P-25 Behavioral Health Strategic Plan Advisory Group
Meeting notes - *November 28, 2023*

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P-25 Behavioral Health Strategic Plan Advisory Group
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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		
☒ Shelley Bogart (Department of Social and Health Services-Developmental Disabilities Administration)	☒ Hugh Ewart *or* Laurie Lippold (Workforce & Rates subgroup)	☒ Sarah Rafton *or* Kristin Houser (Behavioral Health Integration subgroup)
☒ Kelli Bohanon *or* Kristin Wiggins (Prenatal-5 subgroup)	☐ Steven Grilli, Department of Children, Youth and Families	☒ Michele Roberts (Department of Health)
☒ Lisa Callan, Co-Chair (House of Representatives)	☐ Summer Hammons (Tulalip Tribes)	☐ Delika Steele (Office of the Insurance Commissioner)
☒ Diana Cockrell, Co-Chair (Health Care Authority)	☐ Kim Justice (Commerce – Office of Homeless Youth)	☐ Bridget Underdahl (Office of Superintendent of Public Instruction)
☒ Byron Eagle (Developmental Disabilities Administration-Child Study Treatment Center)	☐ Amber Leaders (Governor's Office)	☒ Keri Waterland, Co-Chair (Health Care Authority)
☒ Carolyn Eslick (House of Representatives)		

Staff		
Erika Boyd (Legislative staff)	Diana Cockrell (HCA)	Cindi Wiek (HCA)
Rachel Burke (HCA)	Nate Lewis (HCA)	

P-25 Behavioral Health Strategic Plan Advisory Group
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REVIEW FULL VALUE AGREEMENT

See TVW recording (5:27)

- The Advisory Group reviewed and approved the full value agreement with no new changes.

Full Value Agreement

PROJECT UPDATE

See TVW recording (7:55)

- Diana Cockrell was appointed to serve as co-chair for the P25 Strategic Plan, succeeding Keri Waterland.
- In the past year:
    - Our work with the Advisory Group has helped us capture your experiences and perspectives
    - We have built our knowledge about successful strategies that other states have used to lead change, such as Liz Manley who presented to us at the September Advisory Group meeting about her work in New Jersey.
    - A current behavioral health landscape for children, youth, and families has started to take shape, alongside the vision we are working on in these meetings.
- Last month the assembled Work Group voted to approve a recommendation to adapt the strategic plan process to:
    - Develop actionable steps to address children, youth, and families' immediate needs which remain at crisis levels, while also
    - Building a larger strategic effort that will support system-wide improvement toward wellness and access.
- We have gotten some input on the guiding principles for the strategic planning process, which align with our goal of making the system human-centered:
    - There should be "no wrong door" to access the system.
    - The system of care must be robust and dialable, and cover the full continuum of care across all BH conditions for the P-25 age span
    - Both the way we measure outcomes and the tools that can "course correct" the system need to be flexible enough to create new responses and approaches as times change
    - We must engage people who will use these services – young people, parents, and caregivers – in developing them.
- Keri Waterland will be stepping down as Director for Behavioral Health and Recovery at the end of this year.
- There are two other important changes for 2024:
    - During the legislative session, which runs from January through March, we will not be holding Advisory Group meetings.
    - We'll be aligning our work with the Work Group to address immediate needs at the same time as we build a long-term strategic effort. As part of this we will be securing contractors.
    - We are working on ways to keep all of you in the loop about what's going on during this time, such as holding office hours or sending out updates. Expect to hear from us in January with more information.
- The second change will be refreshing our membership list for 2024. We will send out an email by December 15 with more details about what this will involve.

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PROJECT UPDATE: CURRENT LANDSCAPE –CONTINUUM OF CARE

Diana Cockrell, Health Care Authority (HCA)

See TVW recording (34:56), Access the current state services and supports document

- This document is a high-level glimpse at the current landscape of behavioral health.
- There are some "asterisks":
    - We know that not everything is included on the list.
        - There are many good programs happening at many levels of the behavioral health system across the state.
        - This list captures what the state contracts for.
    - This list could have been done many different ways, so we chose what made the most sense to us.
- The list had contributions from a variety of state agencies and departments, as well as contractors.
- There are many identified programs of different types:
    - Services and supports, or programs that help develop workforce for services and supports
    - Work groups
    - Strategic planning partnerships
- Each program is categorized in several ways:
    - The part of the continuum of care they serve:
        - Wellbeing, education, promotion and prevention
        - Screening, early intervention, and education
        - Outpatient care
        - Intensive outpatient care
        - Long-term in-patient/residential options
        - Recovery supports
        - Discharge transition care delivery teams
        - Crisis services
    - The age groups they serve:
        - Prenatal-5
        - Age 6-12
        - Age 13-17
        - Age 18-25+
    - The agency responsible for the program
    - the type of system the program serves:
        - Mental health
        - Substance use
        - Mental health and substance use
        - Mental health and intellectual disabilities
    - Other lines of service that might affect availability of programs, such as being limited to those in foster care or in the justice system.
        - Foster care
        - Justice system
        - Child protective services
        - Culturally relevant/developmentally appropriate services
        - Transition Age Youth (18-25 age range)

- Workforce development
- In process of implementation (perhaps not available yet)
- Community building

