

Notes: Youth and Young Adult Continuum of Care subgroup meeting  
 Intensive Services and Family Youth System Partner Roundtables (FYSPRTs)  
 September 3, 2020 – 1 to 3 p.m.

| No. | Agenda Item   | Notes   |
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| 1.  | <p><b>Presentations: Developing a shared understanding Wrap-around with Intensive Services (WISe)</b></p> <p>WISe quarterly reports:<br/>                     - <a href="#">WISe service characteristics</a><br/>                     - <a href="#">WISe screening</a><br/>                     - <a href="#">WISe quarterly dashboard</a></p> <p><a href="#">WISe manual</a></p> | <p><b>Tina Burrell</b>, Children’s Behavioral Health Administrator <i>with Kari Samuel</i>, Research Manager, Division of Behavioral Health and Recovery (HCA)</p> <ul style="list-style-type: none"> <li>WISe response to 2009 lawsuit. Finalized in 2013. Final implementation plan in 2014, began building services in July 2014. This summer, partially exited out of settlement agreement – 24 out of 29, 12 mos. left to resolve remaining 5. Need to continue to demonstrate capacity and service intensity.</li> <li>State Plan services – wrap-around model + state plan services.</li> <li>Requires a team: care coordinator, therapist, youth and family peers.</li> <li>Most say it is the most dynamic and impactful service they’ve received.</li> <li>24/7 crisis response.</li> </ul> <p><b>Megan Boyle</b>, Director of Children’s Intensive Services (Compass Health)</p> <ul style="list-style-type: none"> <li>Started serving 40 clients; now 350 at a time; demonstrates the great need for this service.</li> <li>Outcomes: 1,500 youth seen; only 20 have left and gone into more intensive care.</li> <li>Serve all 5 North Sound counties.</li> <li>Clients range in age from 3-21. Most are middle-school age. A few years ago it was more teenagers. Now we’re able to intervene earlier so they’re better prepared when they transition to adolescence.</li> <li>Get such a bigger picture when not limited to an hour a week; see how they are in their home; opportunity to be partners with the family.</li> </ul> <p><b>Discussion</b></p> <ul style="list-style-type: none"> <li><b>Q:</b> Is respite one of the WISe services?<br/> <b>A:</b> (Tina) Respite is not a Medicaid services so it is not included in the WISe service array.<br/>                     (Megan) We do not provide respite, but recognize it as a need. Our team works to identify ways families can find natural respite with friends/family who can be a longer term resource. This may include inviting those people to team meetings so they can be a part of brainstorming and planning. They also have access to our crisis line when youth is there. It isn’t always perfect, but has been proven helpful</li> <li><b>Q:</b> How does WISe intersect with Behavioral Rehabilitation Services (BRS)?<br/> <b>A:</b> (Tina) For info on providing BRS and WISe concurrently please see <a href="https://www.hca.wa.gov/assets/program/wise_guidance_document_october.pdf">https://www.hca.wa.gov/assets/program/wise_guidance_document_october.pdf</a><br/>                     (Megan) We are now able to provide WISe services to youth enrolled in BRS. This has been a wonderful opportunity for those kiddos to have the intensive mental health services that they qualify for and need. The BRS and WISe</li> </ul> |

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|    |   | <p><i>teams work closely to avoid duplication of services. One of the most helpful part of this has been the addition of the peer which is not part of BRS services.</i></p> <ul style="list-style-type: none"> <li>• <b>Q:</b> What are the criteria for admission to WISE?</li> <li>• <b>A:</b> (Tina) Criteria for WISE is Medicaid eligible, between the ages of birth through 20 and meet eligibility through the WISE CANS screen (which has an algorithm) or with a clinician override to access this intense level of care. Information about the screen and algorithm is included in the <a href="#">WISE manual</a>. (Megan) You also need a mental health diagnosis ☺ We serve many youth who have co-occurring disorders.</li> <li>• It seems that one of the problems in WISE is hiring qualified peers. (Tina) <i>Workforce for all positions has been difficult, definitely a shortage in the state.</i></li> <li>• The critical peer role relates to our conversation last mtg. Also connects with the question re cultural responsivity/impact and outcomes with BIPOC communities. Emphasizing lived experience and reducing barriers to workforce access, recognizing value of lived experience as piece of resume, are all essential to diversity workforce and outcomes with different communities.</li> </ul>   |
| 2. | <p><b>New Journeys First Episode Psychosis</b></p> <p><a href="https://www.newjourneyswashington.org">https://www.newjourneyswashington.org</a></p> | <p><b>Ann Christian</b>, Chief Executive Officer (Washington Council) <i>Handout 1</i></p> <p><b>Becky Daughtry</b>, First Episode Psychosis Program Manager (HCA)</p> <ul style="list-style-type: none"> <li>• 2014 – SAMHSA made a ruling to set aside federal block grant funds for first episode psychosis.</li> <li>• Made substantial progress; nine New Journeys teams.</li> <li>• Large portions of the state still needs this service. We ramping up for expansion in Spokane, North Sound and Salish in the future.</li> <li>• Since starting in 2015, New Journeys has received 565 referrals; currently the 9 sites have 137 active clients; and 39 have graduated from the program. 133 referrals since pandemic started; no decline. Majority of sites still have 75% attendance.</li> <li>• A part of the statewide implementation plan is to take a look at identifying and serving the clinical high risk population, that is, those who are at risk for psychosis but have not yet experienced a first episode psychosis.</li> <li>• Age range is 15-40, with most falling between 18-25.</li> <li>• Contact: <a href="mailto:becky.daughtry@hca.wa.gov">becky.daughtry@hca.wa.gov</a></li> </ul> <p><b>Camie Perretta</b>, Thurston/Mason New Journeys Program Director</p> <ul style="list-style-type: none"> <li>• Received 226 referrals; served 75 individuals; currently have 27 individuals.</li> <li>• Work closely together as a team.</li> <li>• Part of what our team has worked to do is to meet people where they're at – in the community, at their home.</li> <li>• We also have a group where individuals have opportunities to interact and engage with each other, and feel like “a normal adolescent.”</li> <li>• Dealing with self-stigma and societal stigma.</li> <li>• We've had people complete high school, complete GED; one had not completed education since the 8<sup>th</sup> grade at 19 – they completed a GED program in 3 months and held a job for a year without any problem; now working on peer support specialist certificate. Several have gone on to college. One completed a recovery video with WSU last week.</li> <li>• Cannot take clients with autism or low IQ; want to make sure they get the DDA services they need.</li> </ul> |

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|    |  | <ul style="list-style-type: none"> <li>We do work with folks experiencing homelessness. Unfortunately, housing is so limited in our area. We do our best to assist linking individuals to community resources for housing.</li> </ul> <p><b>Discussion</b></p> <ul style="list-style-type: none"> <li><b>Q:</b> Do you support your college enrollees with 504 plans? <b>Yes</b></li> <li><b>Q:</b> Any peers essential to the program?<br/><b>A:</b> (Cammie) We do utilize peers in New Journeys! Peers are a wonderful resource to instill hope and assist individuals in gaining motivation for treatment!</li> <li><b>Q:</b> Do you work with the homeless and do you work with housing issues?<br/><b>A:</b> (Becky) Absolutely – especially engagement and outreach.<br/>(Cammie) We do work with folks experiencing homelessness. Unfortunately, housing is so limited in our area. We do our best to assist linking individuals to community resources for housing.</li> <li>Thank you Ted and Jim for your questions/statements regarding youth of color and the cultural essentials begins with adversity/multicultural workforce.</li> <li><b>Q:</b> Within the regions that do have New Journeys, are they able to meet the entirety of the need within their region?<br/><b>A:</b> The ability for the current teams to meet the need within their region varies. But most regions need a frontier team to fully address the need in rural areas. The urban areas have been overwhelmed with referrals.</li> </ul> |
| 3. | <p><b><a href="#">Family Youth System Partner Round Tables (FYSPRTs)</a></b><br/>2<sup>nd</sup> Substitute House Bill 2737 (2020):<br/><i>[The work group shall:]</i><br/>“...(e) Consider issues and recommendations put forward by the statewide family youth system partner roundtable established in the T.R. v. Strange and McDermott,...settlement agreement.”</p> | <p><b>Liz Venuto</b>, Transition Age Youth Integrated Services Supervisor (HCA)<br/><i>See handouts at end of notes.</i></p> <ul style="list-style-type: none"> <li>FYSPRTs bring people together at the local level.</li> <li>Each FYSPRT is tri-led by a system partner, a family member, and a youth.</li> <li>Platform for families and system partners – to come together and collaborate around problems at the local, regional, and state level.</li> <li>Part of the TR Settlement – to improve services with youth and family input.</li> <li>Communication channel that informs the system.</li> <li><a href="#">FYSPRT webpage</a></li> </ul>   |
| 4. | <p><b>FYSPRT Recommendation Pitch</b></p>  | <p><b>Michelle Karnath</b>, Statewide FYSPRT Family Member Tri-lead; Family Assistance Specialist (Clark County Juvenile Court)</p> <ul style="list-style-type: none"> <li>History: <ul style="list-style-type: none"> <li>Until 2012, respite services were Medicaid billable; change was made as a result of budget cuts.</li> <li>In 2017, a region presented the need for respite services as a challenge at the statewide FYSPRT.</li> <li>The challenge was sent to all regions. Many expressed need. In 2017, only one region had respite services, likely funded through local levies; they no longer have it.</li> <li>In 2018, HCA submitted a decision package for respite services; it was not funded.</li> <li>Respite is currently available only through a DDA waiver and for foster parents.</li> </ul> </li> </ul>  |

