye contact. Bringing mindfulness to the work.
    - How to handle that "ouch" in the chat-question.
    - At the beginning of each meeting, people should be reminded of the full value agreement to help have a fluid meeting.

Question 2 Responses:

2. *What needs to be changed?*
    - Things may change as time goes on, would be good to add and revise as needed over time.
    - Be sure to share at the beginning of every meeting so we are all reminded.
    - Using the word "safe" can be triggering to someone.
    - We cannot guarantee that we may not trigger by words that are used.
    - Word smithing. Removing "brave."
    - Simplifying and stating, "creating a space where everyone feels heard and valued."

Question 3 Responses:

3. *How do you expect breaches in this agreement to be handled?*
    - Three strike rule.
    - Facilitators need to d- the work ahead of time to be prepared, we want to keep work moving ahead.
    - Facilitator/moderators address issues in the moment if appropriate.
    - The guidance that is provided in the document is helpful, such as using the term "ouch."
    - How will the statement about trauma be addressed? As health care professionals, rely on facilitator.
    - They should be addressed outside the meeting. You can also direct message people with "ouch "or a reminder about the norms.
    - Not sure, I may have missed the context in the last meeting. Beyond gentle reminding, at some time with repeat offenses the person—not sure how to address this beyond common sense. It is not appropriate to have this and when it stops the progress of the meeting.

Additional comments/questions:

- Two spoke that a separate meeting for young people would be good
- Comment that there was an appreciation of assuming the best intention or intent
- Addressing trauma, rely on the facilitators of the meeting

Full Value Agreement: Summary of the report outs

1. *What is missing?*
    - Remind people at the beginning of each meeting about Full Value Agreement, acknowledged and commit
    - Comprehensive, important, and well done
    - Recognizing biases, not categorizing, or grouping individuals
    - Living document, can make adjustments as needed

2. *What needs to be changed?*
    - Listen to understand, all here with positive intent
    - Keep an open mind, we are all in different places of growth

- Creating a space where everyone feels heard and valued
- Share experiences but elevate to experience and expertise
- Center work more on abundance vs scarcity model

3. *How do you expect breaches in this agreement to be handled?*
    - Address after the meeting or direct message that person (one on one)
    - "Ouch," consequences of saying "ouch"
    - Facilitators may have to address it, as a need basis
    - Three-strike rules depending on level of issue
    - Teaching moment

Breakout Session 2: Qualitative Behavioral Health Landscape Analysis Questions

Breakout Sessions

Total number of notes received via email: eight
Time in breakout sessions: 30 minutes

Jo Ann Kauffman, KAI
TVW recording (1:03)
Frame of reference of breakout session, Keri Waterland, CYBHWG Co-Chair

Breakout Session Questions

1. Based on the focus group preliminary findings, how would you define behavioral health?
2. Where do you see gaps in our current behavioral health system in Washington state?

Breakout Session Notes

Question 1 Responses:

1. *Based on the focus group preliminary findings, how would you define behavioral health?*
    - Information from focus groups seemed different than how I think of a "definition"
    - Seemed to have reactions to the term, not really a definitive definition
    - Cognitive, biological, and behavioral functions are working well. The area of BH is addressing where it isn't working well
    - Behaviors and emotions that effect our everyday life
    - Try to think about it from a more wholistic place
    - Not always sure if people are talking about SUD or mental health when they say "behavioral health"
    - Even though it may have been intended to be inclusive of SUD and mental health, people don't really seem to use it that way
    - Make room for all types of thinking
    - Systems is segmented—can offer different types of services at the same time—prevention, intervention, etc.
    - Therapy is not life—build up resources and community