CHAT

- *Wow! This is great. I can't wait to dig into the details.*
- *Is Homebuilders one of the programs on this list?*
- *Can you also add people that are in the address confidentiality program into the "Exclusive list"?*
- *Given the inclusion of a TAY specialized category, I wonder about adding an IECMH specialized category. I'm curious about this because in my experience as an employee of community behavioral health agencies, I found that typically services were provided for children around the age of 3 years old but were not typically what we would consider IECMH-informed or specialized.*
- *I'd like to see some type of analysis of number of services to the potential population. ex residential beds... we have 290 school districts and 100 beds... so it's clear we don't have enough... what would be the right number? I'd also like to see types of outpatient programs... therapy isn't the only o/p program. ex. equine therapy is an outpatient program (I doubt that HCA pays for it)*
- *also ... early interventions for brain based issues that aren't considered mental health... ex: eye tracking, dyslexia, PT & OT proprioceptic and vestibular supports*
- *Are non public agency specialty schools like NW Soil on there?*
- *Are JR interventions a category?*
- *I am with the ACP program and I feel there is such a gap with communication and was curious if this can be added. People who are in the Address Confidentiality Program are victims and have a high need for mental health services. This program is with the Secretary of State and I challenge programs to provide safe communication to all within this program.*
- *I'm sorry if I missed it, but are services delivered in juvenile detention facilities covered?*
- *figuring out how to track the kids that aren't being served in their schools and need NPAs end up in JR is an important group to not lose track of how we are serving them*
- *This is a cool project! The only column I might add is whether or not they are evidence-based, promising, etc. I think Juvenile Justice can only contract with EBPs and it is a very limited number of programs.*
- *What is being done to promote more youth detox services?*
- *Looking at it by region instead of by county might be helpful. Especially when we have at least one county that has more population than 10 US states have. the regions make the units of analysis sync with the FYSPRTS*
- *There may also be some DD services to include here. Sorry if I missed whether this includes refence to enhanced out-of-home-services for DD eligible youth. Pilot funding included in state budget passed earlier this year.*
- *I don't know where to put these, but we need to understand how a service added somewhere affects a service somewhere else...for example, some clinicians are leaving provider agencies to go to work for schools so the overall impact on the community creates new and changing gaps but doesn't always close a gap when there just aren't enough people to do the work.*
- *Looking again at the Care Continuum section, it might be helpful to include a referral column. (Acknowledging that it might be in one of the categories and just not visible) There's obviously the Children's MH referral line out of Seattle Children's and Help Me Grow, but I would imagine there are*

many others as well. The challenge of finding and actually getting into MH services comes up often with both parents and colleagues in allied fields, so this seems worth including in the landscape.

BREAKOUT GROUP EXERCISE: DEVELOPING THE VISION THROUGH SAMPLE SITUATIONS

See TVW recording (1:12:26). See page 7 for results of breakout group exercises.

- This is the third meeting focused on vision development.
- Exercise will use sample scenarios developed in previous meetings, describing a behavioral health challenge faced by an individual or family.
- Breakout groups will answer a set of questions to explain what they think the response would be in a perfect system.
- Exercise has three parts:
    - Part 1 – breakout groups answer questions on 1-2 scenarios assigned to group
    - Part 2 – large group discussion
    - Part 3 – participants add to any scenario(s) they choose

