December 20, 2023

Governor Inslee and Members of the Legislature,

The Children and Youth Behavioral Health Work Group (CYBHWG) is pleased to share this update on the Prenatal-25 Behavioral Health Strategic Plan (P-25 Strategic Plan).

In response to the continuing crisis in children's and youths' behavioral health – and a shared awareness that its proposed solutions were most often focused on responding to the most severe and life-altering gaps in the system – the CYBHWG proposed this effort in 2021. The P-25 Strategic Plan is an opportunity to affect deep system change across the continuum of care by building a roadmap and process for ongoing assessment and improvements, supported and informed by a growing body of data. In this way, the strategic plan will provide a framework for future CYBHWG recommendations to drive WA State toward our vision for behavioral health care for our children.

The vision of the CYBHWG is that each and every child, youth, and young adult – and their parents or caregivers – has the behavioral health services and supports they need, where and when they need them, across the full continuum of care. This includes no wrong door, and a robust and dialable system delivery with clear and connected outcomes and measure. The strategic plan work so far has brought us closer to that goal as we began identifying what isn't working, what help and support looks and feels like for families, what is happening in other states, and what services and data we currently have in Washington across a full continuum of care from promotion of well-being, through crisis services, recovery and stabilization, and sustained well-being.

We are grateful to the 46 young people, parents, and caregivers with lived experience needing, seeking, and receiving behavioral health services who joined the 2023 Strategic Plan Advisory Group and partnered with us to shape this work. We would also like to thank the other members of the advisory group and the many individuals – system partners; subject matter experts; providers; community organizations, and others who contributed to this work.

We appreciate your support for the P-25 Strategic Plan and look forward to continuing the work of ensuring we're building a system that looks like help while reducing the acuity of crises because needs are met earlier and delivered with high-quality, equitable, developmentally appropriate care for all.

Representative Lisa Callan
CYBHWG Strategic Plan Advisory Group Co-chair
Washington State Representative
5th Legislative District

Diana Cockrell
CYBHWG Strategic Plan Advisory Group Co-chair
Manager, Prenatal-25 Lifespan Section
Division of Behavioral Health & Recovery
Health Care Authority

Children & Youth Behavioral Health Work Group Annual Report

Part 2: Prenatal-25 Behavioral Health Strategic Plan

December 20, 2023

Prenatal-25 Behavioral Health Strategic Plan – Progress Report

Contents

Part 2: Prenatal-25 Behavioral Health Strategic Plan – Progress Report

Executive Summary

In 2022, the legislature passed Second Substitute House Bill 1890 (HB 1890), authorizing the Children & Youth Behavioral Health Work Group (CYBHWG) to convene a Prenatal through 25 Behavioral Health Strategic Plan (Strategic Plan) Advisory Group to develop and draft a statewide strategic plan.

The goal of the strategic plan is to develop longer term, system-wide strategies to ensure access to high-quality, equitable care and supports in behavioral health education and promotion, prevention, intervention, recovery, and ongoing well-being for families in the perinatal stage (pregnancy through the first year of life), children, youth, young people transitioning to adulthood, and their caregivers. HB 1890 directs the CYBHWG to submit the draft strategic plan to the Governor and the Legislature by November 1, 2024.

Progress update

The advisory group began meeting in August 2022. By January 2023, the advisory group had 63 members. The majority (73%) are youth and young adults who have received behavioral health services and parents and caregivers of children and youth who received services. Most meetings include a participatory activity, such as breakout groups, that included non-members. An average of 40 non-members attended these meetings; most are system partners. *See Appendix A for a list of 2022-23 advisory group members.*

Progress on key deliverables is described below.

Current landscape of behavioral health services

- HCA worked with a contractor to develop a preliminary workplan and strategy for completing a landscape analysis and gap analysis.
- In its March and May meetings, the Advisory Group held a series of breakout group sessions, sharing their view of the current landscape and identifying gaps. Non-members who attended these meetings were included in the breakout groups.
- In April, a contractor led focus groups with young people and parents who are advisory group members; participants were asked questions that dug deeper into the issues raised at advisory group meetings. *See Appendix C for full report.*
- A contractor interviewed key system partners in Washington State between March and June 2023.