- Different cultures have different definitions of behavioral health/mental health; definitions need to translate to how services are constructed and provided and not based on Western European definition of behavioral health/mental health
- Don't understand what's wrong with the term
- Really concerned we circle in language, has to be a balance. Not feeling it in this group
- Get too hung up on language, what it comes down to is we are trying to deal with people's challenges that has a lot of stigmas to it. Have to deal with the root cause of why there's a new stigma
- Getting hung up on the fire instead of root cause of the fire
- Can it be part of the larger plan, speak to state resources going to support state agencies that carry out this work to dive into the stigmas of this work
- Language does matter, but don't agree that it matters as much as other people; can get so consumed by it that we move away from actually solving the problem
- Is a way to describe the system of care that provides services for people with MH or mental illness, autism, problem gambling and other SUD that impact their behavior
- A way to remind the system to provide whole person care regardless of what they have going on that may be co-occurring
- Defining as a system and not as a person
- Person centered language does not recognize an in dividual as behavioral health person
- It means any part of a person's health that impacts what they do (their behavior); traditional
- Behaviors are forms of communication and responding to those forms of communication in an appropriate manner
- Any imitation on one's ability to feel emotional comfort and wellbeing impairs your ability to thrive
- Has a problem with the term, implies there is a choice; it should be under mental health
- Unfortunate that saying behavioral health seems like a labeling. Started when SUD was included. It is how people interact in the work around them. Areas where we want families to feel support by the services they are seeking.=
- BH is a system consisting of substance use disorder, mental health, social and emotional health; it is a system to promote health
- For parents, the term BH can be abstract and overused
- I like the term "brain health" it suggests diseases of the brain that people don't have control over; BH suggests people are making choices about their behavior
- The definition needs to encompass developmental disabilities, such as autism; these are hidden under the BH umbrella
- BH—our physical, mental, and emotional well-being
- BH are often siloed services; there is supposed to be no wrong door, but really there are several wrong doors to accessing services and families get bounced around without being served

- Co-occurring behavioral health and mental health should be the norm
- BH feels like an insurance term
- I didn't know if there were programs available. Family culture: we don't allow outsiders; students and young people are not informed about what behavioral health is and what mental health consists of

Question 2 Responses:

2. *Where do you see gaps in our current behavioral health system in Washington state?*
    - More services when youth are younger and then seem to disappear as they get older. Caregivers have to "dig" for resources, and nothing feels available
    - Do we have agreement on what treatment is and what is "good" treatment?
    - Feels like more gaps than functional parts
    - Gaps in capacity and access across the continuum of care. Gaps in cultural competency
    - Gap in services developmentally appropriate for 18–24 year olds
    - Return to community plan or discharge planning for older youth and young adults
    - Not enough prevention, early intervention services. Not enough services to keep youth out of inpatients level of care
    - Access to care and coverage (insurance) for services. Even if you have coverage the waitlist to get into services is too long. Getting youth to the appointments themselves. How to get more access out into the community where the youth who need it are (maybe in schools?)
    - Gaps created when agencies shut down or no longer take Medicaid because the rate is too low
    - Need more capacity for inpatient and other intensive services
    - Gap in how we normalize getting services and taking care of ourselves (stigma around BH services and treatment)
    - Going straight to medication and not looking into the real issues or exploring if there are other options
    - If even people are dual covered (private insurance and Medicaid) sometimes both will deny a needed service)
    - Private insurance might have better payment rates but doesn't cover all the services Medicaid will. Medicaid covers more intensive services but often the rate is too low for providers or the waitlists to get into services are too long
    - Need to include education and partnership with schools as that is where many of the youth are. Not enough educations around behavioral health issues
    - Have services that approach care in a whole person model such as Children's Village in Yakima
    - Wait times for needed services are long—some up to 2 years
    - Needs of children aged 0-12 need to be recognized/addressed
    - Gaps in services provided based on area, specifically rural communities
    - High turnover
    - Lack of experience of some providers to address trauma, sexual assault, etc.
    - Care needs to be based on brain development

