

Youth and Young Adult Continuum of Care subgroup meeting

August 27, 2020

Agenda Items	Summary Meeting Notes
<p>Presentation: Mobile Crisis Intervention Teams</p>	<p>Allison Wedin, Involuntary Treatment Act Administrator (Division of Behavioral Health and Recovery [DBHR]-Health Care Authority [HCA])</p> <ul style="list-style-type: none"> • WA structure for Crisis Services: HCA contracts with BH-ASOs for services. • Must maintain behavioral health crisis system and do that with more than one provider agency. • Requirement is population based, ensuring that anyone who is experiencing a BH crisis can get services • BH-ASOs provide crisis services 24/7 to regions including BH hotline, involuntary treatment, etc. • All regions must be able to respond to 18 and younger population. • No data currently about services tailored to people under 18. • All services are for all age groups. • WAC language around crisis services is more specific than contracts. <p>Discussion</p> <ul style="list-style-type: none"> • Seems like language in contracts is not all the same, so it would be helpful to know what BH-ASOs are doing, look at the requirements, and see what the differences are, and why. <p>Don Koenig, Regional Director, and Brook Vejo, Clinical Supervisor for the Children/Youth Mobile Crisis Team (Catholic Community Services of Western Washington)</p> <p>Crisis family intervention services</p> <ul style="list-style-type: none"> • Offer crisis Services in Pierce, Clark, and Thurston-Mason counties. • CCS integrates, coordinates, and plans crisis care. • Collaboration and coordination: monthly meetings w/ health care providers; ongoing meetings insure necessary communication and problem solving is happening <p>Brooke Vejo – Youth Mobile Crisis Team</p> <ul style="list-style-type: none"> • Pre-Covid – Most of our responses were in ERs or local doctors’ offices; now, most responses are in home or ER. • We are contacted through individual or family members’ calls to the crisis line. • Staffed by 5 mental health clinicians. • Someone certified answers the phone. • Teams of 2, including a MH professional, go out to wherever the crisis is. • Goal: The Crisis Team gets to the location in 90 minutes or less; most of the time they arrive in 40-45 minutes. • Crisis unit has no office-based setting. • 1st goal: To stabilize the individual and make a safety plan; next steps are for families. • Services are available to any youth up to age 18 in Clark County. • Pediatric based model; all team members are children’s mental health specialists. We see children as young as 2 and 3. • Services are contracted/funded through BH-ASOs. • We do outreach in the region, including to homeless shelters. We have diverse teams, including Spanish speakers. All have diversity training. We partner with specialty population groups.

	<ul style="list-style-type: none"> • Demographics of youth served are tracked. • Outcomes: 2-5% of kids we see go to the ER- our focus is to keep them out of the ER. • Overall short term success/ looking at how many times law enforcement is called, etc. • We have no youth partners; we do have family partners. • In southwest WA, domestic violence is increasing, suicidal ideation, acute serious situations, are all increasing; we are afraid the pandemic is going to continue taxing emergency services. Concerns about what will happen in the winter when people can't go out. • Concerns about the lack of schools. We are hearing that schools are repositioning their counselors and other staff. • Summer is usually slower, but referrals have doubled compared to this time last year. And each referral much more intense; uses more resources for each family. • For more information, contact Don at donk@ccsww.org. <p>Discussion</p> <ul style="list-style-type: none"> • Q: Relationships w/ community providers? A: Contract with BHO-ASOs. Participate in BH provider meetings monthly to coordinate with them. Host meeting with everyone involved in crisis services, including schools, police, etc. to communicate and identify issues. Peer and family reps at those meetings. • We need to keep exploring ways to reach out to the homeless, LGBTQ, BIPOC, and non-English speakers. • Making sure systems are accessible is important. • This sounds like a powerful model that should be sustained beyond COVID. • Issue: Sometimes people don't get services when they request them because they don't use the "magic words" – mobile crisis unit. • Q: What about crisis responders for involuntary commitment (ITA)? A: In Clark County, Designated Crisis Responders (DCRs) do those, generally in the ER. We have very few ITAs for youth in this county as we utilize Family Initiated Treatment (ITAs) 99.9% of the time. • Consider ourselves a pediatric based model – see children as young as 2 or 3 – all on team are children's mental health specialists. • Seeing so much more acute and serious situations in the last few months – and DV. Very concerned about the lack of schools. Hearing that schools are repositioning their counselors and other services. We fear that the cumulative effect of the pandemic is going to impact crisis services – looking at how to meet that need. Usually summers are fairly low-key. Doubled or more referrals – this July from last July. Each referral is more intense, uses more resources for each family.
<p>Presentation: Outpatient Mental Health and SUD Evaluation and Services</p>	<p>Overview – Diana Cockrell, Section Manager, Prenatal to 25 Lifespan (DBHR-HCA)</p> <ul style="list-style-type: none"> • Services vary depending on the situation. • All service. should be age, culturally, and linguistically appropriate. • Multiple programs and services are offered - in offices, home, schools, community; adaptations being made with Covid. • Services include mixture of group, family, individual, family-group therapies, medication, care coordination, peer supports. • Differences in structure of delivery depending on the issue. • Number of sessions is increased as needed. <p>Discussion</p>