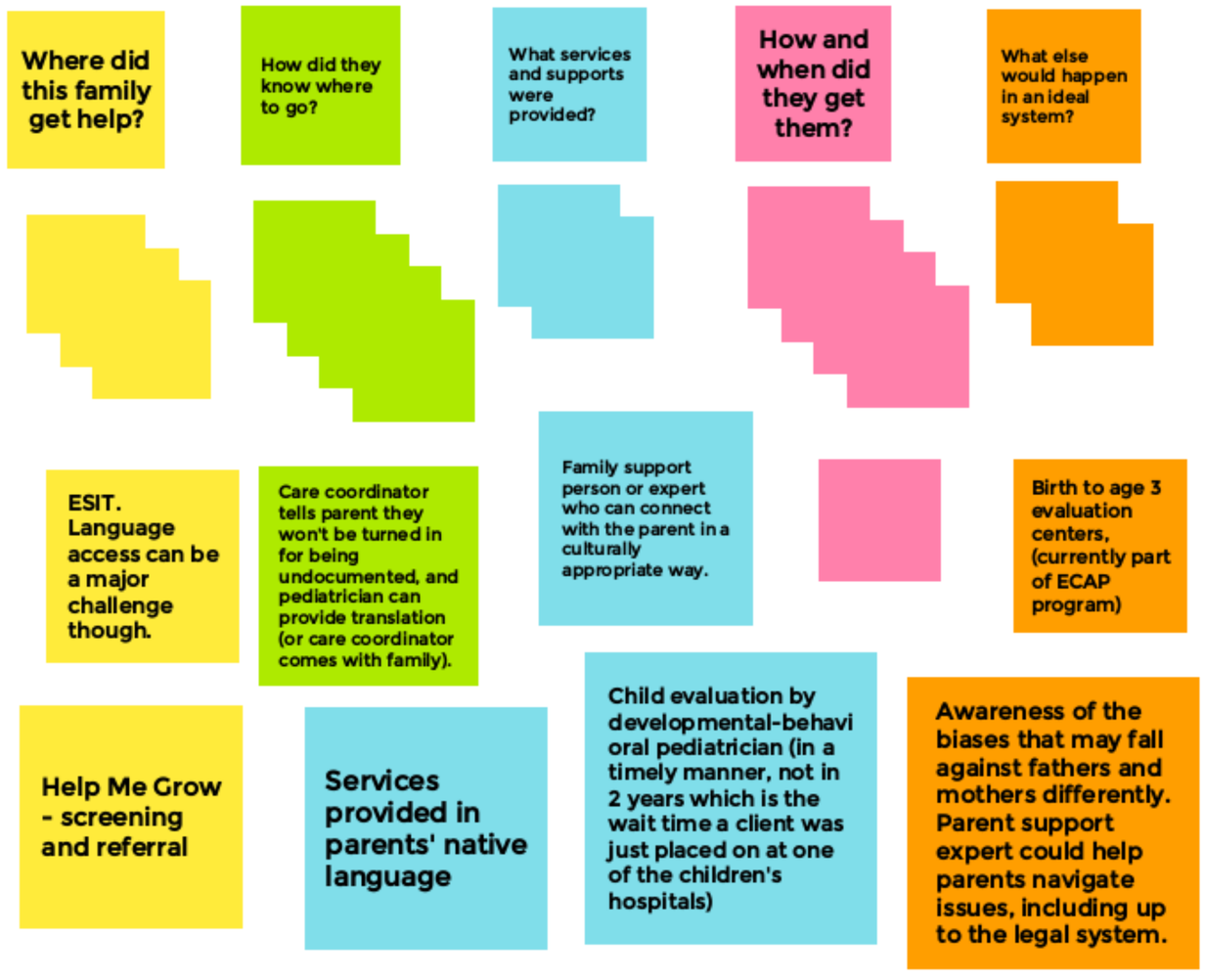
PUBLIC COMMENT

- *I just want to piggy back on some conversations that have been across a couple of different rooms. The earliest intervention with children who have- the separation in our minds of brain and neurological issues really young, not having anything to do with potential problems later on. And how do we catch kids? So for example, I know 3 moms who all have kids that have struggled as teens and all of them have vision issues like strabismus where your eyes don't function necessarily together, but that's not something that's cognitive. So we haven't understood, we've separated the brain. In a cognitive way from behavioral, but in a lot of people's experience, like if you've got proprioceptic or vestibular issues, you're not gonna be- like, my kid needed those addressed before he could learn to write. But with his fine motor skills. And so all of these things build upon each other. And so having some time to really talk about not just the birth to 3 or births to 5, but like birth to 8 of the developmental milestones and really getting into families that have seen their kids struggle at that age and then some of the later problems that they had because none that was available and my kids were 22 and 24 now. You know, they're not that old. But that was not available. The first executive function book that I ever found was when my son was 10. So how can we get at digging out from some of the young, you know, the information of the parents have discovered as behavioral health has really exploded in our awareness. To look at those early issues of development.*

Breakout Group 1

Scenario A

The parent of a family is undocumented and needs to take time off work due to an injury. Their 2 1/2 year old child isn't talking much yet and has behavioral challenges such as excessive tantrums. The parent is offered help to see a pediatrician but is afraid to engage in the BH system because they don't speak or read English as a first language. The child doesn't appear to understand English or the parent's native language very well.



Scenario B

A 10-year-old is brought to the ED after getting into a serious fight with an 8-year-old sibling. This child targeted the younger sibling during the fight, and this is becoming a consistent pattern. The child has not adjusted well to having a new baby in the home and has been unsafe with the infant sibling as well. Mom and Step-Dad are concerned about bringing the child home due to the pattern of aggression.

The family lives in a mobile home and doesn't have the ability to "close doors" to separate siblings during times of escalation. They are developmentally on track, so he is not eligible for any DDA services. Mom is hesitant to work with state resources because she is afraid she could lose her other kids because of this child's behavior. School has already suspended him once or twice and says the next incident may result in expulsion.

Breakout Group 2

Scenario A

A 6-year-old is suspended from school. The teacher is young and new to the field with limited understanding of child development. The child's primary caregiver, a grandparent, needs the child to be in school so they can work. Special ed assesses the child and gives an early diagnosis of ADHD or ODD, and the child is placed in self-contained behavioral classrooms. The caregiver is having difficulty coordinating care and doesn't fully understand how to care for a high needs child. The child was born during the pandemic and did not receive most early childhood supports.

Scenario B

16-year-old with a history of trauma presented to the ED multiple times with strong suicidal thoughts. They have had multiple admissions to inpatient psychiatric treatment given the danger of suicide using plans that are difficult to "safety proof". Family tried to get the youth into a DBT therapy program, but waitlists are so long they are back in the ED again needing another admission. Parents have safety proofed the whole house and often take turns checking on the 16-year-old when the need is very high. Both parents agree they can't keep doing this and need a higher level of care. The most recent admission was an involuntary commitment under Family Initiated Treatment (FIT).

Breakout Group 3

Scenario A

A 22-year-old single parent has a newborn and a toddler and lives with their own parent. The young parent is doing their best keep up with work and school and wants to do a good job with their children, but has very few resources. The toddler is a “bit of a handful,” and is often resistant at childcare drop off.

The 22-year-old is also having challenges with their own parent, who gives advice like “don't pick up the baby so much or you'll spoil the them". Because their parent is the main babysitter, they feel they have to go along. The young parent is relying on TikTok for information and would love help, but doesn't have time to pick up the phone; the last time they tried, they were on hold for 30 minutes.