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|    |   | <ul style="list-style-type: none"> <li>● <b>Recommendation:</b> Fund behavioral health respite services to support youth and their families staying in their homes and in their communities. <ul style="list-style-type: none"> <li>○ To avoid hospitalization, ER, CLIP, keep families together, juvenile justice system.</li> <li>○ To support single parent families and families with multiple children in services.</li> <li>○ To allow time for essential errands like going to the grocery store, so parents/caregivers know their children are safe.</li> <li>○ To create space to learn new skills.</li> <li>○ To facilitate planned, thoughtful, intentional interventions to increase the stability of the families we are serving.</li> <li>○ Also recommended as part of SB 6560 – youth exiting into homelessness, and help transitioning out of CLIP and other facilities.</li> </ul> </li> <li>● Potential cost savings (not recent; needs to be updated): <ul style="list-style-type: none"> <li>○ JR: Maximum monthly cost is \$3,083 (\$101/day).</li> <li>○ Foster care - \$550-\$6,000-8,000/month.</li> <li>○ Inpatient - \$1,000/day.</li> <li>○ In home respite - \$1,000/week (\$143/day)</li> </ul> </li> </ul> <p><b>Discussion</b></p> <ul style="list-style-type: none"> <li>● <b>Q:</b> I think I heard you say there’s an exception that there is skill-building happening during respite stays? If so, do your recommendations include requirements for these skill-building programs?<br/> <b>A:</b> Not an expectation for skill building – it is an idea that could be provided.</li> <li>● Families are experts on themselves! That cannot be said enough when doing family systems work.</li> <li>● I totally support the need for respite. I would suggest you look at the Mockingbird Society Family Model-a model I designed from my experience in foster care. One of the problems I wanted the MFM to address is to ensure the respite was “relationship based” e.g. respite provided by someone the child/youth has an existing, positive relationship with. Too often in foster care the respite is provided by someone unknown to the child/youth. Secondly, suggest the model allow that youth can also initiate respite which is a developmentally appropriate skill-many kids get this when they spend the night at a friend’s house. But this also allows for respite to be something that avoids crisis by taking the break when needed rather than responding to crisis by waiting long. What I hear from youth is that respite typically means “someone who needs a break from me” so I think the respite model can have some intentional elements that address developmental building in emotional/behavioral regulation.</li> <li>● I have looked at that model. I really liked its engagement and relationship and trust building skills.</li> <li>● I fully support Jim’s suggestion that we look to the MFM model – as a former child welfare staff, I was the liaison for a MFM constellation here in Thurston County and respite worked AMAZING well within the model!</li> </ul> |
| 5. | <p><b>Recommendation Pitch</b><br/> More robust services for youth and families prior to a crisis developing, including more peer support, more robust crisis responses, and Level 3 services</p> | <ul style="list-style-type: none"> <li>● Provide more services earlier to avoid more challenging problems and more costs, in terms of personal trauma and expensive treatment, later.</li> </ul>   |

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| 6. | <p><b>Small Group Discussion</b><br/>Priorities and recommendations</p> | <p>1. Short-term:</p> <ul style="list-style-type: none"> <li>• What is the highest need at this time, <i>or</i></li> <li>• A strength we want to ensure continues?</li> </ul> <p><b>Group 1/Nicole:</b> Impossible question – priority is to build the entire continuum of care that has all elements- prevention/early intervention, outpatient, intensive services – give the efforts enough time to see if interventions are working. EBP outcomes measures are difficult to quantify in EBP metrics. Continue providing the services that are working (SPARK, Promoting First Relationships, WISE)</p> <p><b>Group 2/Ted:</b></p> <ul style="list-style-type: none"> <li>▪ Early/preventive- how do we truly integrate bx health in to primary care so it includes schools and child serving organizations.</li> <li>▪ Deep end- services and supports to maintain relationship, connections, supports with youth removed form and returning to community.</li> <li>▪ Who are we not serving? What do we need to serve those communities? Need to not start or be broader then EBPs, which are typically normed with primarily white populations.</li> </ul> <p><b>Group 3/Rachel</b></p> <ul style="list-style-type: none"> <li>▪ Crisis services and intermediate levels of care. Fill in the continuum (step up/step down).</li> <li>▪ Fully fund telehealth.</li> </ul> <p><b>Group 4/Janice</b></p> <ul style="list-style-type: none"> <li>▪ An expansion of both inpatient and outpatient services is needed to provide more options and capacity.</li> <li>▪ More services are needed to fill gaps created by reduced youth detention in JR.</li> <li>▪ More supports for families.</li> </ul> <p>2. Long-term:</p> <ul style="list-style-type: none"> <li>○ What is the most important change that needs to be made, <i>or</i></li> <li>○ What service, strategy, or approach should be expanded?</li> </ul> <p><b>Group 2/Ted:</b> How do we break down silos between health care, JJ and school systems? And how can earlier interventions in those contexts support preventive work to reduce need for later/higher level interventions, or services out of home- meet young people and families where they are without silos and barriers.</p> <p>This also can reduce stigma, especially if definitions are expanded, without same level or emphasis on ‘pathology’- e.g. diagnoses.</p> <p><b>Group 3/Rachel</b></p> <ul style="list-style-type: none"> <li>▪ Provider rates/workforce – really hard ot convince people to enter/ stay in the field when we don’t pay them.</li> <li>▪ Forgive student loans, like we did in the nursing crisis.</li> <li>▪ General access to civil legal aid with young people. Work closely with clinical people.</li> <li>▪ Partnership opps with the school system – mandated MH education, beyond SEL. Standardize and require SEL and MH education.</li> <li>▪ Add MH counselors, not just navigators, to districts and schools. School role in prevention.</li> </ul> |
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**Group 4/Janice**

- Our system needs to allow for more individualized service and supports for families and youth.
- Services must treat the whole family – not just the youth in crisis.
- Better crisis response with non-law enforcement teams.

3. Recommendations:

- What is one recommendation I want to make?
- Is this a policy recommendation or does it have a cost? Is the cost high, medium or low? (*It's okay to say "I don't know."*)

**Group 1/Nicole:** Listening to most of the programs that have been presented, seems like there is a big difference in all of these. Families are so unique and a lot of this has to be able to categorize what is best for a specific situation. Prioritizing by who needs what, what is available and what is the specific circumstances. Behavioral health needs impact all walks of life. We need to be able to provide a dynamic robust services and provide individualized treatment needs and services to match to the families we serve. Identifying experts with lived experience who are willing to do the boots on the ground work. We must have a wide variety of services available in every county.

**Group 2/Ted:**

Back: DSHS data (A Way Home WA)- mostly youth returning from behavioral health facility (Or JR facility). These are youth with courage to go inpatient. Vicarious trauma prevalent among workers in this space as consequence of inadequate services- releasing youth to shelter or context where drugs are present. (Reach in with community supports, leverage tech to coordinate care)

Front- Coordinated care, with statewide plan and infrastructure to eliminate silos, and coordinate virtually (telemed/EMR) – tech allows wrap around/modified WISE responsive to family needs, and exchange data virtually.

Match/responsive- How to offer community-based partnership and supports that are outside of the system stigma that is responsive to fact that many communities/people in communities may do everything to avoid system contact, based on past experiences/messages from system- develop supports that meet people where they are that are separate/independent of systems.

**Group 4/Janice**

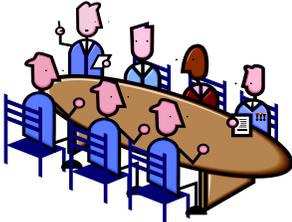
- Expand the youth mobile crisis team model that is available in the SW region statewide.
- More services available to youth and families at lower stages of need (early intervention), including peer services and respite.
- Better support for marginalized and non-English speaking communities.
- Enhance WISE to a higher fidelity model with flex funds for supporting families in an individualized manner.