These conversations have yielded some common themes about the current landscape:

- Barriers to access, including prohibitive costs, limited insurance coverage, insufficient service capacity (across Medicaid and private insurers), inadequate reimbursement rates, and a lack of culturally and linguistically responsive providers.
- Workforce issues, resulting in a shortage of providers, long wait lists, and inconsistent service quality, due to limited experience of new clinicians, overworked professionals, and high turnover.

- Gaps in the Continuum of Care, including a lack of infrastructure, insufficient support for school-based services, and the need to better leverage existing resources like collaborative care models.
- Accessibility and availability of services, in terms of location and operating hours, as well as the need for services tailored to different developmental stages, including emerging adults, and different demographic groups, including race, ethnicity, culture, and community.
- The importance of prevention and early intervention efforts.
- The need for more comprehensive and diverse services beyond those currently offered.

These findings align with what the CYBHWG and others working on improving behavioral health outcomes for children and youth have identified in the past five years.

Vision

The advisory group began working on its vision for a future behavioral health system at its July meeting. At its September meeting, the group began working on a series of sample scenarios of young people and families experiencing behavioral health crises, building out their vision of what an ideal pathway forward would look like. This work will continue through early 2024.

Research on best practices in other states

HCA worked with a contractor to conduct research on promising initiatives aimed at improving behavioral health services for children, youth, and families in other states. The resulting Emerging State Strategies report *(see Appendix E) co*vers 30 initiatives in 20 states.

The initiatives highlighted in the Emerging State Strategies report show a range of approaches and, in the longest-lived case, evidence of improved outcomes and reductions in the need of intensive services. While the goal for the Strategic Plan is to develop strategies that fit the landscape and people of Washington state, there is much to learn from the groundbreaking work being done in other states. A leader from the New Jersey Children's System of Care Transformation shared information with the advisory group. We will be arranging presentations from other states in 2024.

Moving forward

The Children and Youth Behavioral Health Workgroup (CYBHWG) has strived to provide actionable steps toward addressing the crisis level service demands and needs for our children and youth, while also identifying systems level changes needed to reduce the number and intensity of behavioral health crises. In June 2023, the CYBHWG co-chairs, Rep. Lisa Callan, and Dr. Keri Waterland, in consultation with staff on outcomes of work to date and connection with community members, reviewed the efforts so far and recognized the need and opportunity to adapt the strategic plan process to further connect and leverage the work to meet both these goals. With the needs of children, youth, young adults and families at a crisis level, leveraging the strategic planning process will maximize the CYBHWG's deliverables for the near and long term.

Moving forward the strategic process will strive to meet the following big frames of:

1. No wrong door entry,
2. A robust and dialable system of care from education and wellbeing through robust response and supports for ongoing management of behavioral health conditions, and
3. Outcome measures and levers that are nimble enough to identify needed responses from the system as times and needs change.

By using a strategic planning process that drives actionable steps along the way, is people centered, is developed with an understanding of system impacts and intersecting system inputs and outputs, and is connected to other initiatives underway to improve Washington state's behavioral health system, we can build Washington's roadmap to deliver behavioral health care that promotes wellbeing and meets the needs of every child and family.

Next steps include:

- Assessing the availability of data that allows us to see outcome measures and levers connected with access to robust and dialable delivery of the full continuum of care across all behavioral health conditions for young people from 0-25;
- Creating actionable feedback loops in current high need areas in the system to learn what changes are needed;
- Building a statewide coalition for this work that includes public and private participants;
- Identifying national partners, and incorporating lessons learned from successful system-wide change initiatives for children and young people's behavioral health services in other states;
- Aligning with other state efforts at improving behavioral health care and outcomes;
- Implementing advisory group members' and other stakeholders' input on how to engage diverse stakeholders, especially those communities and populations who have historically experienced health inequities to ensure we define what an equitable system looks and feels like to our families, caregivers, children, youth, and young adults; and
- Recognizing the ongoing changes in the behavioral health landscape in Washington state.