- There needs to be a value placed on family/parent/caregiver involvement. People (children/young people) need natural support throughout their life span. Parents/family need to be part of the care model for children/youth.
- The concept of behavior is a way for a child/young person to communicate and not volitional
- Lack of housing for young people exiting residential treatment
- Being a parent with dual diagnosis, autism, and mental health disabilities, I identify with that situation of BH, complex issue of behavioral stigma—being able to control themselves or not. It is implied with teachers or therapists, sometimes not intentionally but feeling as a parent, even other children, maybe they can control themselves. As a parent, you can see that's not the case most of the time. Sad to see that repeatedly.
    - Apparent that they cannot control these symptoms. It should not be called behavioral health because it implies that they have control over their actions.
    - Selective mutism—that term alone, 'selective' like they have a choice of who they talk to and cannot talk to
- We have to ask who is asking the question. We are asking the question from PN-25. We have not defined behavioral health or disability or disorder. We should talk about well-child care, maternal, and childcare. Identify maternal depression during pregnancy. Newborn to 21 years of age, well prescribed preventive system of care, called well-child care. At that time, families discuss with their pediatrician or families their concerns and the physician screens for other concerns.
- Well-child care focuses on the whole child. Parent and child focus on what the child needs.
- Preschool to age 5, education or childcare, use the same approach. Working together with teacher and family and discuss concerns and what is needed for those concerns.
- Each birthday, there may be a diagnosis, and if so, what support and care does that child and family need to receive whole-child care.
- In developing a vision for P25, make it a preventive approach.
- Incidentally, 25% have health insurance. Preventive approach covered by coverage and law; preventive care is not a cost to children. Should build P25 BH system.
- Need collaboration and coordination at every level in the state. Funding sources and state agency sources need to be collaborative and coordinated. Until then, it is a fragmented system.
- Strong reaction against term of behavioral health. As medical professionals, we use these terms and for families, those terms may not be working.
- Disservice by short handing things. We don't stakeholder those types of things. Combined mental health division and drug and alcohol substance use and gambling service.
- Hearing how it impacts folks, it is meaningful.

- Eastern part of state services differs than western part of state.
- Lack of inpatient residential treatment capacity
- Some children/youths are in hotels. Not enough people to manage highly intensive behaviors.
- Not being able to find the right treatment.
- Crossover between mental health and mental disability—hard to find correct approach in service world.
- Continuum is not smooth. Families are having a really hard time, cannot take children home without proper care, which is not available.
- Lack of availability of outpatient services.
- Service deserts.
- Language and access are barriers as well as the availability of cultural services.
- School based health centers—in rural areas, finding BH providers is challenging in child/adolescent space.
- Challenge ourselves with emotional growth and reaction versus diagnoses.
- Surgeon general did an advisory on a public health issue/crisis around loneliness/isolation/not having community.
- None of those are diagnoses or formal treatment. All of those have been shown to have massive impacts.
- Walkable communities—would be great to have.
- Recently pushed out of neighborhood, west Seattle, due to no longer being able to afford it, so moved to rural area and now feeling isolated/lonely. Resulting in children's depression skyrocketing.
- Children have not had education since the pandemic, they were unable to deal with online instruction. Youngest child was inpatient twice during the pandemic, Seattle children's psychiatric unit were not set up to take care of someone at his level of care, mom had to sleep in his room with him to take care of him because he would not communicate with the staff. They sent her home with no support. He refused to communicate with any school-based service. We looked into getting him into inpatient CLIP and they said his level of social anxiety and that his ongoing health would decline. He lives under a blanket, even from us. We have nowhere to turn. If we were to do residential, he would be placed out of state.
- Individuals with less need have no support.
- When children become 13 in the state of WA, they are able to reject parent care. My second oldest is 14 now and will not sign an ROI so I can speak with his therapist, and this has caused a huge communication breakdown and causing severe care issues for that child. His mental health has gotten ten times worse.
- Family impact and support is important. Think about the system from the family perspective.
- Gap: Prevention services for SUD and mental health and other disabilities aren't covered by insurance.
- Older kids/teens don't have a lot of resources for older kids. Not a lot of support other than counseling once a week. Need other methods and help.