## Attendees

Kashi Arora (Seattle Children's)  
Janet Bentley-Jones (Clark County Juvenile Justice)  
Eric Boelter (Seattle Children's)  
Megan Boyle  
Rachel Burke (HCA)  
Tina Burrell (HCA)  
Dr. Phyllis Cavens (Child and Adolescent Clinic, Longview)  
Ann Christian (Washington Council for Behavioral Health)  
Rosemarie Clemente (DCYF)  
Diana Cockrell (HCA)  
Rebecca Daughtry (HCA)  
Rep. Lauren Davis  
Kaila Epperly (Lutheran Community Services NW)  
Brad Forbes (NAMI)  
Ann Gray (OSPI)  
Kimberly Harris (HCA)  
Libby Hein (Molina Healthcare)  
Avreayl Jacobson (King Co Behavioral Health and Recovery)  
Charlotte Janovyak (Asst to Rep. Davis)

Kim Justice (Office of Homeless Youth, Dept of Commerce)  
Michelle Karnath (Clark County Juvenile Court, FYSPT Parent Tri-lead)  
Laurie Lippold (Partners for Our Children)  
Erin Shea McCann (Legal Counsel for Youth and Children)  
Nicole Miller (DCYF, FYSPT Tri-lead)  
Taku Mineshita (DCYF)  
Kayla Jessica Newcomer  
Penny Quist (Parent advocate)  
Cammie Perretta  
Kristin Royal (HCA)  
Ted Ryle (Juvenile Rehab, DCYF)  
Kari Samuel (HCA-DBHR)  
Janice Schutz (Washington State Community Connectors)  
Anne Stone (DSHS Fatherhood Council)  
Jim Theofelis (A Way Home Washington)  
Bobby Trevino (Consultant)  
Liz Venuto (HCA)  
Kimberly Wright (HCA)

## FYSPRT - Frequently Asked Questions

| Question   | Answer  |
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| <p><b>What is a FYSPRT?</b></p>   | <p>FYSPRT stands for Family Youth System Partner Round Table. They create a platform for family, youth and system partners to collaborate, listen, and incorporate the voice of the community into decision making at the regional and state level. FYSPRTs are based on the core values of System of Care including: <b>family and youth driven; community based; and culturally and linguistically competent</b>. All FYSPRT meetings are open to the public.</p> <p>FYSPRTs are a critical part of the Governance Structure that includes family, youth and system partner voice. It is a required element of the <a href="#">TR Settlement Agreement</a> agreed on by the plaintiffs and Washington State to inform children’s behavioral health system change.</p> |
| <p><b>What is the Vision of FYSPRT?</b></p>  | <p>Through respectful partnerships, families, youth, systems, and communities collaborate, influence, and provide leadership to address challenges and barriers by promoting cohesive behavioral health services for children, youth and families in Washington State.</p>  |
| <p><b>What is the Mission of the FYSPRT?</b></p>   | <p>Family, Youth and System Partner Round Tables provide an equitable forum for families, youth, systems, and communities to strengthen sustainable resources by providing community-based approaches to address the individualized behavioral health needs of children, youth and families.</p>  |
| <p><b>How many FYSPRTs are there?</b></p>  | <p>There are ten regional FYSPRTs and one Statewide FYSPRT. Click the link to see a <a href="#">map of the regions</a>. Each regional FYSPRT is led by a family, youth, and system partner Tri-lead. The Tri-leads from each regional FYSPRT plus state partners from multiple child serving systems make up the membership of the Statewide FYSPRT.</p>  |
| <p><b>How can FYSPRT support community needs of youth, families and system partners?</b></p>                       | <p>FYSPRTs support the community needs of youth, family, and system partners through collaboration, listening, and resource sharing. FYSPRTs provide a forum to make connections with others in the community, offering validation and hope.</p>  |
| <p><b>What can I expect to happen at a FYSPRT Meeting?</b></p>   | <p>At a FYSPRT meeting you can expect a safe, collaborative, welcoming environment to share your thoughts, voice, and listen and learn from others. It is a place where different perspectives can come together to build relationships and develop suggestions for ways to make things work better. You can propose topics to add to the current meeting agenda and/or to a future meeting agenda that addresses a need or needs important to your community.</p>  |
| <p><b>How do we as a FYSPRT make a difference?</b></p>   | <p>FYSPRTs make a difference by welcoming the voice of youth, family and system partners in sharing strengths and needs regarding behavioral health services for youth. Information and feedback discussed at FYSPRTs have the potential to initiate and influence system-wide change at the regional and state level.</p>  |
| <p><b>What is my role/ how do I fit?</b></p>   | <p>Each person coming to the table brings a unique perspective, please come to a meeting to explore how you fit it.</p>   |
| <p><b>What is Youth Voice and why are youth so important to this?</b></p>  | <p>Youth Voice is really about what you have to say! As a youth in our community, your views and experiences are valuable, and by giving “youth voice”, you have the opportunity to give helpful input about systems, from the view of a young person receiving services. Most of all, your voice is valuable because nobody knows you better than you!</p>   |
| <p><b>How is my FYSPRT connected to other local initiatives and partners? What topics are being addressed?</b></p> | <p>Since each Regional FYSPRTs answer may be different, please <a href="#">visit the website for the Regional FYSPRT in your area to get more information</a>.</p>  |
| <p><b>Where can I get more information about FYSPRTs and how I can get involved?</b></p>                           | <p>There are several options for getting more information about the Regional FYSPRTs and the Statewide FYSPRT:<br/> <a href="#">FYSPRT webpage</a> on the <a href="#">Health Care Authority website</a><br/> <a href="#">Regional FYSPRT websites</a></p>   |

## **Behavioral Health Respite 2020**

### *Briefing document for the Youth and Young Adult Continuum of Care Subgroup*

#### **Context for challenge/history of the challenge from the regions (if any).**

The Statewide FYSPRT initially moved this challenge around the need for youth behavioral health respite forward in 2017 after identifying this as a need statewide for youth and families. In 2017, only one region had behavioral health respite for youth ages 10-18, paid for by regional sales tax dollars. The remaining nine regions identified no access to respite through behavioral health services. [Click this link to read the briefing paper/response from 2017 for more details.](#)

Up to July 1, 2012, respite services were provided through Medicaid as part of the 1915(b) waiver. When this waiver was terminated due to Legislative action and proposed budget cuts, funding for respite became dependent on other funding available in the regions. For example, Regional Service Networks could identify state or block grant funds to be utilized for respite services if outlined in their expenditure plans for state or block grant funding.

#### **Statewide FYSPRT discussion/context**

Since 2017, youth behavioral health respite services continues to come up as a need/theme in many dialogues at the Statewide FYSPRT. One area of need is around community resources to support youth and families in the home to prevent hospitalization or placement in a Children's Long Term Inpatient Program (CLIP) or juvenile detention facility. It has also come up as a need to support long term success for youth who are discharging from CLIP or other institutional placements. In addition, youth behavioral health respite was identified as a recommendation from the Substitute Senate Bill (SSB) 6560 workgroups. These workgroups were formed to develop recommendations to make sure that no youth is discharged into homelessness from a system of care (such as behavioral health, juvenile rehabilitation, foster care). Add sentence here about cross system group/May 26 webinar. Currently, there is an active Cross-Agency Coordination of Children in Complex Situations workgroup that has identified respite (with ABA trained providers) as a potential service to meet the needs of youth and families.

Per information gathered by the Statewide FYSPRT in 2020, respite services as part of behavioral health are not available and when respite services are available [through Developmental Disabilities Administration (DDA) and the Department of Children, Youth, & Families (DCYF)], they are very limited and difficult to access.

Additional information gathered by the Statewide FYSPRT in 2020 is below identifying who has the most critical need for respite:

- Families and youth that experience complex behavioral/medical health needs (or other complex diagnosis – for example developmental disabilities and mental health).

- Single parent families or families with multiple children in services.

The Statewide FYSPRT also gathered information about what situations or circumstances behavioral health respite would be helpful to keep youth with their families and in their communities:

- To prevent use of emergency departments or higher level of care (such as CLIP, juvenile justice, or behavioral rehabilitation services) or prevent escalation (police involvement).
- To assist with transitions from inpatient or CLIP back home to increase long term success.
- Assist children/youth having a difficult time with family dynamics/environment.
  - Respite provides a break from volatile home situations that allows for time to learn and practice skills in safe environments (for both children and parents), to improve family functioning, avoid family conflict, stabilize the household, and support safety in the household.
  - Prevent running away and youth becoming homeless.
- To manage or prevent crisis through planned, routine breaks while knowing your child is safe.
  - Avoid burnout and help caregivers stay healthy and able to better meet the needs of their child/youth.
  - Opportunity for learning and practicing skills when not in crisis.

Potential cost savings from supporting youth and families in the community and avoiding the cost of hospitalization or being placed in an institutional setting such as CLIP or juvenile rehabilitation facility.

### **Attempted Solutions**

Efforts since 2017 have included the Statewide FYSPRT members identifying this as a priority need for youth and families. In 2017, the Regional FYSPRTs gathered information related to the availability of respite in their region to share at the Statewide FYSPRT. The information included whether or not youth and families have adequate access to respite services in their region and if so, what does that respite look like. And if not, what were the main challenges or barriers in the region to access respite. This information gathering revealed that most regions in the state did not have access to behavioral health respite although had some access through Developmental Disabilities Administration and the Department of Children, Youth, & Families (if the youth was enrolled in foster care or developmental disability services). In October 2017, the Statewide FYSPRT Tri-leads presented this challenge to the Children’s Behavioral Health Executive Leadership Team (CBH ELT) along with two recommendations from the Statewide FYSPRT:

1. Work on the state plan to include respite offered through behavioral health, much like personal care and nursing is currently offered through Health Care Authority.
2. Offer additional supports to informal and natural supports through Child and Family Teams.

Although the CBH ELT response was that a state plan amendment was not something the state would pursue at that time, the Division of Behavioral Health and Recovery (DBHR) identified continued exploration of how to resolve this challenge.