With this focus, the CYBHWG adopted an overarching recommendation to update the P-25 strategic plan legislation and extend the delivery time to align with the framework and direction described above.

The goal of the P-25 strategic plan effort is to create real change and improvements in services, supports, and outcomes for children, youth, young people transitioning to adulthood, and their families.

As the plan is developed, we know that the behavioral health landscape in Washington state will continue to change. A major objective of this recommendation is to build the strategic process as an ongoing framework while establishing the state's vision and plan. The strategic process in this framework would allow state agencies, providers, parents, young people, and other stakeholders to see themselves in the processes. It also builds a system that is able to answer requests with help and supports that truly feel helpful to the child and family, with clear levers for adjusting areas of the system if they are not meeting the needs of our children, youth, young adults, and their families.

As the strategic plan moves forward, the CYBHWG's recommendations will build from the strategic process and framework, developing recommendations and continuing to adjust as the landscape changes, as our state moves toward our future vision in which every Washington child, youth, and young adult, along with their families, is thriving.

Background

While investments have been made toward improving behavioral health supports and services for children and youth, Washington still ranks 40th in the nation for youth mental health care.[1] In December 2023, the Health Care Authority (HCA) reported that:

- 1 in 3 children and youth enrolled in Apple Health (Medicaid) who needed mental health services did not receive them, with young children less likely to receive needed services. *This number includes only children and youth whom a health care provider has identified as needing services; there may be many children and youth whose need for care that has not been documented by a provider.*
- Approximately 3 in 4 youth and young adults enrolled in Apple Health who needed substance use-related services did not receive them.
- 69 percent of youth who had a substance use-related emergency department visit, did not receive follow-up services within 30 days.
- Provider availability continues to be a key challenge in access to care. [2]

Challenges in receiving services affect families covered by private insurance as well as those on Medicaid. Between July 2021 and June 2022, it took Washington's Mental Health Referral Service for Children and Teens, a phone line staffed by Seattle Children's Hospital with a database of over 4,000 child- and youth-serving providers, an average of nearly three weeks from a family member's initial inquiry to find and connect them with an available provider.

In 2021, in response to the ongoing crisis in children's and youths' behavioral health – and a shared awareness that its proposed solutions were most often focused on responding to only the most severe and life-altering gaps in the system, the Children & Youth Behavioral Health Work Group (CYBHWG) proposed the development of a statewide Prenatal through 25 Behavioral Health Strategic Plan (P-25 Strategic Plan).

Second Substitute House Bill 1890 (HB 1890), enacted in 2022, authorized the CYBHWG to convene a P-25 Strategic Plan Advisory Group to guide the development of a strategic plan to be submitted to the Governor and the Legislature by November 1, 2024.

The goal of the strategic plan is to develop longer term, system-wide strategies to ensure access to high-quality equitable care and supports in behavioral health education and promotion, prevention, intervention, recovery, and ongoing well-being for families in the perinatal stage (pregnancy through the first year of life), children, young people transitioning to adulthood, and their caregivers.

For the first year, Rep. Lisa Callan and Dr. Keri Waterland, the co-chairs of the CYBHWG, also served as co-chairs of the Advisory Group. In September 2023, Diana Cockrell began co-chairing the Advisory Group.

Health Care Authority (HCA) staff support this work. However, the strategic plan is the work of the Children and Youth Behavioral Health Work Group. While state agencies are represented on the advisory group, the work is independent and is not under the purview of any state agency. Decision-making rests with the CYBHWG co-chairs, the Strategic Plan Advisory Group co-chairs, and the Strategic Plan Advisory Group.

[1] Youth Ranking 2023. Mental Health America, https://mhanational.org/issues/2023/ranking-states#youth_data

[2] Access to Behavioral Health Services for Children and Youth, HCA, 2023, anticipated publication date: January 2024.