Scenario B

14-year-old non-verbal teen with ASD and intellectual disability has always had some challenges with self-injurious behavior such as biting himself or head banging, but since puberty has had more and more aggressive outbursts. They used to be just at school with a paraprofessional and additional supports, but now they also happen at home where it's often just the 14-year-old and one parent. The teen has had multiple inpatient psychiatry admissions in a year and numerous ED visits for the same aggressive behavior.

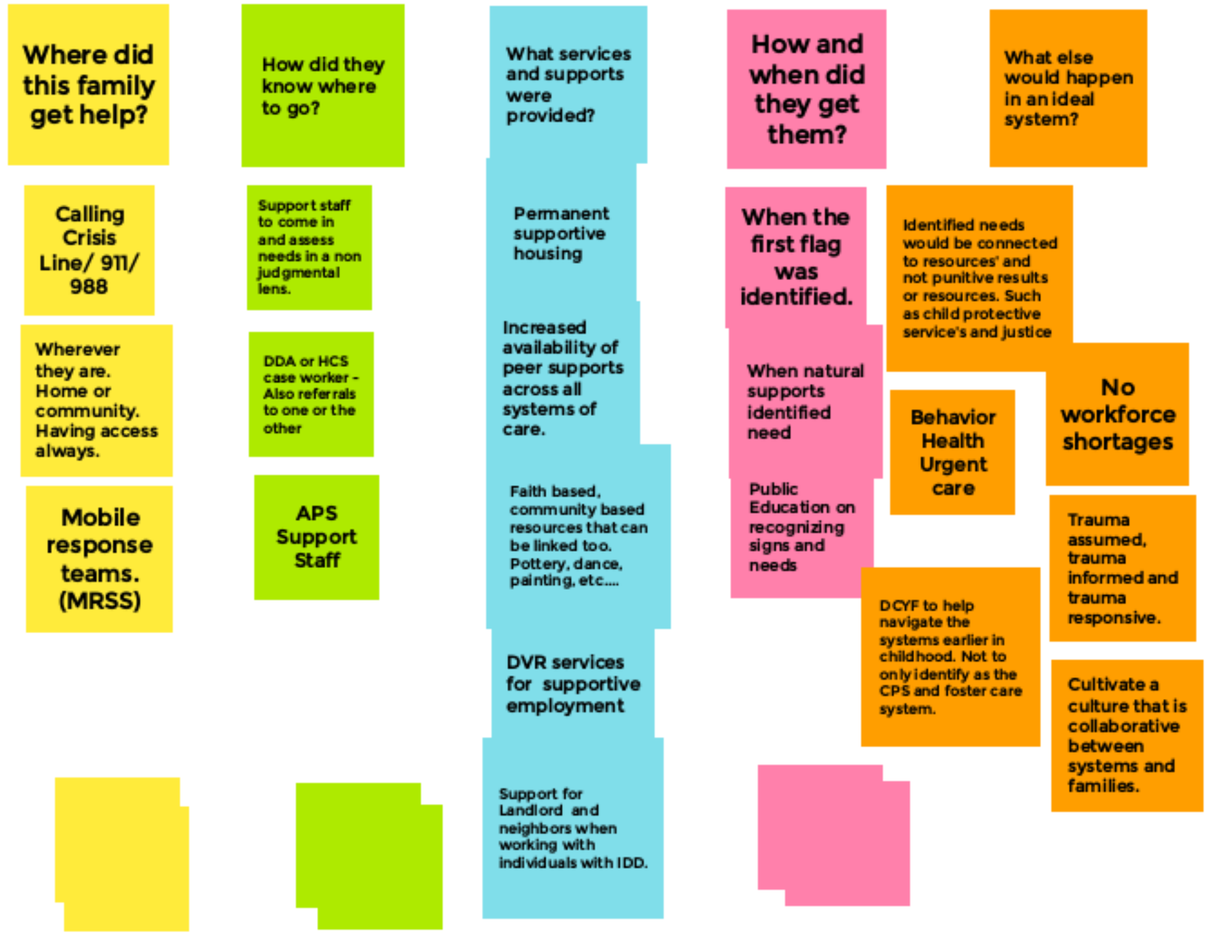
They qualify for in-home supports through DDA but no caregivers have remained in the home for longer than a month or two due to the high level of aggression. Parents have started to explore residential and out-of-home services but there are long wait lists and the residential options are too expensive unless the school will pay for it. At this point, the school will not do so as they are able to manage the behaviors with multiple staff. The parents are concerned they cannot safely have the teen in their home much longer.

Breakout Group 4

Scenario A

A 23-year-old with intellectual impairments has been living independently but has started to have more and more trouble being functional in their daily life. They lost their job months ago and family visitors have noticed their apartment smells rotten with many things broken beyond function, including the bathroom door. The 23-year-old cannot figure out how to purchase things, including groceries.

One relative reported that when taking them out for coffee, they inappropriately exposed their body in public and later tried to tip the barista $50. In another case they tried to get out of a moving car. Their landlord says they are verbally aggressive and were unable to correctly write a check for rent. The landlord is compassionate but says eviction may be necessary. The 23-year-old refuses to use their phone because "the gods are taking care of me."