In 2018, the Division of Behavioral Health and Recovery submitted a decision package to the Office of Financial Management requesting state dollars to fund youth behavioral health respite services, however, youth behavioral health respite was not included in the Governor's proposed budget for the Health Care Authority.

### **Who should we be coordinating with?**

- Developmental Disabilities Administration – around how youth behavioral health respite might impact their funding to provide respite.
- Department of Children, Youth, & Families – around how youth behavioral health respite might impact their funding to provide respite.
- Department of Commerce, Office of Homeless Youth – around recommendations that came from workgroups for SSB 6560 for respite services.
- Cross-Agency Coordination of Children in Complex Situations; Health Care Authority Convenes..

### **Perceived barriers**

Depending on funding type, some other child serving systems who offer respite services may be affected. Workforce challenges and availability of youth behavioral respite providers. Each region having access to youth behavioral health respite. State budget challenges as a result of COVID-19.

### **Recommendations from the Statewide FYSPRT**

The Statewide FYSPRT recommends that youth behavioral health respite services be funded to support youth and families in their communities and prevent hospitalization, emergency department use, placement in juvenile detention facilities, and homelessness.

Additional recommendations and feedback from the Statewide FYSPRT when looking at program development or funding requests for youth behavioral health respite include:

- Family and youth have the choice to accept the respite or not.
- Respite is discussed with youth and family present and the choice of providers is driven by youth and family voice.
- Flexibility of respite to match youth and family need. Such as:
  - Crisis stabilization
  - Planned/preventative respite - once a week, every other week, once a month
  - In home respite – where the child may be most comfortable

- Out of home – could be like going to a “healthy” friends home, a place that supports wellness and gives adolescents a chance to re-group, re-ground themselves and gain necessary tools needed to return back home
  - short term/brief
  - long term/30 days
  - drop in respite centers for daily respite with well-trained peer counselors to reduce traumatization
  - recovery crisis centers or youth crisis house in each county
- Respite should be available in all regions.
- Wraparound with Intensive Services (WISe) should have a respite component with its services.
- Respite availability for a variety of ages.
- Training for the respite provider on the specific needs of the individual/family.
- Respite is not just for Medicaid families - make youth behavioral health respite available to all youth and families, including those on private insurance.
- Respite should provide a place where the child/youth feels confident and safe. Sensitivity to respite services not turning into a traumatic event for the youth and family.
  - Possibly natural supports who are paid and receive training
  - Collaboration with families, youth and respite providers. Asking the youth and family what respite looks like for them.
  - Ensure providers are trained or willing to be trained in cultural bias/trauma.
    - Create a vetting process for respite providers around attitude, culturally appropriate care, knowledge and application of Children’s Behavioral Health Principles, etc.
- Respite services that involve building trust and a positive relationship while learning and practicing new skills with a professional.
- Respite as a way to gain skills to support the youth and family in reaching their therapeutic goals.

Report to:

Southwest Washington Accountable Community of Health

# SOUTHWEST WASHINGTON BEHAVIORAL HEALTH SERVICES

CURRENT STATE OF AND GAPS IN BEHAVIORAL HEALTH SERVICES IN SOUTHWEST  
WASHINGTON

November 23, 2019

Program and Policy Insight



Contact: Kendra Lodewick  
[klodewick@programandpolicy.com](mailto:klodewick@programandpolicy.com)  
541/514.2687  
[www.programandpolicy.com](http://www.programandpolicy.com)

## TABLE OF CONTENTS

|   |    |
|---|----|
| Table of Contents .....   | 2  |
| Introduction .....  | 3  |
| Statewide Context .....   | 3  |
| Southwest Washington Behavioral Health Services and Gaps .....                    | 5  |
| Clark County .....  | 9  |
| Klickitat County .....  | 11 |
| Skamania County .....   | 13 |
| Cross-County Southwest Washington Behavioral Health System Findings .....         | 14 |
| Southwest Washington Behavioral Health Priorities and Funding Opportunities ..... | 14 |

## INTRODUCTION

Washington's behavioral health system is transforming to better support individual's mental health and substance use disorder needs, treating more adults and children at home, in their communities, and in smaller facilities. The behavioral health system changes began in 2016 with Fully Integrated Managed Care (FIMC) and continue to evolve, in part, as a result of a settlement from the Trueblood v DSHS lawsuit, Governor Inslee's Behavioral Health Five-Year Plan and related legislative initiatives. These changes are collectively overhauling the state's behavioral health system into a patient-centered system with increased capacity to treat people effectively in their communities.

This report provides information on the state's and southwest region's behavioral health systems to support decision-making. Specifically, the report provides additional statewide context, maps current behavioral health services in southwest Washington, identifies gaps in current behavioral health services, and prioritizes needs. This report is not a needs assessment or a comprehensive assessment of service contexts and gaps; rather it summarizes stakeholder input on context, gaps, and funding priorities provided through a facilitated process.

## STATEWIDE CONTEXT

Washington's behavioral health care system is undergoing significant change as it implements various initiatives associated with, but not limited to, Trueblood and the Governor's Behavioral Health Plan. The state is implementing the following strategies in the first phase (2019-2021 biennium) of the Trueblood Settlement, which includes southwest Washington:<sup>1</sup>

- **Competency evaluation** access through additional staff.
- **Competency restoration team** enhancement, including creation of residential support for outpatient competency restoration.
- **Crisis triage/crisis stabilization and mobile crisis team** enhancement.
- **Diversion support** for people with behavioral health needs arrested for misdemeanors.
- **Engagement and outreach** through intensive case management and case finding services focused on individuals identified as high (and potentially high) utilizers of the forensic mental health system.
- **Housing supports** including forensic Housing and Recovery through Peer Services (HARPS) teams, supportive housing services and transitional housing vouchers, and intensive case management.
- **Forensic navigators** to be hired.
- **Forensic bed capacity** increased.
- **Technical assistance** for jails.

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<sup>1</sup> Washington State Health Care Authority, Department of Social and Health Services, 2019-2021 Biennial Budget Summary for Trueblood Agreed Settlement

- **Crisis Intervention Training (CIT)** to law enforcement agencies and increased funding for the Criminal Justice Training Center (CJTC) and the Washington Association of Sheriffs and Police Chiefs (WASP) co-responders.
- **Workforce development** to support settlement requirements.
- **Enhanced peer support** including continuing education curriculum for peer counselors in the criminal justice system and new peer respite centers.

The Governor’s five-year behavioral health plan aligns with and enhances Trueblood Settlement requirements through broader, systemic change to the state’s behavioral health system. The plan specifically:<sup>2</sup>

- **Expands behavioral health treatment options** ensuring a full continuum of care for individuals with behavioral health needs, including those who are diverted from and transitioning out of state hospitals and the criminal justice system.
- **Increases housing supports** through: pairing stable housing with community treatment options; providing rental assistance for permanent supportive housing; and increasing funding for the Housing Trust Fund for permanent supportive housing.
- **Enhances workforce development** including compensation increases and loan repayment for state hospital employees, new behavioral health scholarships, increased psychiatry residency positions, and training and support for behavioral health providers caring for people in the community.
- **Increases access to appropriate community-based facilities** by: moving all civil commitments into the community over time through community provider increases and new state owned and operated facilities in local/regional settings; expanding the capacity to divert and discharge people from state hospitals through increased community capacity; beginning work on state-operated behavioral health facilities in smaller, community-based settings; the pre-design of a behavioral health focused teaching hospital at the University of Washington; and two new secure withdrawal facilities, including an Enhanced Services Facility (ESF) which will provide a community placement option for individuals whose complicated personal care and behavioral challenges do not rise to a level that requires an institutional setting and a Behavioral Health Intensive Facility (BHIF) with limited egress for people coming from the state hospital.
- **Continues to invest in state hospitals** through critical infrastructure improvements.

This work has resulted in several administrative changes in Washington’s behavioral health system, including:

- The Division of Behavioral Health and Recovery (DBHR) was moved from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA). DSHS was the respondent of the Trueblood lawsuit and still houses the forensic behavioral health division.

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<sup>2</sup> 2019-21 Budget & Policy Highlights, *Transforming Washington’s Behavioral Health Care System*

- The Department of Commerce manages most capital funds for new behavioral health facilities. The Washington State Department of Health is often also involved due to licensing issues.

This means legislative, regulatory, and policy changes can involve up to four departments (DSHS, HCA, Commerce, and Health). Department stakeholders are in the process of developing tools to coordinate and collaborate effectively within the new administrative structure.