	<ul style="list-style-type: none"> Agencies have to make sure they are needs driven and appropriate. <p>Anthony Orias, Clinical Supervisor, Child, Youth and Family Outpatient Services (Navos)</p> <ul style="list-style-type: none"> Serve children, youth, and families- different age ranges and developmental stages; we start at 6 years of age, and end at 24.. Infant/early childhood services (6 mos – 6 years) offered in a different department. Clients in King Co BHO, Medicaid. MOU w/ different school districts - can be embedded in the schools, within high schools (Seattle, Tukwilla). For children 12 and under, intake is done with the family. Clients who are 13 or older can do their own intake - process requires tweaking because parents don't know. Services include medication management. 2 prescribers- they see major depression, ADHD, bipolar disorder, schizophrenia, etc. Family system works for all age ranges; many clinicians serve the whole family. Some were 22 in CYF, other were 18 and in adult services- researched why that was Jeffrey Arnett - Theory of emerging adulthood 15, 16, 17- prep for adult services, if they want it Challenges when there is no school around confidential sessions (summer, pandemic). Don't know what will happen this year. Staffing issues ended Hispanic team - lost many Spanish speaking therapists. Alcohol and other drugs (AOD) program - temporary shut down due to funding. Contact info: Anthony.orias@navos.org <p>Discussion</p> <ul style="list-style-type: none"> Q: What happens when kids turn 18? A: We work collaboratively with Adult Services, developed a bridge between the two groups. Where young adults are served depends on individual. When last reviewed, roughly half were served in each system, with some 22-year-olds in CYF, and some 18-year-olds in the adult system. Use Jeffrey Arnett's model of comprehensive age-related services. Q: How many students require confidential services? A: We don't have numbers, and it changes over time; clients bounce back and forth between wanting confidentiality and involving their family. Q: Have you had many Family Initiated Treatment (FIT) referrals? A: A few, not many. We have had an increase in parent initiated hospitalizations coming from the ER.
<p>Presentation: Youth Peer Supports</p>	<p>Overview – Evelyn Clark, Youth Peer Liaison Program Manager (DBHR-HCA)</p> <ul style="list-style-type: none"> Youth peer network, to support peers; will be hiring a contractor to do this work; we are looking for one that is youth guided and driven. We want to make sure EDI is included; need for more leaders of color. Issue: Disparity in payment rates for peers vs. clinicians. Need youth peers for FEP, and in schools; prevent preschool to prison pipeline. <p>Discussion</p> <ul style="list-style-type: none"> Q: What are the requirements for youth peers and how are they provided? A: Youth peers must be at least 18 years old. They are required to take the standard DBHR peer training, and have to have lived experience. They get the same training and