Progress Update

P-25 Strategic Plan Advisory Group

…the work group shall convene an advisory group for the purpose of developing a draft strategic plan…
- HB 1890, Sec. (6)(a)

Since its formation in August 2022, the P-25 Strategic Plan Advisory Group (Advisory Group) has met ten times. Through July 2023, these meetings were chaired by the CYBHWG co-chairs, Representative Lisa Callan and Dr. Keri Waterland, State Behavioral Health Authority. Beginning in September 2023, Dr. Waterland handed off the co-chair position on the Advisory Group to Diana Cockrell. The Advisory Group is a subgroup of the CYBHWG and, when completed, the Strategic Plan will be reviewed and approved by the CYBHWG before submitting to the Governor and Legislature. The notes and materials for all Advisory Group meetings are posted on the CYBHWG website, along with links to the TVW recordings of these meetings.

With a commitment to ensuring that the perspectives of youth/young adults (young people) and their parents and caregivers (parents) are part of developing the plan, the co-chairs, staff and facilitation contractor decided to accept any young person who applied to be an advisory group member who had received behavioral health services or needed these services but could not access them, and any parent or caregiver whose child had received or needed behavioral health services.

Young people and parents were onboarded at the January 2023 meeting.

The original advisory group includes: 16 youth and young adults (25%), 30 parents or caregivers (48%), 1 tribal representative, and 16 system partners.[3] Youth/young adult members ranged in age from 13 to 26. Caregivers include mothers and fathers and at least one grandparent.

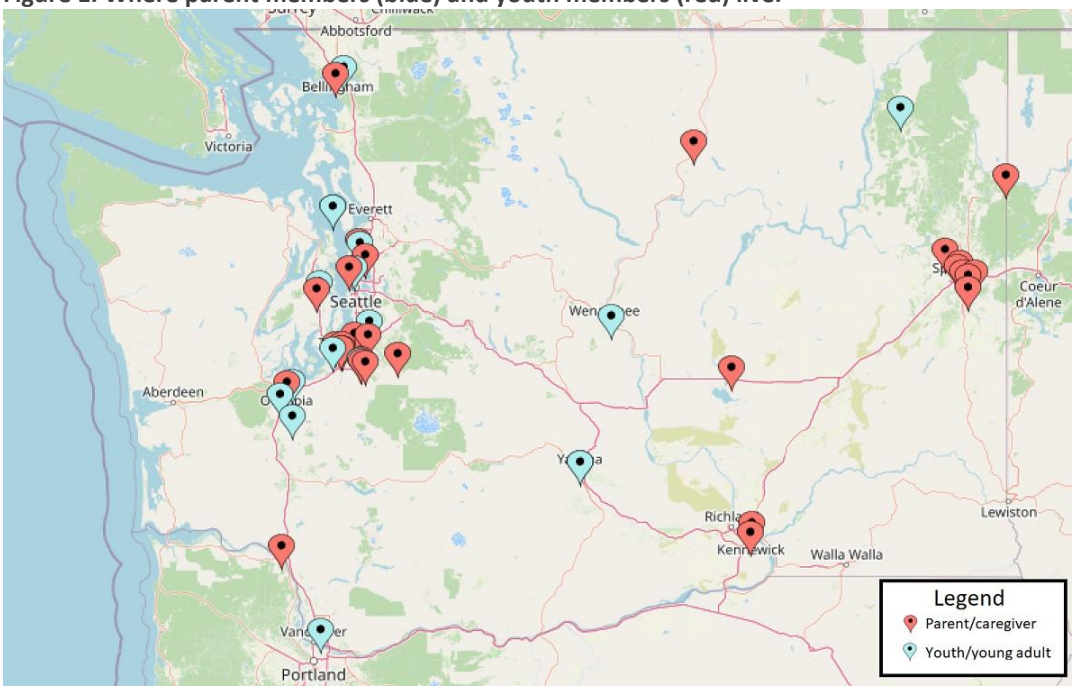
In their applications, members shared the following:

- 11 of the 46 parents and young people self-identified as being a person of color (Black/African-American, Latina/Mexican heritage, Asian, or of indigenous descent).
- 5 of the 16 young people identified as LGBTQ+, and 3 parents identified as LGBTQ+ or shared that their children were LGBTQ+.
- Mothers, fathers, and at least one grandparent participated.
- Several foster parents and young people who had been in the foster care system applied.
- Young people and parents' experiences included substance use and addiction, mental health issues, and co-occurring conditions, including autism and intellectual or developmental disabilities.
- Their experiences with the behavioral health system included school-based services, crisis services, outpatient care, intensive outpatient services, inpatient hospitalization, and out-of-state residential care.