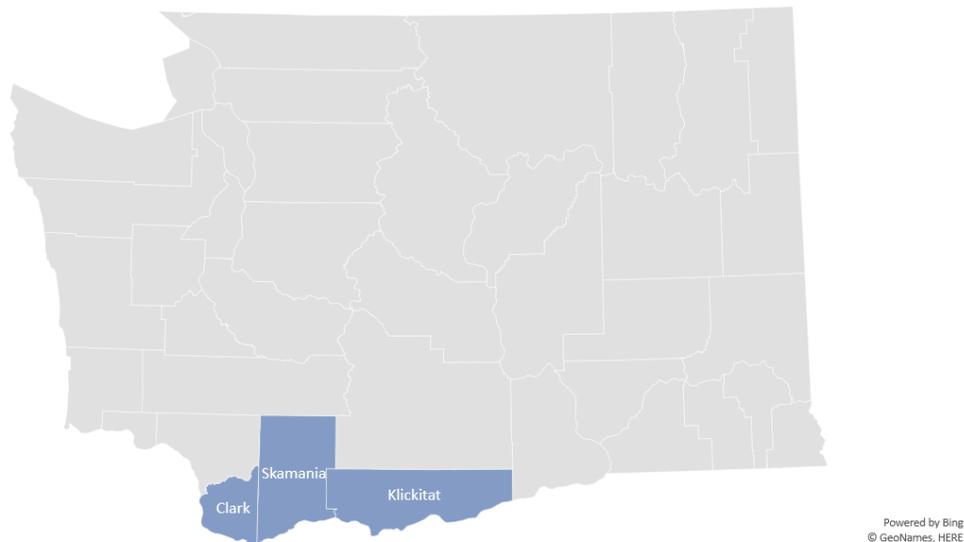
As the state implements Trueblood requirements, clarity is needed about the two types of funding (fines and settlements) and the three resultant initiatives (Trueblood Grants, Trueblood Settlement, and Prosecutorial Diversion). Additionally, sustainability of behavioral health system development occurring under Trueblood is reliant on ongoing state leadership and funding, which is not fully guaranteed or secured.

## SOUTHWEST WASHINGTON BEHAVIORAL HEALTH SERVICES AND GAPS

### OVERVIEW

The southwest region of Washington is comprised of three counties – Clark, Klickitat, and Skamania.

Figure 1. Southwest Washington map



Clark County is the largest of the three counties, with demographics most closely resembling those of the state. Klickitat and Skamania counties are geographically larger and more rural, with less racial/ethnic diversity and higher disability and poverty levels.

Figure 2. Southwest Washington county demographic information<sup>3</sup>

<sup>3</sup> US Census Bureau, QuickFacts Clark County, Washington; Klickitat County, Washington; Skamania County, Washington; Washington, <https://www.census.gov/quickfacts>

|   | Clark County | Klickitat County | Skamania County | Washington |
|---|--------------|------------------|-----------------|------------|
| <b>Population estimates, July 1, 2018</b>           | 481,857      | 22,107           | 11,924          | 7,535,591  |
| <b>Persons under 18 years, %</b>                    | 23.9%        | 19.4%            | 18.5%           | 22.1%      |
| <b>Persons 65 years and over, %</b>                 | 15.5%        | 23.9%            | 21.0%           | 15.4%      |
| <b>White alone, not Hispanic or Latino %</b>        | 78.0%        | 82.1%            | 87.6%           | 68.0%      |
| <b>Hispanic or Latino %</b>                         | 10.0%        | 11.9%            | 6.3%            | 12.9%      |
| <b>Two or more races, %</b>                         | 4.3%         | 2.9%             | 3.2%            | 4.8%       |
| <b>Asian alone, %</b>                               | 4.3%         | 0.9%             | 1.0%            | 9.3%       |
| <b>Black or African American alone, %</b>           | 2.3%         | 0.7%             | 0.7%            | 4.3%       |
| <b>American Indian and Alaska Native alone, %</b>   | 1.2%         | 2.6%             | 1.9%            | 1.9%       |
| <b>With a disability under age 65, %, 2013-2017</b> | 8.6%         | 14.3%            | 10.1%           | 9.0%       |
| <b>Persons in poverty, %</b>                        | 10.2%        | 14.5%            | 12.0%           | 11.0%      |

Washington has one of the highest rates of mental illness nationally, with 24 percent of adults statewide experiencing a diagnosable mental health condition and seven percent meeting criteria for a serious mental illness.<sup>4</sup> Available behavioral health data show the southwest Washington region to generally be in line with statewide trends. Klickitat and Skamania counties have higher reported suicide rates; however, their small population size means small numbers can have an outsized impact on population percentages. Among adults statewide, self-reported poor mental health was more prevalent among females, those under 24 years of age, and American Indian or Alaskan Natives. People with less education and less income generally reported poorer mental health.<sup>5</sup>

Figure 3. Southwest Washington population behavioral health status

|   | Clark County | Klickitat County | Skamania County | Washington |
|---|--------------|------------------|-----------------|------------|
| <b>Adult poor mental health days (per 30 days)<sup>6</sup></b>                                | 3.8          | 4.1              | 4.3             | 3.8        |
| <b>Adult population reporting 14 or more poor mental health days per month, %<sup>7</sup></b> | 11%          | 12%              | 12%             | 11%        |
| <b>Suicide crude rate per 100,000<sup>8</sup></b>   | 15.2         | 18.3             | 25.5            | 14.2       |
| <b>Adult binge drinking, %<sup>9</sup></b>  | 18%          | 16%              | 17%             | 18%        |
| <b>Patients with any opioid prescription, rate per 1,000, all ages<sup>10</sup></b>           | 63.8         | 38.8             | 61.3            | 60.9       |

<sup>4</sup> Washington State Institute for Public Policy, *Inpatient Psychiatric Capacity and Utilization in Washington State*, 2015. [https://www.wsipp.wa.gov/ReportFile/1585/Wsipp\\_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State\\_Report.pdf](https://www.wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf)

<sup>5</sup> 2018 Washington State Health Assessment.

<sup>6</sup> Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute School of Medicine and Public Health, County Health Rankings & Roadmaps, <https://www.countyhealthrankings.org/app/>

<sup>7</sup> Ibid

<sup>8</sup> Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Causes of Death 1999-2017 on CDC WONDER Online Database, released December 2018, ICD-10 codes X60-X84 Intentional Self Harm

<sup>9</sup> Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute School of Medicine and Public Health, County Health Rankings & Roadmaps, <https://www.countyhealthrankings.org/app/>

<sup>10</sup> Washington State Department of Health, Opioid Prescriptions Dashboard – County, 2019 Q1, <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/OpioidPrescriptionsandDrugOverdosesCountyData>

In general, southwest Washington’s behavioral health system capacity is lower than the statewide average, with less overall capacity in rural Klickitat and Skamania counties.<sup>11</sup> The figure below shows that Clark County has larger numbers of mental health providers and psychiatrists compared to Klickitat and Skamania. The Washington State Directory of Certified Mental Health, Substance Use Disorder, and Problem & Pathological Gambling Services<sup>12</sup> shows that Clark County has 24 substance use disorder providers, compared to one in Klickitat (Comprehensive Healthcare in Goldendale and White Salmon) and one in Skamania (Skamania County Community Health).

Figure 4. Southwest Washington behavioral health provider overview<sup>13</sup>

|   | Clark County | Klickitat County | Skamania County | Washington |
|---|--------------|------------------|-----------------|------------|
| <b>Mental health providers (one provider for number of residents)</b> | 360          | 790              | 820             | 330        |
| <b>Psychiatrists (rate per 100,000)</b>                               | 5.4          | 0                | 0               | 10.1       |

#### BEHAVIORAL HEALTH DISPARITIES BY RACE/ETHNICITY

National data suggests that individuals from racial and ethnic minority groups experience worse behavioral health access, status, and treatment outcomes than their peers from non-minority groups.<sup>14</sup> The National Institute of Mental Health states that “members of racial and ethnic minority groups in the U.S. are less likely to have access to mental health services, more likely to use inpatient hospitalization and emergency rooms, and more likely to receive lower quality care.”<sup>15</sup> Nationally, among low-income adults with a mental illness, whites utilize mental health services more than their black or Hispanic peers, cost is the most commonly report barriers to using mental health services, and use of mental health services is relatively low among blacks, Asians, and Hispanics.

The National Alliance on Mental Illness identifies the following barriers that prevent racial and ethnic minorities for accessing and receiving appropriate behavioral health care:<sup>16</sup>

- Lack of availability
- Logistical barriers related to lack of transportation, child care, or ability to take time off of work
- The belief that mental health treatment is ineffective
- Perceived stigma associated with mental health conditions
- A mental health system aligned disproportionately with non-minority values and norms
- Racism, bias, and discrimination in treatment settings
- Language barriers and insufficient language capacity among providers

<sup>11</sup> University of Washington Center for Health Workforce Studies, AMA Physician Masterfile, 2016 Analysis

<sup>12</sup> <https://www.hca.wa.gov/assets/free-or-low-cost/directory-certified-behavioral-health-agencies.pdf>

<sup>13</sup> University of Washington Center for Health Workforce Studies, AMA Physician Masterfile, 2016 Analysis

<sup>14</sup> National Conference of State Legislatures: The Costs and Consequences of Disparities in Behavioral Health Care. February 2018. Accessed November 23, 2019. [http://www.ncsl.org/Portals/1/HTML\\_LargeReports/DisparitiesBehHealth\\_Final.htm](http://www.ncsl.org/Portals/1/HTML_LargeReports/DisparitiesBehHealth_Final.htm)

<sup>15</sup> National Institute of Mental Health, “[Minority Health and Mental Health Disparities Program](#)” (Bethesda, Md.: NIMH, n.d.).

<sup>16</sup> Shushansky, Larry. Disparities Within Minority Mental Health Care. National Alliance on Mental Illness. July 31, 2017.