Scenario B

A 3-year-old child is brought to the emergency room by a 20-year-old parent who says the child's tantrums are not manageable. The parent shares that they are at risk of losing their housing due to the severity of the tantrums, which include shrieking and other loud outbursts that the neighbors are complaining about. The parent has no family or other strong supports nearby and is feeling overwhelmed.

Breakout Group 5

Scenario A

An 18-year-old with a history of psychiatric hospitalization calls a crisis line saying they are having suicidal thoughts. The crisis line notified police, who responded. The 18-year-old was in a bad mental state and became combative and was arrested. They continue to experience suicidal thoughts but now they are afraid to call for help.

Scenario B

A 15-year-old has started using marijuana daily and has lost interest in friends and activities that he used to enjoy. He sometimes goes to school but often leaves before the end of the day.

Breakout Group 6

Scenario A

A 21-year-old is hospitalized for psychotic and aggressive behavior. After two weeks they are discharged, despite ongoing threats to kill members of their family. They refused outpatient care after discharge. Later, they attack their mother and the responding law enforcement officers hit and taze the 21-year-old before being taking them to jail.

Where did this family get help?	How did they know where to go?	What services and supports were provided?	How and when did they get them?	What else would happen in an ideal system?
where ever they are or have needs	because behavioral health is treated like medical health and there is no stigma. ads and social media campaigns make access widely known	Intensive in home supports. availability of direct support staff and intensive peer support (NOT WISE) coming right into the home and community	as soon as needs identified	In an ideal world, a person like this would not be released until they are safe and have a safe place to live. The way we treat mentally ill people in our society is shameful.
There isn't help for this type of situation under current policies.				

Scenario B

A 19-year-old with a history of serious depression, chronic heavy drinking and marijuana use has started to struggle in community college. During a meeting with a school advisor they are visibly under the influence of drugs or alcohol and when the advisor presses this the student eventually admits to the advisor they're drinking and vaping every day because they feel trapped and hopeless and have frequent thoughts of suicide. The student is employed but uninsured and has limited social and family supports.

Where did this family get help?	How did they know where to go?	What services and supports were provided?	How and when did they get them?	What else would happen in an ideal system?
				In an ideal world it wouldn't matter if the student was employed or had insurance. the services would be available on campus and there would be sober peer to introduc

Breakout Group 7

Scenario A

The parent of a family is undocumented and needs to take time off work due to an injury. Their 2 1/2 year old child isn't talking much yet and has behavioral challenges such as excessive tantrums. The parent is offered help to see a pediatrician but is afraid to engage in the BH system because they don't speak or read English as a first language. The child doesn't appear to understand English or the parent's native language very well.

Scenario B

A 13-year-old with undiagnosed autism and learning disabilities is becoming increasingly aggressive at school and in the home. They are frequently suspended from school, and the IEP team is unable to make any service changes that result in improvements. Parents requested respite care and were denied.