	<p>certificate as adult peers. It is a certificate, not a credential, through HCA – https://hca.wa.gov/billers-providers-partners-behavioral-health-recovery/peer-support</p> <ul style="list-style-type: none">• There is a standard peer training, and a youth and family peer training.• Once you receive your CPC certificate and are hired by an agency, you apply for your affiliated counselor credential through DOH.• Q: What work do peers do?• A: Peers can stand in for the behavioral health specialist, but cannot provide clinical services or respite. They can help clients navigate systems. Youth peers are part of WISe. They can take youth to apply for jobs, attend family meetings and court hearings, etc. Their role is to empower youth to make decisions in their treatment.• SPARK agrees that the application process needs worki. <p>SPARK – Maria Nunez, Contract Manager (SPARK)/Peer Counselor (Comprehensive) and Carolyn Cox, Co-founder (SPARK), Peer Support Specialist (New Horizons Alternative High School, Pasco)</p> <ul style="list-style-type: none">• SPARK has a a 12 week course for peers – Covers: Love Notes (tool), SMART goals, ACEs, and more.• Started in a small school; now expanding.• Board is 60% youth, 40% adults.• Maxed out in current class, all are bilingual.• Wages for youth peers are an issue; not a living wage so youth need to find other positions that pay more..• Need to lift up youth, need to be looked at as professionals w/ a fair wage. <p>Discussion</p> <ul style="list-style-type: none">• Youth are running it, but they are not getting paid like they should.• Past criminal history is an issue, but lived experience is what makes peers able to do the job they do.• Sometimes the youth workers get triggered; its important that they know when to step back. The “homeless again” rate is high for youth peers.• Support self-advocacy, speaking up, talking about services in a way that is not scary.• We have found that youth are willing to talk to youth peers when they are not willing to talk to behavioral health professionals.• Agencies hardly promote youth peers as supervisors and do not pay well so they leave the workforce. I support many who have experienced this and I left the field because of treatment among youth peers. This has been happening since I was certified in 2012.• Peers at state level get paid less than other roles, too.• I asked my Senator to consider bringing to the State budget that counselors and peers be paid by salary for a 32 hour week so they would have a weekly recovery day. Empathetic crisis is real. We families that advocate without pay go through it all the time. Those doing this for a job day in and day out must experience it.• It is a choice by the organization to value employees with lived experience, and to ensure they are represented at all level of the org. Rates don’t support the solutions needed, it is a value based decision...(value based payment)• I think we need some state policy and/or standards so that it is not totally left up to the organization that might not have that value or quite frankly is new to this work and
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	<p>don't have the young person's self-care as a first thought in their program development.</p> <ul style="list-style-type: none"> • And standards that allow for an org to be responsive to its community, not engaged by standards; there was a report on transferring CPC to DOH in 2019 to support similar intentions. • How do we empower young people and continue to pay them, even if they need to work less for self-care? Part of why youth peers leave. <i>Yes, high burnout rate for youth and parent peers.</i> • Might look at how do to get insight from youth and organizations? To pay a compensatory rate and to set a minimum level of expectations of what org provides.
<p>Presentation: Family Peer Supports</p>	<p>Patty King, Family Liaison Program Manager (DBHR-HCA)</p> <ul style="list-style-type: none"> • Regional WA support networks were started in the mid 1990s; in 2000s, peer support began to be supported and reimbursed. • 2005: Peer counselor classes started. • 2009: SAFE WA- gave support to Family Peers transitioning to in BH agencies. • 2013-2014: WISE employs family peers; if employed by a Medicaid agency, peers must be certificated. • Family peers are a bridge between the family and the system; they make sure families are heard and their needs are addressed. • Decline in parent peers being hired.
<p>Idea Pitch: Integrated behavioral health supports in primary care</p>	<p>Dr. Thatcher Felt</p> <ul style="list-style-type: none"> • Integrated BH #43 in nation for access to BH access • Referrals take months; immediacy of kids' needs is very real. • In this model, providers have a warm handoff with a counselor. • Increase BH reimbursement for Medicaid (parity) - needs to match medicare • Pays 55% of medicare prices for Medicaid • Practices cannot afford to hire counselors <p>Discussion</p> <ul style="list-style-type: none"> • The Federally Funded Clinics in my county and the two surrounded and are already doing that. Whole Health Model. • We just did public comment on Whole Health through the HCA this past month. I am very hopeful for this very thing to take place.
<p>Idea Pitch: Access to behavioral health supports for youth and young adults re-entering communities after confinement</p>	<p>Ted Ryle</p> <ul style="list-style-type: none"> • JR serves 3-5% y who come into contact with courts • Y who are sentenced unfairly • They get court orders • 87% have.. depression • 78% traumatic exposure • 58% ptsd • Medicaid reimbursement is a cost barrier • If meaningful engagement is not in place before the youth returns, things can go back <p>Tyus Reed</p> <ul style="list-style-type: none"> • Likes the program