- Lack of adequate health insurance coverage

Low use of medication and poor doctor-patient communication were also identified as key barriers to equitable access to and treatment of mental illness across racial and ethnic populations.<sup>17</sup>

Washington state and the Southwest Washington region face similar disparities in mental health for non-white populations. For example, data from the Washington Health Alliance show poorer behavioral health outcomes for Black and Latinx populations compared to other peer racial groups.<sup>18</sup> In the Columbia River Gorge region, which includes Skamania County and Klickitat County, mental health diagnosis are more widespread among Non-Hispanic whites, low-income, and Medicaid populations. Furthermore, low-income and Medicaid populations face the greatest access challenges to behavioral health care.<sup>19</sup> In Clark County, American Indian and Hispanic youth populations experience increased incidence of poor emotional or mental health. Black, American Indian, and Hispanic youth populations also experience increased rates of substance abuse.<sup>20</sup> Moreover, the Clark County 2019 Community Health Needs Assessment identifies discrimination and racism and trauma as the key drivers of health outcomes, including behavioral health, and social factors, including access to health care, community representation, and culturally responsive care.

In 2017, the National Conference of State Legislatures identified several approaches for reducing health disparities that have been adopted in states across the country:<sup>21</sup>

- Improving awareness about difference in behavioral health status and access to services
- Addressing behavioral health disparities directly and indirectly
- Engaging diverse perspectives and populations
- Promoting cultural and linguistic competence

Additionally, recent review of behavioral health literature suggests increasing cultural and linguistic competence and integrated health care as key strategies to reduce disparities. These themes emerged during stakeholder facilitation regarding the current state of and gaps in behavioral health services in Southwest Washington, as described below. Further development of these issues can support more equitable care all across racial and ethnic groups.

The subsections below summarize current behavioral health services and gaps for Clark, Klickitat, and Skamania counties.

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<sup>17</sup> Sanchez, K., and R. Ybarra, T. Chapa, O. Martinez. Eliminating Behavioral Health Disparities and Improving Outcomes for Racial and Ethnic Minority Populations. *Psychiatric Services in Advance*.

<sup>18</sup> Washington Health Alliance. 2016 Disparities in Care: Increasing Health Equity in Washington State.

<sup>19</sup> Columbia Gorge Health Council: Columbia Gorge Regional Community Health Assessment, 2016.

<sup>20</sup> 2016 Clark County Population Health Indicator Table. Retrieved November 23, 2019.

[https://www.clark.wa.gov/sites/default/files/dept/files/public-health/data-and-reports/2016\\_CC\\_Population\\_Health\\_Indicator\\_Table.pdf](https://www.clark.wa.gov/sites/default/files/dept/files/public-health/data-and-reports/2016_CC_Population_Health_Indicator_Table.pdf)

<sup>21</sup> National Conference of State Legislatures: The Costs and Consequences of Disparities in Behavioral Health Care. February 2018. Accessed November 23, 2019. [http://www.ncsl.org/Portals/1/HTML\\_LargeReports/DisparitiesBehHealth\\_Final.htm](http://www.ncsl.org/Portals/1/HTML_LargeReports/DisparitiesBehHealth_Final.htm)

CURRENT BEHAVIORAL HEALTH SERVICES

Clark County is the largest of the three southwestern Washington counties, and has the most robust behavioral health system. The figures below summarize the county’s adult mental health, children’s mental health, and substance use disorder services and supports. The county has a full continuum of care for adults with behavioral health conditions. Participating stakeholders noted significant focus on implementing recovery programs.

Figure 5. Clark County Current Adult Mental Health System

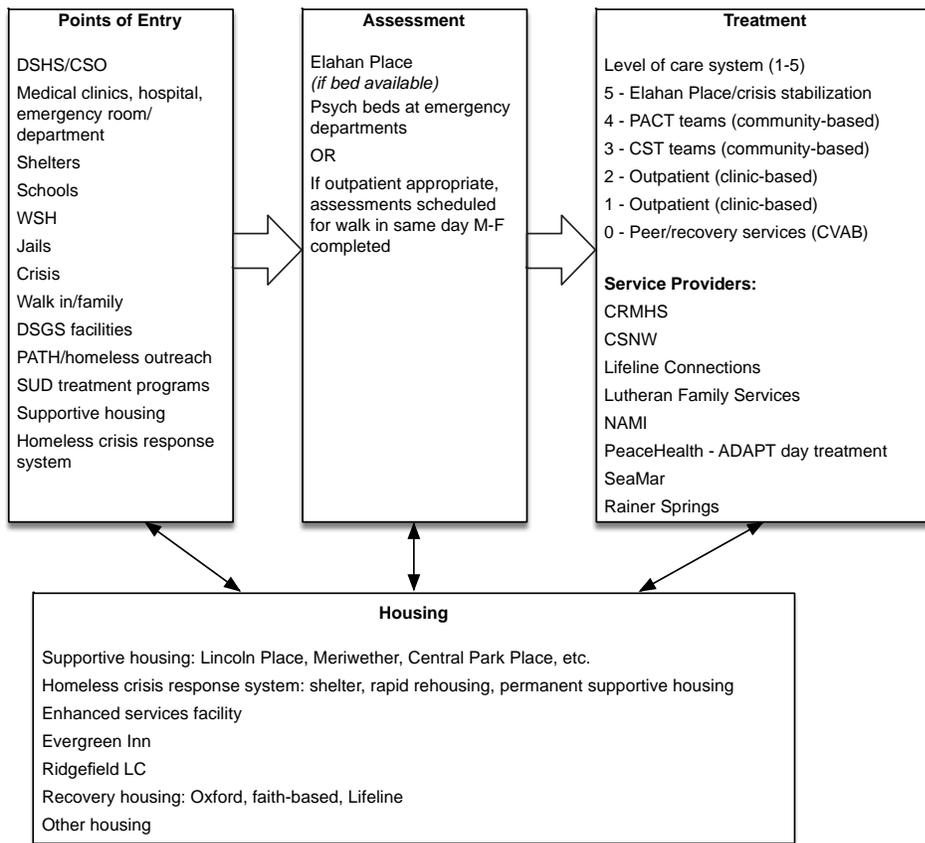


Figure 6. Clark County Current Children’s Mental Health System

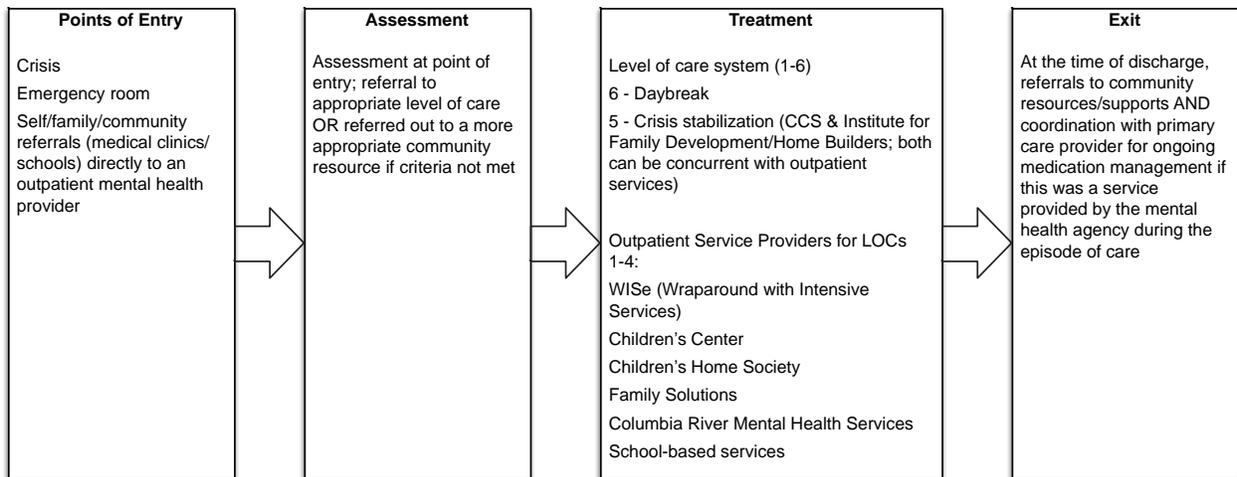
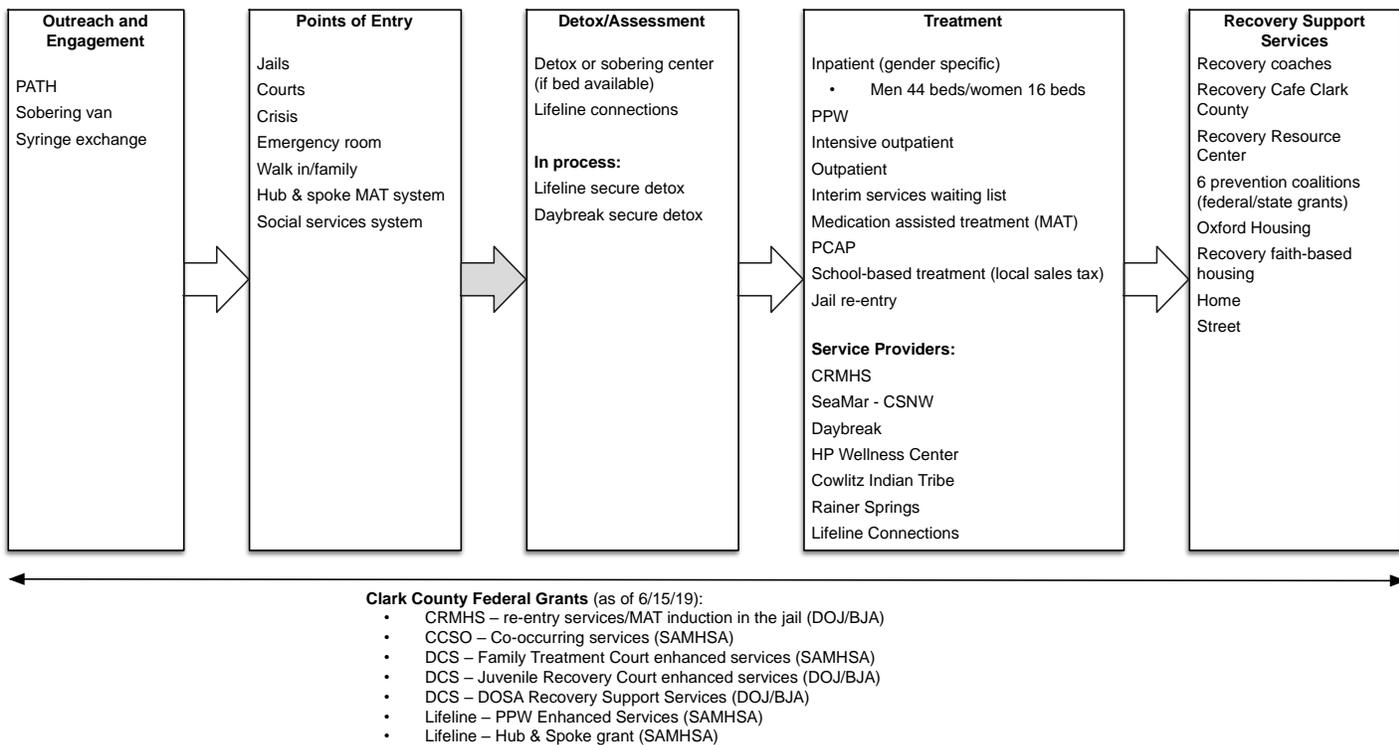