- Lack of short-term crisis stabilization for youth; doesn't exist
- Having care that meets your needs if you have more than one condition, cultural needs, etc., having a choice of resources to go to for your needs,
- Low barrier services like they have for younger kids, low barrier options that don't have so many restrictions
- Age based gaps, geography gaps, very rural remote communities where nothing is available.
- Behavioral Health is an umbrella term and prevention work thinking about resiliency, having young people receive tools to be successful
- The definition of what is our behavioral health system—isn't a landscape picture, can't look at a set of language
- Drawing on those subgroups, getting them involved more
- Transition—when they are transitioning to adults, not very seamless
- Transition from any type of service, back into the community, all those transition spaces
- Supports for families, as children get older less and less support for families
- Lack of an articulated career professional path forward
- High school/education, here is some ways to get involved
- Workforce support—burnout, difficult work
- Using behavioral wellness and not health. It makes it medical, and diagnosis focused. This is a wellness journey, a process and focus more on getting better.
- Cognitive behavioral therapy is thoughts emotions and behavior
- Behavioral health system can serve the three legs
- Underpaid staff
- Not enough service providers
- Criteria of services
- In Kitsap no one to treat autism, no ABA services.
- Complete lack of family center resources that relate to prevention.
- Lack of residential resources, that need a longer level of care and not needing to send out of state.
- Lack of beds for youth under age 13
- WISe teams that specialize in YDD or ABA no services outside of Medicaid
- Hospitals don't have to take people!
- 13-year-old having to consent to services
- Compassionate involuntary services as part of the continuum of care.
- Complete lack of care coordination providing services that are needed.
- Services are not based on need.
- Lack appropriate medication management.
- Peers
- Respite for youth and families
- Crisis diversion
- Care that is less accessible in the most complex situation

- Hard to maintain my child's therapist, hard for mental health. Parents are blamed for their child's issues, which lead to a lot of traumas, but still feel the stress. mental health is a huge hard ship for my family.
- Not enough providers, enough focus on pediatric behavioral health, not enough focus on the topic, but we are taking the steps, with this work group. There are not enough of those things to address the number of people that have those concerns.
- Not enough across all levels of services family services, treatment. No real consistency for a family with a need to know what to do and where to go. Facilities, providers, services and not enough of a pathway for families to follow. Needs to be a clear pathway for people to follow.
- They are everywhere, there are not the right services. Let's normalize mental health and well-being, start talking about it in pediatrician's office. Integrated care in doctor's offices, let's identify and assist. Not enough of services up stream.
- Accessibility, long wait times with initial intake to being prescriptive and restrictive. Programs have only X amount of time. Continuum of care or wrap around services. When age markers are met, services and programs come to an end for the youth.
- Not the right kind of services.
- Early childhood services, working with parents and helping with social determinants of health, supporting parents. Screens early on. Integrated behavioral health, every time a child comes in for a well child visit, they should have some BH, and referrals, care coordination, we don't have the fundamental care. Care coordination should include schools.
- Parent education early, even prenatal, lack of services the middle of continuum of care-services that are not outpatient therapy, intensive outpatient, we do not have enough of that—they end up getting stuck in crisis care.
- Kids with complex needs end up getting struck in hospitals, parents may not feel equipped to deal with them or there are not enough services—we do not have services to bring those children home.
- Those families need to bring their child to ER or hospital do not have the services—their trauma enables them to feel their home is safe for that child or may harm other children in home. Their parents do not know how to move forward; their trauma has enabled them to move on with what to do or services to help.
- Received funding to provide case managers (DDA) to receive services (not paid), check in with families to link to services.
- Age 12/13 trying to address services that a child may not feel they need. You can take a child to therapy but may not even talk or participate.
- There are gaps in prevention. There needs to be prevention as every level of service (e.g., Tier 1, outpatient services; Tier 2, residential). The system should not require people to be at imminent risk in order to access services.
- Mental health feels more like a negative label than BH.

