Youth and Young Adult Continuum of Care

October 8, 2020

No.	Agenda Item	Leads
1.	**Discussion: Respite services recommendation**	**Proposal: 4th recommendation - Paying for respite services for youth and families.** • Scaleable option – fund as entitlement or direct state to explore respite services as a Medicaid option (HCA, DCYF, DSHS-DDA). • Outside the house, inside the house, with a family member. • Really impt to recognize the hard work the FYSPRTs have done. • Kashi – partner, run the numbers – did someone get this? – number crunching – data for back when it was a Medicaid entitlement. **Decision: Add to list.**
2.	**Update on the DCYF Office of Youth Engagement's activities**	**Greg Williamson** • Don't believe in youth voice unless it's met with responsive action by agencies. • Community does it well. State systems are learning (have a long way to go). • 5 roles: indivs involved in their own planning, youth peers and mentors, teaching adults how to do this work, members of committees, changing policies. • 12 different state agencies attending meetings – interagency learning. • (1) Share meaningful ways to engage youth in making changes in systems. (2) How do we measure this for individuals and agencies – are things getting better? (3) Supporting other organizations' work like Mockingbird. (4) Interagency learning community.
3.	**Youth peer panel**	**SPARK: Carolyn Cox** (Spark Program Manager)**, Brandon Jimeniz** (IT management, Certified Peer Counselor)**, and Maria Nunez** **Aliyah Zeien** (Life Skills Specialist, Youth Advocate) **Tyus Reed** (Peer Engagement Specialist, Casteele, Williams and Associates, and DCYF) **What would help remove barriers for people who want to become a youth peer, once we get people into that role what would retain people in that job?** • More diversity, hiring people of color, people with lived experience. • Equal pay. • Lessen extensive background checks; develop acceptance procedures fo minor offenses. • Shortening the application process; many youth struggle with anxiety. • Assistance with training. • Weekly staff meetings with youth peers to proposesolutions together. • Empower youth to get their degree if they don't have one; don't allow staff to stay on at the same level that they came in. • All self-care days. • Don't look for the perfect person; don't tiptoe around behavioral health issues; with the right treatment, everyone can be a fully functioning adult. • Support from the system you're employed in. **What would help support you in your youth peer role, what kind of supervision to be helpful?** • Developing an action plan – person to help them learn, grow and develop.

		• Training. • Constructive and supportive criticism to help people improve in their role. • • Youth are not getting supervision and coaching – takes a back seat to other things. There is a difference between coaching and supervision – a lot of agencies get it mixed up. • Opportunities to advance, become a supervisor. • Need for emotional support for youth peers who may be experiencing secondary trauma while managing their own recovery. • Peer support groups; statewide virtual peer support group. Have a clinician or system person come in once or twice a month. Share with them what we've come up with. • Newly hired peer staff should fil out a confidential trigger plan, outlining the types of cases that might be difficult for them so staff know when they may need extra support.. • Peer supports and system people have to come together to get to the goal. • Emotional support, share best practices, body to voice/make policy change. Have to bring people together to make changes. **What could be done to recruit more people of color to begin working as youth peers? What would help retain people of color working as youth peers?** • Issue: judgement of lived experience. • End stigma about how we dress and about hair – there are lots of different ways to be professional. • Show you have people of color in leadership and supervisor roles. No one wants to be the token black person. • Environment free of racism, stigma, colorism. Showing you are not in support of racism. • Don't ask them to speak for every POC in America; they are one person.
4.	**Family peer panel**	**Karen Kelly, Jasmine Martinez, and Janice Schutz** **What would help remove barriers to becoming a parent peer?** • Everything that youth partners said is true for parent peers. • 32 hour work week be full time for peer partners. • Most don't feel like they're treated or paid like equals (because of education). • Increased public awareness of parent peers and what they do. Coworkers and parents in community didn't understand my role. • Increased value of the role in agencies; valuing collaboration and the voice we bring to the table. **What would help retain more people working in the parent peer field? What would help support you in your parent peer role? What kind of supervision would be helpful?** • Continuing ed about being a parent peer. Beyond the 40 hr certification training. Used to be additional training in some other progams years ago. Need, for instance, for parents to learn about the systems they aren't familiar with. Also

		about how to work with a clinical team. Goal is about helping families, not helpful to say "you should go on and get more education." • Collaborative training – so clinician understands the peer/partner role as well. Including supervisors. • Peer certification. • Love to see the state create a mentorship program for peers. • Peers are sometimes let go for doing their job too well – they're asked to "tone down their advocacy" for families they support. • Support group for secondary trauma. • Real education around self-care. **What could be done to recruit more people of color to begin working as parent peers? What would help retain people of color working as parent peers?** • Recruiting, sharing the power of the role. **Other issues:** • A way to have an opportunity for peer work to be available for families that aren't on Medicaid/WISe – and in lower levels of care. • Many organizations do either/or – youth can have a peer partner, or parent can have a peer partner. Families shouldn't have to choose. They may not even know that it's a choice/one or the other.
5.	**Youth mobile crisis unit panel**	**Beacon Health Options** • Leah Becknell and Inna Liu **Catholic Community Services of Western Washington** • Julie Bacon, Nolita Reynolds, and Brook Vejo **Comprehensive Healthcare** • Crystal Shipley **Greater Columbia AS-BHO** • Kris Brown **King County CCORS - YMCA** • Dianne Boyd and Angela Cupp **Are there enough teams to meet the need for youth mobile crisis in your region?** • Pierce –Massive increase in referrals in past 2 months; still able to meet the need. Team flexes because they provide other services. • SW – We are meeting the need but are now verging on the edge of our capacity, because there has been a flood of referrals. Record #s coming in, esp. for acute needs kids. Each of these referrals takes more time and is more intense. Really life-threatening crises. We are seeing a huge # of kids with private insurance accessing mobile crisis services – they don't have other resources, not even schools. They are cycling through crisis services over and over and going into inpatient treatment because there is nowhere else. • King Co – barely meeting the needs. Getting increasing acuity of referrals. CCORS not only provides immediate crisis response; it also offer families an enrollment of up to 8 weeks.