[3] Current system partner members are legislators, representatives from state agencies and tribes, and CYBHWG subgroup leads.

The map below shows where in Washington state these advisory group members live, with 26 members (57%) living in the Puget Sound corridor, 7 (15%) living in the Spokane area, 5 (11%) in southwestern Washington, 4 (8.7%) in central Washington, and 2 each (4.3%) in the Tri-cities area and northeastern Washington.

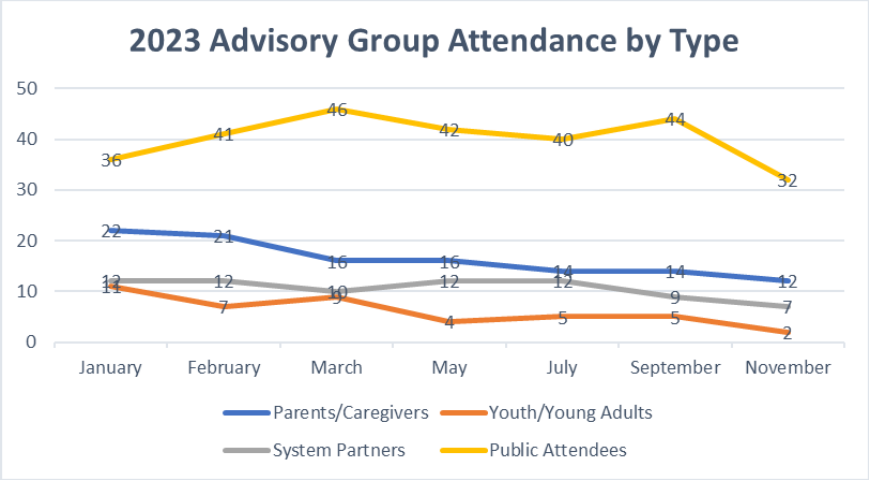
Figure 1. Where parent members (blue) and youth members (red) live.



The passage of Second Substitute House Bill 5793 (2SSB 5793, enacted in 2022) and provisions in HB 1890 authorizing stipends for low-income or underrepresented community members' participation in committees and advisory groups, may be the reason for the unprecedented numbers of young people and parents who applied. Anecdotally, we heard from several people that the stipends and childcare reimbursement made it possible for them to participate. *See Appendix A for a complete list of Advisory Committee members and Appendix B for the advisory group's charter.*

Since January, there has been a decline in both parent and youth/young adult attendance at advisory group meetings, as shown in Figure 2.

Figure 2. Advisory group attendance



Steering committee

The Strategic Plan Advisory Group voted to form a steering committee in February of 2023, consisting of one parent member and one youth/young adult member, to be selected for a one-year term by a vote of the advisory group members, and the co-chairs. A total of 4 youth members and 8 parent members submitted statements of interest. Members received these statements in email and voted by survey.

The Steering Committee began meeting in March, working with staff to plan meetings.

Inclusion of other voices

Advisory group meetings are virtual public meetings, available via Zoom or phone and live-streamed and archived on TVW. Besides a public comment period, every advisory group meeting includes at least one activity, such as breakout groups, that anyone attending the meeting can participate in. At most meetings, a small number of parents and/or young people who are not members and a larger number of system partners attend and participate in these discussions. At times, the breakout groups are divided by role – young person, parent/caregiver, and system partner. The feedback gathered in these sessions informs future meetings and is saved as part of the public record to inform the development of the strategic plan and its components.

Current landscape

> *[The draft strategic plan shall describe]…the current landscape of behavioral health services available to families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth in Washington state…*
> - HB 1890, Sec. (6)(a)(i)

As described in HB 1890, the description of the current landscape shall include:

- Gaps and barriers in access to high-quality equitable care and supports across the continuum of care,
- Current supports and services that address emerging behavioral health issues before a diagnosis and more intensive services or clinical treatment is needed, and
- The current behavioral health care oversight and management of services and systems.