- The availability of BH services across the state is limited because of a lack of providers. People are sending family members out of state to get care. We shouldn't have to send children out of state!
- We do need a working definition of BH for the strategic plan that everyone understands. If it's an umbrella term, the services underneath should not be siloed.
- There are a lot of services for younger people, but not for adolescents. This needs to be fixed.
- There are gaps in discharge planning.
- I think that there are a variety of gaps within the behavioral health system. I think in my personal experience, I found the largest issues (for me) related to behavioral health was barriers to support as well as a tendency to treat those receives support for mental health resources as being "other" (sorry I'm really not feeling the best, so hopefully that made sense!)
- I see gaps in behavioral health because there's not a lot of DBT being taught
- Dialectical behavior therapy
- DBT, a form of cognitive behavior therapy, is designed to help people change unhelpful ways of thinking and behaving while also accepting who they are.
- More than half of all rural counties report they do not have any behavioral health professionals and nearly three-quarters of all U.S. counties report serious shortages. To address these gaps, I feel like this could also be a problem
- Example: Gap between clinical vocabulary and what people can understand. It can get confusing. No way to simplify.
- More youth friendly language.
- Share information in schools—emails, someone to come in to talk to everyone. Just talk of depression and suicide but not the reasons for them. Help your friends who are depressed.
- Mental health—communications in the brain and lack of chemicals and the way that brain works, lack of appreciation and feelings in the brain, the effect of stress
- Cultural humility, finding people who look like me, who I can relate to, who can communicate and understand my family, my community, representation.
- In general, I think having mental health discussions and education in schools should be a more common thing. I can say from personal experience that the thing that initially encouraged me to seek behavioral health resources was from having discussions in school regarding educating for mental health/illnesses!
- For many who wouldn't be exposed to this sort of info otherwise, school can be a way to introduce these sorts of topics.
- Might be useful to have some program which you can ask or put information about yourself to give you an idea of if you need therapy. A website … official … govt … hospital … anonymous … overview of your feelings and stuff like that. Rough estimate of things you can do.

Additional comments/questions:

- Are we stuck with calling this a BH system strategic plan or is there another option?

Group Discussion- Future Advisory Group Meetings

Jo Ann Kauffman, KAI
See TVW recording (1:38)
July 6, 2023 (3-5 p.m.) PDT

- Initiate discussion around a shared vision for PN-25 behavioral health services

September 7, 2023 (3-5 p.m.) PDT

- Identify obstacles, barriers, challenges preventing our future vision.

November 2, 2023 (3-5 p.m.) PDT

- Develop strategic directions, goals and objectives that address the root causes of obstacles, barriers, and challenges.

NOTE: Information is open to feedback and may change.

Advisory Group Meetings

- How much time is needed for future meetings?
- How often would you like to meet?

- Comments:
  - Like longer meetings, breakout rooms, great in-depth conversations.
  - Helpful to have consistent days and time consistent to plan around it
  - Same time and same day of the month
  - Wouldn't do less than every other month, 3 hours is good
  - Can be demanding when signing up for other meetings
  - Open to more frequent meetings if regular
  - Monthly, 2.5 hours
  - Is there a potential opportunity to meet in person in July

Public Comments

See TVW recording (1:50:40)

- Comments:
  - Deepest concern, strategic plan has to have a plan. Two sides: who needs something from the system and what outcomes need to be enabled for those people. That is the framework for a strategic plan. The system design goes into between those two parameters. The system design is dependent on assumption and the group is going to have to agree on certain things in order to design a system that takes the person over here to the outcomes over here. The two assumptions that the state of Washington does not have the courage to agree upon is that a voluntary only system will never be accessible to some people who need the most sophisticated care. And so involuntary as part of the continuum of care is part of that system. Number two, adolescents to young adults are the most likely to have these psychotic breaks (16-24). Severe mental illness, but generally includes psychosis is never going to be prevented, it has always been

a part of the human experience. Our system has to be prepared for that. Intervention must be swift and comprehensive; some kids are going to have schizophrenia.