	<ul style="list-style-type: none"> Says life experience is the same as having a degree/being a clinician and they need to get paid the same <p>Discussion</p> <ul style="list-style-type: none"> If we don't have funding for the wrap around services in place we end up with the outcomes like Alfred Nelson shot dead on the streets of Tacoma within 12 hours of discharge. Sen. Claire Wilson had a reentry bill that spoke to these ideas although it wasn't specifically focused on youth – SB 6638 (2020) Tyus, we need you influencing engagement strategies for as many orgs as possible, we need you training and building this bridge!
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Attendees

Endalkachew Abebaw (HCA)
 Kashi Arora (Seattle Children's)
 Janice Bentley-Jones, Clark County Juvenile Justice
 Chelsea Berg
 Kevin Black (Senate Human Services)
 Rachel Burke (HCA)
 Dr. Phyllis Cavins (Child and Adolescent Clinic, Longview)
 Evelyn Clark (HCA)
 Rosemarie Clemente (DCYF)
 Diana Cockrell (HCA)
 Carolyn Cox (SPARK)
 Rebecca Daughtry (HCA)
 Rep. Lauren Davis
 Tristan Eddy (Justice for Girls Coalition of WA State)
 Katie Eilers
 Dr. Thatcher Felt (Yakima Valley Farmworkers Clinic)

Brad Forbes (NAMI)
 Sydney Forrester (Governor's staff)
 Ann Gray (OSPI)
 Gabriel Hamilton (FYSPRT Youth Tri-Lead)
 Kimberly Harris (HCA)
 Libby Hein (Molina Healthcare)
 Andrew Hill (Excelsior Wellness)
 Avreayl Jacobson (King County BH and Recovery)
 Charlotte Janovyak (Asst. to Rep. Davis)
 Kim Justice (Office of Homeless Youth, Commerce)
 Michelle Karnath (Clark County Juvenile Justice, FYSPRT Tri-lead)
 Laurel Kelso (Navos)
 Ahney King (Coordinated Care)
 Patty King (HCA)

Don Koenig (Catholic Community Services of Western WA)
 Maria Nunez (SPARK)
 Anthony Orias (Navos)
 Barb Putnam (DCYF)
 Penny Quist (Parent advocate)
 Tyus Reed (Youth rep)
 Ted Ryle (DCYF)
 Janice Schutz, WA State Community Connectors
 Wendy Skarra
 Anne Stone (DSHS)
 Ashley Taylor (HCA)
 Jim Theofelis (A Way Home WA)
 Rep. My-Linh Thai
 Bobby Trevino (Consultant)
 Brooke Vejo (Catholic Community Services of Western WA)
 Liz Venuto (HCA)
 Allison Wedin (HCA)
 Kimberly Wright (HCA)