Current programs and services

In 2023, an initial review of existing data sources and a draft workplan for a data-driven landscape analysis were developed by a contractor. In June 2023, the co-chairs, in consultation with staff, assessed strategy and decided, before engaging in a new contract, to focus Washington state resources on building the first iteration of the landscape, reserving the use of state dollars for activities that cannot be done with existing state resources.

Program staff in HCA's Division of Behavioral Health & Recovery (DBHR) Prenatal-25 Section, in consultation with other state agency staff, have been building a catalog of current state services and supports through the age span and continuum of care. *For more information, view model and working draft of catalog.*

How people who need services see the current landscape

The March and May advisory group meetings included breakout sessions where participants focused on identifying gaps in the current landscape of behavioral health services and supports. Everyone who attended

the meeting was invited to participate in these groups.[4] The parents and young people in the focus groups were all advisory group members.[5] *See Appendix C for the full report.*

Key findings

Common thematic elements in the focus groups and advisory group discussions included:

- **Barriers to access**, including prohibitive costs, limited insurance coverage, insufficient service capacity (across Medicaid and private insurers), inadequate reimbursement rates, long waiting lists, a lack of culturally and linguistically responsive providers. Transportation issues and a shortage of providers were all noted, especially in rural areas.
- Concerns about the **quality of providers**, ranging from lack of experience (students in training, for example) and overworked professionals.
- **Gaps in the Continuum of Care** including a lack of infrastructure, insufficient support for school-based services, and the need to better leverage existing resources like collaborative care models.
- **Accessibility and availability of services**, in terms of location and operating hours, as well as the need for services tailored to different developmental stages, including emerging adults, and different demographic groups, including race, ethnicity, culture, and community.
- All groups underscored the importance of **prevention and early intervention efforts.**
- All groups expressed the need for **more comprehensive and diverse services** beyond those currently offered.

Future Vision

> *[The draft strategic plan shall describe]…the vision for the behavioral health delivery system for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth…*
>
> - HB 1890, Sec. (6)(a)(ii)

As described in HB 1890, the vision shall include:

- A complete continuum of services from education, promotion, prevention, early intervention through crisis response, intensive treatment, postintervention, and recovery, as well as supports that sustain wellness in the behavioral health spectrum;
- How access can be provided to high quality, equitable care and supports when and where needed;
- How the children and youth behavioral health system must successfully pair with the 988 behavioral health crisis response;
- The incremental steps needed to achieve the vision based on the current gaps and barriers; and
- The oversight and management needed to ensure effective behavioral health care.

The Advisory Group began working on a vision for the future at its July meeting. At the September 7 and November 28 meetings, breakout groups began developing sample scenarios in which a child, youth, young adult, and their family might need or benefit from behavioral health services and/or supports – and what help would look like in an ideal future vision. They included scenarios in which the need for intensive services

[4] 6 youth/young adults and 21 parents/caregivers attended the March meeting; the remaining 73 participants, members, and guests, were primarily system partners. 3 youth/young adults and 16 parents attended the April meeting.

[5] 13 parents and 4 youth/young adults participated in the focus groups. There were 4 providers in the provider focus group: 2 from schools, 1 psychiatrist, and 1 physician.

was likely, as well as those in which preventive supports (education, promotion, prevention), brief interventions and/or outpatient counseling and related services might help.

These sample scenarios will continue to be built out as illustrations of what *should* happen for individuals and families in these situations – the services and supports that are offered, how young people and families learn about them, and how when and where they get them.

Research activities

> *…The activities that entities [contractors] selected under this subsection must complete include…an analysis of peer-reviewed publications, evidence-based practices, and other existing practices and guidelines with preferred outcomes regarding the delivery of behavioral health services to families in the perinatal stage, children, youth transitioning into adulthood, and the caregivers of those children and youth across multiple settings…*
> - HB 1890, Sec. (6)(d)(iii)

Research activities are to include:

- Approaches to increasing access and quality of care;
- The integration of culturally responsive care with effective clinical care practices and guidelines;
- Strategies to maximize federal reinvestment and resources from any alternative funding sources; and
- Workforce development strategies that ensure a sustained, representative, and diverse workforce.