- Additional comments can be sent to the Children and Youth Behavioral Health Workgroup email: cybhwg@hca.wa.gov

Closing Comments/Survey

Jo Ann Kauffman, KAI
See TVW recording (1:56:10)

- Survey link provided in chat
- NOTE: If you cannot complete the survey now, it will be open until the end of the day today to complete.

Chat

- **Introductions**
  - Kitsap County Parent Coalition, diagnosed with autism and mother of kids with autism
  - M. Seattle Children's, Health Coalition for Children and Youth and CYBHWG Subgroup co-lead on Rates/Workforce
  - Public, member of the stakeholder outreach subcommittee
  - Member, Dept. of Health, Prevention and Community Health
  - HCA-DBHR, staffing the Children & Youth Behavioral Health Work Group and the P25 Behavioral Health Strategic Plan Advisory Committee
  - HCA, DBHR Prenatal through age 25 Behavioral Health Section Manager and Stoked for this group and opportunity for WA
  - With gratitude to all of you! Lisa Callan, Member, State Rep for 5th LD, co-Chair for CYBHWG, serving on House K12 Committee, Human Services & Early Learning Committee, and Vice Chair of Capital Budget Committee
- **General Questions and Comments**
  - At the end of the meeting, right before public comment, Jo Ann will be leading a discussion with members about how often and for how long you want to meet moving forward.
  - I don't have that Q&A option.
  - Is it not to the right of the participants button at the bottom of the screen for you? Is there anyone who can see the Q&A button?
  - My Q&A button is to the left of the chat button
  - I'm attending via mobile device (as I almost always do), and there's no Q&A unfortunately.
  - Thanks for adding that, Jo Ann!
  - There's no Q&A on my computer also.
  - For those who do not have chat, it should appear to the left of the chat icon at the bottom of the page.
  - Thank you.

  - Send the info to my email please.
  - Can you say again when the vision discussions will start? Thank you!
  - Thank you!
  - I have to head out, thanks, and I look forward to seeing the notes for the rest of the meeting. Thanks.
  - THANK YOU for being here!
  - Thanks for leading our group through this, Riley! Your report-out was awesome.
- **Full Value Agreement**
  - FYI, the full value agreement is attached to the meeting invite.
  - The statement I reviewed in the meeting materials looked good to me!
  - Great ideas
  - Refer to suicide as cause of death, not something you "commit"
  - I know there is legitimate concern about conduct that is upsetting or difficult to handle. I'm glad we're stressing respectful interactions and think the Value Agreement is very well done. I do want to put out there that, conversely, there sometimes can be pressure toward consensus. I think we should say something like that principled disagreement is also an expected part of this process and OK, as long as it's respectfully expressed. I think another group said something like this, so I may just be supporting their statement.
- **BH Breakout Session**
  - Are the next set of breakouts 20 or 30 minutes?
  - 30 minutes
  - Can you share the break return time in chat pretty please?
  - Can we get those questions posted again please?
  - Review and discuss the definition of behavioral health. What does behavioral health mean to you? Based on the focus group findings, where do you see gaps in the current behavioral health system in the state?
  - Prevention services for SUD and mental health and other disabilities aren't covered by insurance.
  - Bravo to another participant for her last statement about parents.
  - That was cut off as we moved over here
  - DBT is dialectical behavioral therapy
  - CBT is cognitive behavioral therapy
  - Thank you! for this clarification.
  - Yes, yes, yes, mental wellness education for all students!!
  - That's an aspect of the parent portal under construction
  - WISe is only available to Medicaid recipients
  - Hopefully that will begin to change. In pierce county, we have at least one organization that provides WISe services for families with private insurance.
  - Just want to clarify that the comment around care coordination was related to there not being a system in place to initiate care coordination that corresponds to level of need. I as a parent had to call/write legislators to find out who needed to be brought to the table, and then invite 30+ people to care coordination team that