		Do you get referrals from 911 directly? Are response times fast enough to address acute crises in progress and avert 911/law enforcement intervention? What would it take to improve response times? • Beacon/Nolita – We are seeing a number of youth with no previous MH history with very acute symptoms and serious suicide attempts. We have prioritized with EMS and law enforcement. We make it work whenever they are willing to partner with us. • Southwest – We don't have the staff to take direct calls. • Greater Columbia – Real capacity issues. Get calls from 911 through the Crisis Line, but there is a delay. • King Co – We don't take direct calls from 911, but law enforcement can get in touch with us quickly through the crisis line – our main source of communication. **What kind of efforts have been made to make the community aware of youth mobile crisis teams as a resource? Has there been any extra push to make parents aware since their children are home from school and experiencing more significant psychological distress?** • Pierce Co: Do outreach to known clinics, providers, schools – quarterly. • King Co: Local Y's, schools, DCYF. **For BH-ASOs: Why do we not have this everywhere? What are the barriers?** • Greater Columbia – different crisis provider over 9 separate counties. They each have their own way of doing things; we are not overly prescriptive. Will take this back to leadership and have conversations with providers. • Crisis response is recovered. Youth crisis is not. So it is a funding issue. ASOs have seen an increase in more ITAs; there have been more court costs. Also people are staying in community beds longer with Western State winding down. This costs the ASOs more, too. There is an assumption that usage is 70% Medicaid. If true utilization does not match, we will need to spend more state $. • Eastern WA: Across all of our counties for august we had a 42 min response time and no youth mobile crisis. If we add this program, where do we get the people and funds? **Other comments:** • Would love to have a deeper rotation, provide clinicians and staff a debrief allowing some time for them to recover from the crisis they are going out to, have youth peers going out on calls with us. • Have people understand the level of crisis, the demand. Youth and family. • Funding for youth mobile crisis statewide. • The sooner we can get to the family faster so they don't have to tell their story twice. • PAL model – commercial plans pay their fair share. • Anything we can do to increase the capacity. • Limited for youth crisis – can only use MHPs who want to work with youth. Want to retain them. That's why we need a deeper rotation. Would be nice to use non-MHPs that go through our extensive training. MHP is not all we need to help a youth in crisis.

		• Nice to have more regional teams in King Co so they are not travelling so far and can respond quicker. • King Co: Medicaid families have to show up at the ER to get seen by the agency. Safely divert hospitalization whenever possible – can increase a youth's suicide risk. What hospitals do and don't need to do to receive reimbursement. • Solution for rural areas – how do you have teams that are responsive? • Crisis is part of a larger system – need a more robust system to prevent crisis and to exit crisis – gaps in system. • DCRs do in-community response within 42 minutes. Do that with crisis responders.

Attendees

Endalkechew Abebaw, HCA
Kashi Arora, Seattle Children's
Lynn Ausley, Parent
Leah Becknell, Beacon Health Options
Kevin Black, Senate Behavioral Health and Human Services Staff
Dianna Boyd, CCORS
Rachel Burke, HCA
Dr. Phyllis Cavens, Child and Adolescent Clinic, Longview
Evelyn Clark, HCA
Diana Cockrell, HCA
Alice Coil, DCYF
Carolyn Cox, SPARK
Angela Cupp, King County CCORS
Rebecca Daughtry, HCA
Representative Lauren Davis, Washington State House of Representatives
Kimberly Harris, HCA
Mandy Huber, HCA
Charlotte Janovyak, Legislative Assistant for Rep. Davis
Brandon Jimenez, SPARK
Michelle Karnath, FYSPRT Tri-lead, Clark County Juvenile Court
Karen Kelly, Parent
Hollie Kelly, Youth/young adult
Inna Liu, Beacon Health Options
Jasmine Martinez, Parent
Taku Mineshita, DCYF
DeShaun Nabors, Community Passageways
Maria Nunez, SPARK
Penny Quist, Parent Advocate
Kris Royal, HCA
Ted Ryle, DCYF
Representative My-Linh Thai, Washington State House of Representatives
Jim Theofelis, A Way Home Washington
Liz Trautman, The Mockingbird Society
Bobby Trevino, Trevino/Davis Consulting
Liz Venuto, HCA
Greg Williamson, DCYF
Aliyeh Zeien, Youth/young adult