In Spring 2023, the organization under contract to do this work developed a plan for the research tasks outlined in legislation. In addition, they held meetings with key subject matter experts within Washington state as well as national experts on efforts to transform the delivery of behavioral health services for children, youth, and families. *See Appendix D for a list of the individuals interviewed.*

After co-chair and staff assessment of the initial research plan, including recognition of the significant work Washington state has done around evidence-based practices[6], the strategy was refined to focus on statewide efforts to transform delivery of behavioral health services and supports to improve outcomes for children, youth, and families.

Emerging State Strategies report

Beginning with suggestions by the co-chairs and interviewees, the contractor followed up with research, and in some cases, interviews with creators and leaders for promising initiatives in other states. The resulting draft report (*see Appendix E*) covers 30 initiatives in 20 states. This draft will be updated once statewide community outreach has been done, to include additional initiatives that address parts of the vision that were not included in the initial search.

[6] Organizations that have conducted this work include UW's Evidence-Based Practice Institute and the Washington State Institute for Public Policy.

Community outreach and stakeholder engagement

> *The activities that entities [contractors] selected under this subsection must complete include:* ***Following a statewide stakeholder engagement process****, a behavioral health landscape analysis for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth…a gap analysis…and [the research activities described in the previous section of this report].*
> - HB 1890, Sec. (6)(d)

While systematic statewide community engagement has not yet occurred, some initial steps have been taken – through conversations with advocates, representatives of community organizations, and others involved in community outreach work – to gather input on how to approach building a plan for statewide engagement in which individuals, organizations and communities can meaningfully contribute to the strategic plan.

The project currently has a list of 87 organizations to include that have been identified by the Advisory Group co-chairs, staff, members of the Advisory Group's Community Engagement subcommittee, and others.

Additionally, initial outreach was conducted by staff and parent/youth advisory group members at the 2023 Spring Youth Forum, which brings together youth prevention teams from across the state, and the Say It Out Loud conference, which focuses on the experiences and behavioral health needs of LGBTQ+ individuals and issues and inequities related to addressing those needs.

Moving forward

As described in the Executive Summary, in June 2023, the CYBHWG co-chairs, in consultation with staff, recognized the need and opportunity to adapt the strategic plan process to further connect and leverage the work to meet two goals:

- Providing actionable steps toward addressing the crisis level service demands and needs for children and youth, and
- Identifying and providing a roadmap for systems-level changes to improve the health and well-being of children and youth so the number and intensity of behavioral health crises are reduced.

Moving forward the strategic process will strive to meet the following big frames of:

1. No wrong door entry,
2. A robust and dialable system of care from education and wellbeing through robust response and supports for ongoing management of behavioral health conditions, and
3. Outcome measures and levers that are nimble enough to identify needed responses from the system as times and needs change.

In October 2023, the CYBHWG adopted an overarching recommendation to update the P-25 strategic plan legislation and extend the delivery time to align with the framework and direction described above.

The work group's recommendation to update the P-25 Behavioral Health Strategic Plan legislation will make it possible to drive actionable steps in high need areas immediately, while also building a larger strategic effort to support systemic movements toward wellness and access to a robust and dialable delivery system that supports the health and well-being of all our children, youth, and young adults.

Continue to develop analysis of the current landscape

Once all state services and supports are documented, the next phase of the work will be focused on gathering information about services and supports that are not provided by the state. These include services and programs offered by schools, counties, managed care organizations and private insurers, community organizations, and others.

We will be engaging a contractor in 2024 to conduct the technical parts of the landscape analysis – including quantifying the identified and projected needs of children and young people from 0-25, the capacity of the current system, and the gaps in services and supports.

Develop actionable feedback loops in current high need areas

States that have successfully accomplished system-wide changes that have improved behavioral health care for children and youth have data that documents these improvements.[7] The landscape analysis will help map the needs for a system that collects the data needed to allow identification of problem areas and provides data-driven feedback loops to gather information on additional changes that may be needed.