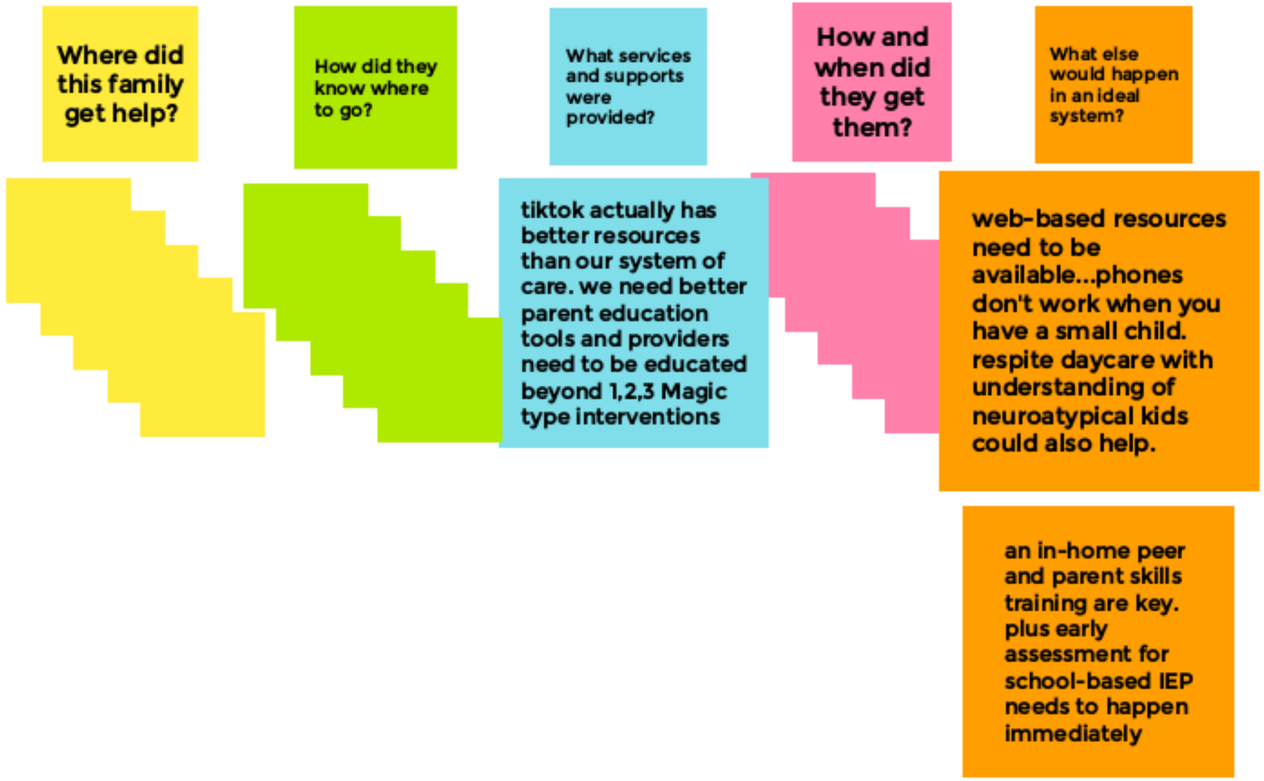
Breakout Group 8

Scenario A

A 14-year-old has suddenly developed regular and debilitating headaches and stomachaches and the pediatrician cannot find any known cause for these medical problems. The family is left to problem-solve without any idea what might be wrong.

Scenario B

A 22-year-old single parent has a newborn and a toddler and lives with their own parent. The young parent is doing their best keep up with work and school and wants to do a good job with their children, but has very few resources. The toddler is a "bit of a handful," and is often resistant at childcare drop off. The 22-year-old is also having challenges with their own parent, who gives advice like "don't pick up the baby so much or you'll spoil the them". Because their parent is the main babysitter, they feel they have to go along. The young parent is relying on TikTok for information and would love help, but doesn't have time to pick up the phone; the last time they tried, they were on hold for 30 minutes.



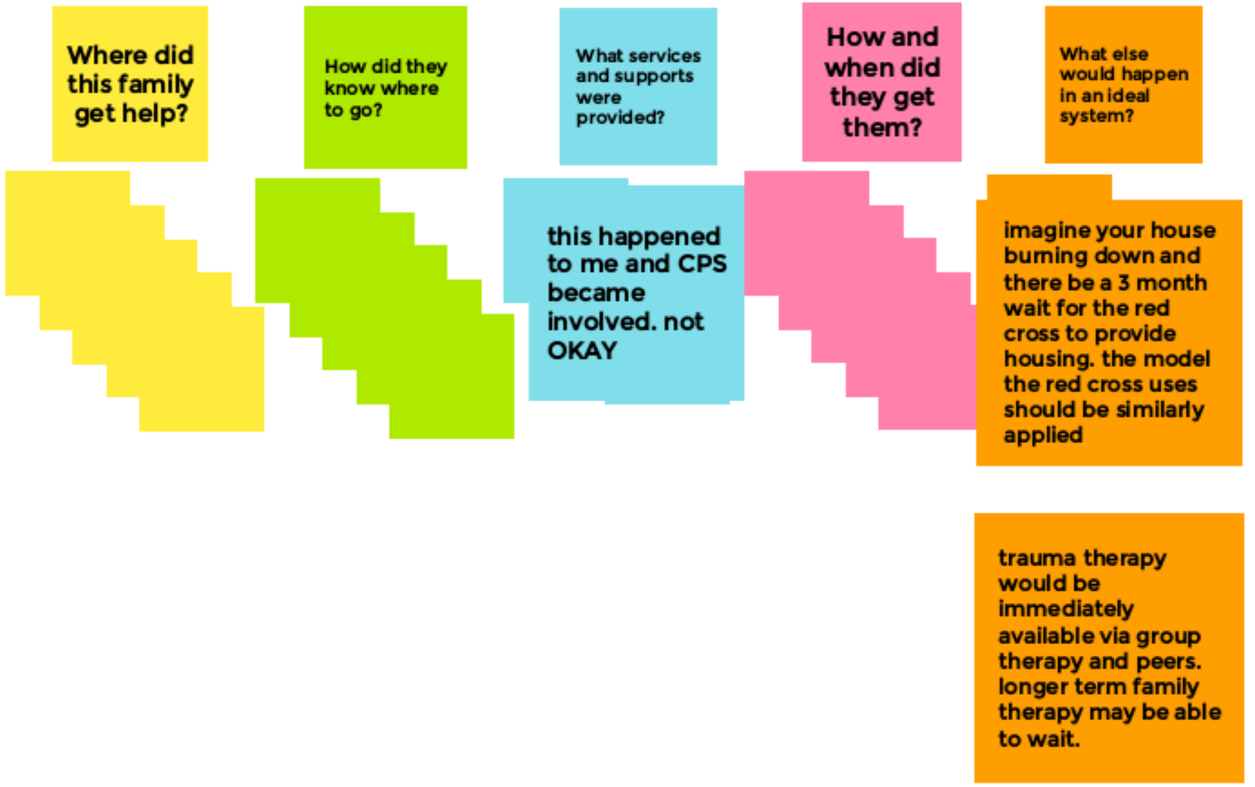
Breakout Group 9

Scenario A

An 18-year-old with a history of psychiatric hospitalization calls a crisis line saying they are having suicidal thoughts. The crisis line notified police, who responded. The 18-year-old was in a bad mental state and became combative and was arrested. They continue to experience suicidal thoughts but now they are afraid to call for help.