Figure 7. Clark County Current Substance Use Disorder System



**PRIORITIZED NEEDS**

Clark County stakeholders prioritized outstanding needs for the county’s behavioral health system, with a focus on meeting needs for specific demographics and cultures as well as general service gaps.

Figure 8. Clark County prioritized behavioral health system needs

|                           |  |
|---------------------------|--|
| <b>Housing</b>            | <ul style="list-style-type: none"> <li>Housing for individuals with high acuity behavioral health needs</li> </ul> |
| <b>Children and Youth</b> | <ul style="list-style-type: none"> <li>Increased hospital diversion</li> </ul>                                     |

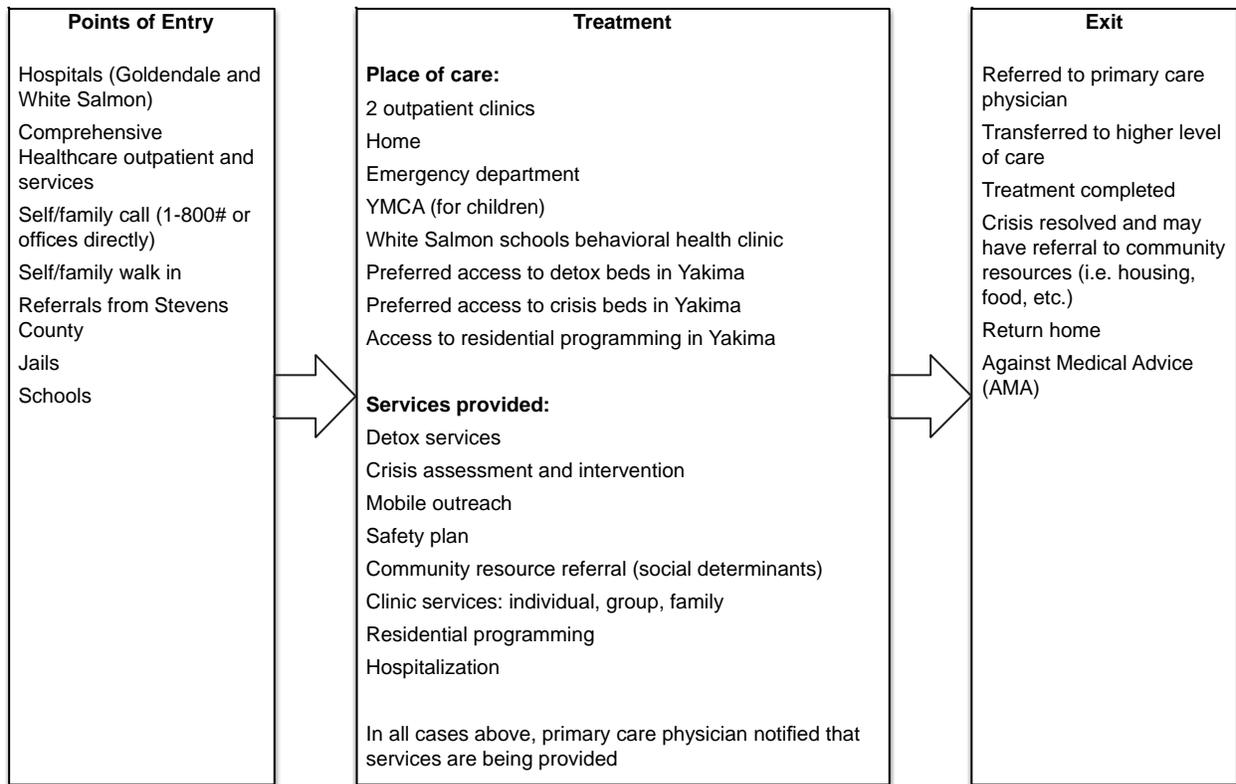
|                              |  |
|------------------------------|--|
|                              | <ul style="list-style-type: none"> <li>• Increased access to psychiatry services</li> <li>• Increased access to homebuilders or longer term stabilization</li> <li>• Increased access to day treatment and intensive outpatient services</li> <li>• Expanded capacity of child and adolescent treatment at levels 3, 4 and 6</li> <li>• Expansion of level of child and adolescent treatment care at levels 3, 4 and 6</li> <li>• Development of psychiatric inpatient services for high acuity/comorbid patients</li> </ul> |
| <b>Seniors</b>               | <ul style="list-style-type: none"> <li>• Increased focus on/access for seniors across all behavioral health services</li> <li>• Development of psychiatric inpatient services for high acuity/comorbid patients</li> </ul>   |
| <b>Adults/General</b>        | <ul style="list-style-type: none"> <li>• Expansion of level of care at levels 3, 4 and 6</li> <li>• Increased access to psychiatry services</li> <li>• Development of psychiatric inpatient services for high acuity/comorbid patients</li> </ul>  |
| <b>Diversity/Inclusivity</b> | <ul style="list-style-type: none"> <li>• Increased provision of culturally relevant services and supports, particularly for Russian, LGBTQ, Latino/a, and African American</li> </ul>  |
| <b>Workforce</b>             | <ul style="list-style-type: none"> <li>• Increased support for behavioral health workforce including increased professional development and recruitment/capacity</li> </ul>  |

**KLICKITAT COUNTY**

**CURRENT BEHAVIORAL HEALTH SERVICES**

Klickitat is a relatively small county and their behavioral health system reflects the rural nature of their county. The two hospitals, Klickitat Valley Health in Goldendale and Skyline Hospital White Salmon, are two points of entry for the mental health and substance use disorder system. Other entry points include Comprehensive Healthcare outpatient and crisis services, as well as law enforcement, self-referrals, schools and primary care, community based social service providers and faith-based networks.

Figure 9. Klickitat County Current Mental Health and Substance Use Disorder System



Stakeholders noted effective collaboration between law enforcement and behavioral health services providers. Law enforcement accompanies providers on home visits and other home-based service/support delivery.

Participants also commented on the strength of the faith-based community in providing recovery services. Referrals to faith-based services are based on client preference with no formal partnerships.

### PRIORITIZED NEEDS

Klickitat stakeholders discussed numerous behavioral health service gaps to enhance the local continuum of care. Children and youth were identified as an underserved population, with most youth going to neighboring Yakima for support.