I had to orchestrate. We need there to be thresholds for an automation of that process, so families don't bear the burden of it.
Yes. I've participated in some of those huge teams. A problem is that no one is in charge.
- Yes, we were just talking a tad about the Surgeon General's Advisory on the public health concern around loneliness and social isolation!
- There's a family in west Seattle trying to set up an autism friendship group for tweens/early teens. The isolated families have because we can't take our kids to many traditional outlets—church, playgroups, holiday parties.
- It really surprised me that she didn't know where to turn to create this for herself other than Facebook.
- Add housing to the list of issues for leaving inpatient.
- Shared the U.S. Surgeon General's Advisory *Our Epidemic of Loneliness and Isolation*. The U.S. Surgeon General's Advisory on the *Healing Effects of Social Connection and Community*. Really relevant to the conversation. In case others are interested, here's the link (since I don't think everyone could see our chat during breakout groups): https://www.hhs.gov/surgeongeneral/priorities/connection/index.html?utm_source=osg_social&utm_medium=osg_social&utm_campaign=osg_sg_gov_vm
- Thank you for sharing this link!
- The meditation videos which were used in California. https://pureedgeinc.org/brain-breaks-video-library-english/
-

- **Future Advisory Group Meetings**
  - I appreciated having 30 minutes. I often feel breakouts can lack comprehensive substance when they're only 10 minutes especially because some people take longer to feel comfortable raising their voice. Thank you for the 30 minutes!
  - Yes, big difference
  - Three hours seemed more productive
  - Translated brain break cards on five languages, including Chinese, Ukrainian, Farsi, Spanish.
  - https://pureedgeinc.org/languages/
  - This works for me!
  - I think the length of the meeting is good at 3 hours. There seemed to be a good flow.
  - I agree with the previous comment about the longer breakout groups being really valuable, regardless of the frequency and total duration of the meeting.
  - I like the longer meetings too–this one was well run, thank you!
  - Yes
  - I think we are leaving it up to you as the way and are flexible.
  - I would suggest keeping it e/o month unless there is a need to schedule additional meetings. There is other work being done in between this meeting!
  - Great idea
  - I love that idea!!! With a hybrid option for virtual for those that prefer

- I cannot participate on 7/6
- Preach.

- **Closing comments/ Survey:**
  - Thank you for raising your voice. and thank you for your bravery to raise it, in consideration of all you have sacrificed to gain the knowledge you are sharing.
  - Thoughts and suggestions can also be sent to cybhwg@hca.wa.gov
  - Yes! I was speaking about the prescriptive nature of programs and "aging out"
  - This is also why I'm talking about BEHAVIOR is communication in our children, youth and young adults is COMMUNICATION and it is not appropriate to consider it choices.
  - Thank you for your voice and comments! I hear you.
  - I would add that the New Journeys program—the First Episode Psychosis program in WA needs to allow all who qualify regardless of insurance to be funded. Right now, only two non-Medicaid slots are allowed. Also there need to be exceptions allowed for the rare instances where those younger than 15 do qualify.
  - Thank you!
  - Thank you, for your insights and recommendations. And thank you for that clarification as well. I had wondered whether there were specific barriers in the early psychosis intervention work that is currently happening.
  - There is also a connection to mental illness and brain development that overlaps with attachment, autism and FASD
  - This may seem like an off question. How do I know what category I'm in? I placed an M next to my name, not sure I was supposed to.
  - New Journeys is voluntary
  - I believe that BHAC will be having a forthcoming conversation on that topic.
  - Thank you very much!
  - Thank you.

Appendix B – Power Point Slides

Instructions: Double click the image below to populate the PDF file. The file will open in PDF browser.

5/15/2023

1

2

1