Scenario B

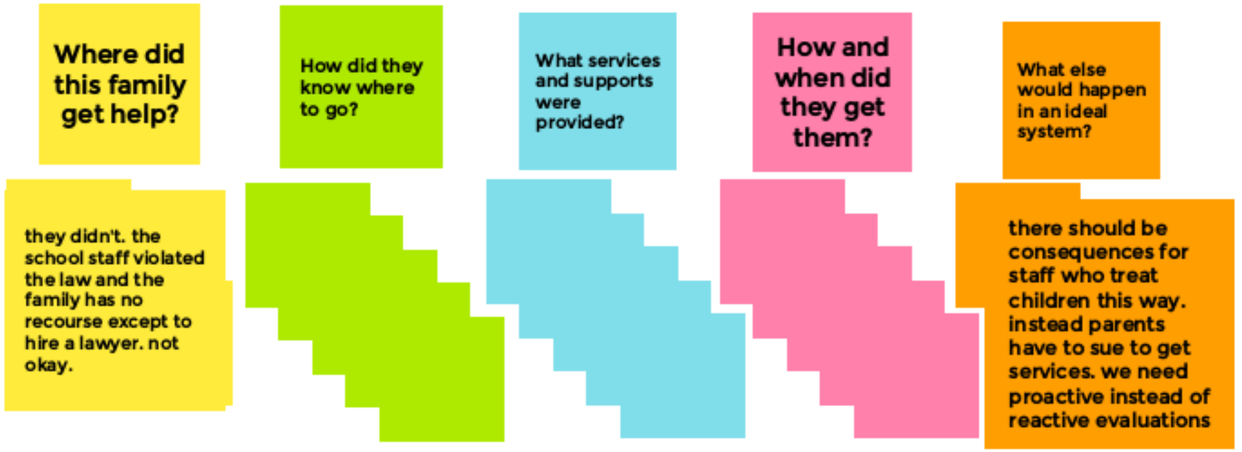
A parent goes through behavioral health crisis that includes a suicide attempt. Several teen siblings are traumatized, and the family cannot find trauma therapy with less than a 3-month waiting list.



Breakout Group 10

Scenario A

A 6-year-old enters school with no diagnosed needs but has shown developmental delays. The school uses punishment to address frequent behavior concerns such as keeping the child in from recess due to not completing work. The school does not identify the child as having a learning disorder.



Scenario B

A 13-year-old with undiagnosed autism and learning disabilities is becoming increasingly aggressive at school and in the home. They are frequently suspended from school, and the IEP team is unable to make any service changes that result in improvements. Parents requested respite care and were denied.

Prenatal through 25 Behavioral Health Strategic Plan Advisory Group

November 28, 2023

BY-NC-

Advisory Group Co-Chairs

Representative Lisa Callan
Washington State Representative
5th Legislative District

Diana Cockrell
Section Manager, Behavioral Health and Prevention
Health Care Authority

Agenda Review

3:00 – 3:10	Welcome
3:10 – 3:20	Review full value agreement
3:20 – 3:45	Project update: Plans for 2024 *Rep. Lisa Callan*
3:45 – 4:15	Project update: Current Landscape – Care continuum *Diana Cockrell, HCA*
4:15 – 4:25	*BREAK*
4:25 – 4:40	Introduction to Breakout Sessions *Diana Cockrell and Nate Lewis, HCA*
4:40 – 5:05	Breakout Session Part 1: Ideal Responses
5:05 – 5:20	Breakout Session Part 2: Discussion
5:20 – 5:40	Breakout Session Part 3: Feedback
5:40 – 5:55	Public comment
5:55 – 6:00	Closing *Please use this time to complete the short survey about this meeting.*

Full Value Agreement

- Be respectful of each other.
- Speak your truth, from your own expertise.
- Keep an open mind; listen to understand.
- Honor this time as a space for you and others to share perspectives across differences without judgement.
- Use plain language (explain acronyms, if used).
- Use first names.
- Stories stay private, but the lessons may carry forward.
- Practice patience with ourselves and each other.
- Step up then step back so that everyone has a chance to be heard – one at a time when speaking and give attention to facilitators/speakers.
- Be mindful of trauma and recognize the impact of that trauma.
- Your experience matters; so does your knowledge and experience.
- Encourage grace, compassion and kindness for self.

Announcements and information sharing

Diana Cockrell

Diana has served as Section Manager of the Prenatal through 25 Behavioral Health section of the Washington Health Care Authority since 2018.

Diana previously served as a Child, Youth & Family Behavioral Health supervisor in the Division of Behavioral Health and Recovery, and before that as a substance use treatment specialist and development analyst for the Thurston/Mason Behavioral Health Organization.

She has supported the Strategic Plan from the beginning and is a very welcome addition to our team!

Project Update

Year 1

- Advisory Group formed
- Knowledge built about successful strategies leading change in other states
- Development of current behavioral health landscape for children, youth, and families
- Development of future vision
- Exploration of existing data sources and gaps in available data

Project Update

Approved CYBHWG overarching recommendation:

Update House Bill 1890 to adapt strategic plan process to:

- Develop actionable steps to address children, youth and families' immediate needs which remain at crisis levels

while also

- Building a larger strategic effort to support systemic movements toward wellness and access to a robust and dialable delivery system that supports the health and well-being of all our children, youth, and young adults, and their parents and caregivers.

Project Update: Plans for 2024

Input on Guiding principles for the strategic planning process

- No wrong door.
- A robust and dialable system of care that covers the full continuum of care across all behavioral health conditions for the P-25 age span.
- Outcome measures and levers that are nimble enough to create new responses and approaches from the system as times change.
- Engage people who will use these services – young people, parents and caregivers, and communities – in developing them.