Figure 10. Klickitat County prioritized behavioral health system needs

|                                      |   |
|--------------------------------------|---|
| <b>Children, Youth, and Families</b> | <ul style="list-style-type: none"> <li>Increased access to specialized services for children and youth</li> <li>Increased access to services and supports for low income families</li> </ul>          |
| <b>Native American</b>               | <ul style="list-style-type: none"> <li>Increased provision of culturally relevant services and supports for Native American residents</li> </ul>  |
| <b>Adult/General Access</b>          | <ul style="list-style-type: none"> <li>Increased responsiveness/timeliness of services (decrease delays/waiting lists)</li> <li>Increased responsiveness of after-hours services</li> </ul>           |
| <b>Service Gaps</b>                  | <ul style="list-style-type: none"> <li>Increased access to secure hold beds to decrease utilization of emergency room beds</li> <li>Increased access to sexual abuse services and supports</li> </ul> |

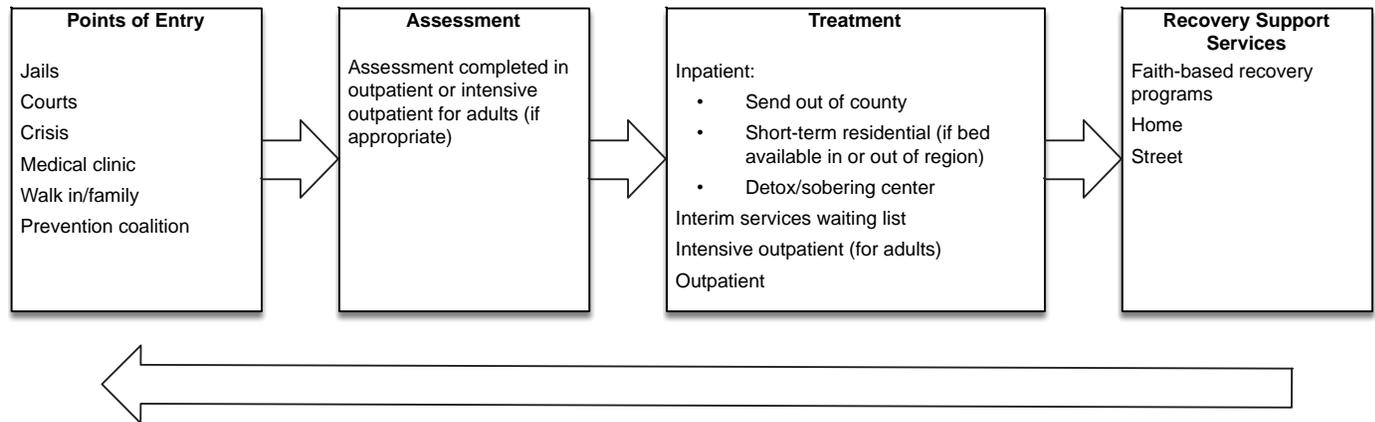
|  |  |
|--|--|
|  | <ul style="list-style-type: none"> <li>• Increased access to stabilization services (adjunct services), including housing, employment, and related supports</li> <li>• Provision of comprehensive housing supports focused on population with behavioral health needs</li> </ul> |
|--|--|

**SKAMANIA COUNTY**

**CURRENT BEHAVIORAL HEALTH SERVICES**

Skamania County has the smallest population of the three southwestern Washington counties, and is reliant on neighboring Clark County for inpatient behavioral health services and supports. Local resources support the remaining components of a continuum of care for all ages, including short-term crisis response/evaluation, intensive outpatient, outpatient, and recovery support services. The county does not yet provide medication assisted treatment.

Figure 11. Skamania County Current Mental Health and Substance Use Disorder System



**PRIORITIZED NEEDS**

Skamania stakeholders discussed gaps or prioritized needs primarily focused on housing, recovery services, and transportation. The county has a contract for supported housing and employment, but, according to participants, additional supports were needed. Stakeholders felt it was unlikely the county would ever have a hospital due to its small population, and so felt that they would need to continue to coordinate closely with Clark County to support a full behavioral health continuum of care.

Figure 12. Skamania County prioritized behavioral health system needs

|                       |   |
|-----------------------|---|
| <b>Housing</b>        | <ul style="list-style-type: none"> <li>• Increase access to affordable comprehensive supportive housing for people with behavioral health needs</li> <li>• Increase access to recovery housing (e.g. Oxford House)</li> </ul> |
| <b>Recovery</b>       | <ul style="list-style-type: none"> <li>• Further develop recovery services and supports as a county-wide focus</li> </ul>   |
| <b>Transportation</b> | <ul style="list-style-type: none"> <li>• Increase public transportation options</li> </ul>  |

## CROSS-COUNTY SOUTHWEST WASHINGTON BEHAVIORAL HEALTH SYSTEM FINDINGS

Across the three-county region, several common behavioral health system needs emerged, including care coordination and integration, housing, behavioral health programming for patients with high acuity needs, and services for children and youth.

**Care coordination and integration.** Stakeholders discussed care coordination challenges, particularly for complex cases. Participants discussed the need for improved:

- Complex care referral
- Care coordination support
- Closed-loop referrals
- Care integration (less disjointed services/transitions)

**Housing.** Housing for people with behavioral health conditions, especially high acuity needs, and integrating services with housing was a consistent gap/need across counties.

**Programming for patients with high acuity needs.** Stakeholders discussed lack of sufficient programming or psychiatric inpatient services for patient with complex, high acuity needs.

**Services for children and youth.** All counties felt their service system provided less support for children, youth, and families, particularly high acuity children and youth.

The variation in behavioral health service and support availability necessitates cross-county and broader regional collaboration. Stakeholders discussed universal and distinct regional needs. Meeting participants discussed the importance of acknowledging that responding to a regional need in only one county may not sufficiently address the need across all counties or adequately support the goal of recovery and stability in home and community settings. Responses will need to consider both regional and county specific contexts and considerations.

## SOUTHWEST WASHINGTON BEHAVIORAL HEALTH PRIORITIES AND FUNDING OPPORTUNITIES

Regional stakeholders prioritized behavioral health system needs for Southwest Washington, and signified whether the needs would require capital resources, policy change, new services, or training. The following figure shows the collective prioritization.

Figure 13. Southwest Washington behavioral health priorities

| Need  | Number of priority votes received | Requires capital resources | Requires policy change | Requires new service | Requires training | Notes  |
|---|-----------------------------------|----------------------------|------------------------|----------------------|-------------------|--|
| Behavioral health housing with supportive services  | 8                                 | X                          | X                      | X                    | X                 | Needs for capital will vary by county within the Southwest Washington region and will need to be met on a county-specific basis                              |
| Housing for individuals with high acuity needs  | 8                                 | X                          | X                      | X                    | X                 |  |
| Stabilization services for adults/hospital diversion for youth  | 6                                 | X                          | X                      | X*                   |                   |  |
| Acuity E&T beds/co-occurring  | 5                                 | X                          | X                      | X*                   |                   |  |
| Peer supports across the full system  | 5                                 |                            | X                      | X                    | X                 | Policy change is required to make peer supports more systematic and systemic   |
| MH/SUD professionals in schools   | 5                                 | X                          | X                      | X                    | X                 | Requires capital for more space, policy to track school-based services and develop sustainable infrastructure, and training to integrate into school culture |
| Expansion of level of care between levels 3 and 4—more for youth but also adults  | 4                                 | X                          | X                      | X                    | X                 |  |
| Complex care referrals (regional system concern): BH/SUD/DD-IDD/Medical/Youth   | 4                                 |                            | X                      | X                    | X                 |  |
| More bilingual culturally relevant services built into top priorities (workforce); general lack of workforce capacity across services and systems | 3                                 |                            | X                      | X                    | X                 |  |
| Access to updated and accurate resources/info   | 2                                 |                            |                        | X                    | X                 |  |
| Transportation (Skamania)   | 1                                 | X                          | X                      | X                    |                   |  |
| Geriatric/long-term care  | 1                                 | X                          | X                      | X                    | X                 | Discussion of the universal need for this that feels bigger than the 1 priority vote it received   |

\*Stabilization and high acuity evaluation and treatment services are under active development with Lifeline’s facility.

## SW Washington Youth Services Work Group (YSWG)

### Purpose:

The YSWG is created to focus on capacity development needs for youth mental health with a focus on the services between level 3 and WISe (level 4). The YSWG was established in response to the report released on November 23, 2019, *Southwest Washington Behavioral Health Services Current State of Gaps in Behavioral Health Services in Southwest Washington*. The YSWG will have administrative backbone support provided by Community Health Plan of Washington and YSWG will make recommendations regarding the services for youth between levels 3 and 4.

### Deliverables:

- Conduct a deep dive assessment and document current continuum of care for level 3
- Provide an overview of the need for youth continuum of care for higher levels of care
- Identify and document gaps within the continuum of care for level 3
- Identify and document barriers within the continuum of care for level 3 (i.e. workforce, regulations, funding, etc.)
- YSWG develop recommendations for enhance the continuum of care for level 3

### Process

- Work group will be made up of representatives form youth serving provider organizations, community members, FYSPRT representatives and health plans.
- Work group will meet face to face (with call in option as needed) every 6 weeks until work is completed. Estimated time for completion is Q4 2020.
- CHPW will provide administrative support to produce the deliverables noted above and work alongside YSWG.

### Success Measures

- Work group participation is consistent and includes family and community voices alongside youth serving organizations
- Community understanding of youth services continuum and document created by work group to be shared with community.
- Recommendations developed by YSWG.

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*It is assumed that the YSWG will have a focus on the Mental Health system, however the workgroup will have an opportunity to address gaps in Co-Occurring Programs as well as gaps in care for youth with an Intellectual and Developmental Disability and a mental health diagnosis.*