Project Update

Dr. Keri Waterland is stepping down as Director for Behavioral Health and Recovery (DBHR) at the end of this year. She will be missed!

Project Update

Other changes:

- No Advisory Group meetings during legislative session (January-March).
  - In January we will have more information about how we will keep you updated on the work during this time.
- 2024 membership list reset
  - We will send an email by December 15 with more details about what this will involve.

Project Update: Current Landscape – Care Continuum

Breaktime!

Introduction to Breakout Sessions

July Meeting
- Developed the values we want in our system.

September Meeting
- Created sample scenarios
- Real and fictional situations
- Diverse age ranges and continuum of care

Today
- Telling “what happens next” in the sample scenarios, in a perfect behavioral health system.
- Everyone gets the help that they need

Introduction to Breakout Sessions

Part 1: Ideal responses

- Everyone is assigned to a breakout room.
- Each room has two scenarios, mostly from the September meeting.
- “Writing the story” of what would happen next in a perfect system.

Part 2: Discussion

- Guided discussion in the main room.
- Preparing for Phase 3 by discussing why we gave the answers we did in Part 1.

Part 3: Feedback

- Breakout rooms are open and you may freely move between them.
- Adding to the work done by other groups by offering a different perspective or adding what’s missing.

Discussion

1. What part of making the ideal response did you think was hardest?

2. Was there anything you found surprising or unexpected about making up an ideal response?

3. What did you think was the most important part of the ideal response(s) that your group came up with?

4. What makes that part the most important to you?

Feedback

Room #	Facilitator	Scenario A	Scenario B
1	Nate Lewis	2 1/2 yo - Undocumented, non-English-speaking family	10 yo - aggressive behavior at home and in school
2	Danna Summers	6 yo - suspended from school	16 yo - repeated instances of extreme suicidal thoughts
3	Amanda Lewis	Young parent w/ newborn and toddler - lives with their own parent	14 yo - nonverbal, autism & intellectual disability; aggression and safety issues at home and school
4	sonya Dalazar	23 yo - living independently, struggling with daily living tasks	3 yo - young parent at risk of losing housing due to "unmanageable tantrums"
5	Dana Bogess	18 yo - multiple hospitalizations, suicidal thoughts	15 yo - daily marijuana use; lost interest in friends, activities, school
6	Vashti Langford	21 yo - psychotic, threats to family	19 yo - serious depression, heavy alcohol/marijuana use, limited supports
7	Rachel Burke	13 yo - undiagnosed autism	2 1/2 yo - Undocumented, non-English-speaking family
8	Quentesa Garraway	14 yo - headaches, stomach aches, no known cause	6 yo - suspended from school

Q9 - Do you have comments on the flow of the meeting? What went well? What could be improved? Please specify the date and function of the meeting you are referring to.

Do you have comments on the flow of the meeting? What went well? What could be improved? Please specify the date and function of the meeting you are referring to.

The content used in the breakout groups is way too tactical at this point in the discussion to generate any meaningful input. Admittedly, I am fairly critical of this committee and leadership. It is highly gender and ideologically biased, which ultimately leads to poor solutions. Diverse ideas lead to better outcomes. There is a reason why mental illness is on the rise while at the same time resources and awareness of mental health issues are also increasing. Until those reasons are understood and addressed, this committee will likely create recommendations that do more harm to society than good.

I have enjoyed the flow of each meeting and find them to be very helpful in 1) sharing information and updates and 2) completing some actual work in the breakout groups.

I felt the flow of the meeting was fine. It was hard to see/read the scenarios. Meeting date 11/28

The time and day were perfect. The link didn't work so I couldn't get in

The flow of the 11/28/2023 P25 Behavioral Health Strategic Planning meeting felt good. I appreciated the balance of updates/information with group work. As someone who loves a good Excel spreadsheet, I have to express appreciation for the incredible continuum of care information you have compiled in that format. I am really curious about how you'll portray all of that in a more pictoral/graphic manner!

In the breakout groups, I found myself struggling to offer imagined system ideas at the "right elevation" of action oriented suggestions and practical vs monumental (and perhaps impossible) systems changes. Particularly given the CYBHWG recommendation about adding actionable steps to the scope of work, I was unsure how to focus. Perhaps spending some time with the vignettes individually before talking about them with a group would have helped (I process information more slowly and piecemeal, so jumping right into conversation is a little challenging for me.). I did really like the initial stretch of working with a vignette outside my zone of expertise followed by the opportunity to self-select into breakout groups focused on issues I'm more familiar with. And I liked having access to the jamboard so I could continue to reflect and process and add to it.

the jamboard is great especially the ability to get onto it after the meeting

test

Q20 - Is there anything else we could do to make advisory group meetings better or easier to attend?

Is there anything else we could do to make advisory group meetings better or easier to attend?

No suggestions.

nothing at this time

In person or hybrid options

No, I thought it was easy and smooth. I do wish that we could gather in person at least once because I do think that affects relationships, which really matters in this kind of work. But I know virtual meetings are more accessible for folks statewide, so I'm resigned to this format. :)

maybe rotate times? saw a number of parents headed off to support sports... or dinner

but stable meeting time really helps too for people who set the work schedule around the meeting.

test