Begin addressing children, youth, and families' immediate needs

Even as this plan is being developed, children, youth and their families continue to experience life-threatening behavioral health crises within a system that does not have the capacity to meet their needs. The strategic plan work will strengthen links with the CYBHWG's other subgroups, whose members include professionals and subject matter experts in each of these areas – youth and young adult continuum of care, school-based behavioral health and suicide prevention, prenatal – 5 relational health, workforce and rates, and behavioral health integration.

In 2024, we plan to take one or more specific high-need areas, which have been identified across the CYBHWG's subgroups and affirmed by the strategic plan advisory group and develop strategies to make improvements in the near term. Proposed solutions will include actionable feedback loops, as described above, so we can gather information about their effectiveness and continue to learn as the broader plan is built.

Include the people who will be using services in developing them

What we have heard from young people, parents, and others throughout the past year is that behavioral health services and supports must look like help to the children, youth, young adults, and families that need them. To that end, the advisory group began with a majority of members being young people, parents, and caregivers.

Over time, the numbers of parents and young people attending advisory group meetings has dropped. The decrease in youth voice is most notable as no more than 5 youth/young adult members have attended since May.

In 2024, we will be implementing advisory group members' and other stakeholders' input on how to engage diverse people and groups, especially those communities and populations who have historically experienced health inequities. We hope to reach out to people where they live, preferably with someone who they

[7] New Jersey's redesign of its children's system of care, begun in 2000 and still evolving, for example, has demonstrated a 70% decrease in residential care with no children in out-of-state residential care. It has also closed a child treatment center and 9 detention centers as a result of reduced needs and has one of the lowest suicide rates in the country.

already know and trust. We will also be taking advisory group members, young people, and others' advice on ways to involve young people that work for them.

Build a statewide coalition for this work

In 2024, we will continue to expand our network of people and organizations contributing to this work, including both public and private participants.

Align with other state efforts

In the months to come, the co-chairs, staff and advisory group will be connecting with other state initiatives for improvements in behavioral health, to ensure that we are aligning and leveraging the work between done to improve access to behavioral health services for people of all ages.

These groups include:

- Joint Legislative Executive Committee on Behavioral Health,
- Crisis Response Improvement Strategy (CRIS) Committee, and
- Substance Use Recovery Services Advisory Committee (SURSAC).

Learn from national partners

We will continue to identify national partners and incorporate lessons learned from successful system-wide change initiatives for children and young people's behavioral health systems in other states. While we don't expect another state's landscape and needs to mirror Washington, we will look for strategies and approaches that might be adapted to meet the needs of children, youth, and families in our state.

Build a roadmap that recognizes ongoing changes

As the strategic plan is developed, we know that the behavioral health landscape in Washington will continue to change. A major objective of this recommendation is to build the strategic process as an ongoing framework, and to develop an understanding of system impacts and intersecting inputs and outputs so that new approaches and programs can be adjusted and improved upon over time.

To do this, it will be essential for state agencies, providers, parents, youth, and other partners to be part of the strategic plan process – to ensure that they see themselves in it, feel that it's equitable, and believe it holds the promise of delivering help that looks like help to them, when and where they need it.

By using a strategic planning process that drives actionable steps along the way, is people centered, is developed with an understanding of system impacts and intersecting system inputs and outputs and is connected to other initiatives underway to improve Washington state's behavioral health system, we can build Washington's roadmap for delivering behavioral health care that promotes wellbeing and meets the needs of every child and family.

In the years to come, the CYBHWG's recommendations will build from the strategic plan process and framework as our state moves toward our future vision in which every Washington child, youth, and young adult, along with their families, is thriving.

Appendix A: Advisory group members

Strategic Plan Advisory Group Co-Chairs		
Representative Lisa Callan *House of Representatives*	Dr. Keri Waterland *Health Care Authority (HCA)* *Through September 2023*	Diana Cockrell *HCA* *Beginning in October 2023*
Steering Committee		
Representative Lisa Callan *House of Representatives*	Diana Cockrell *HCA*	Amanda Shi *Youth/Young Adult member*
Danna Summers *Parent/Caregiver member*	Dr. Keri Waterland *HCA*	
Youth and Young Adult Members		
Hannah Adira	Tracey Hernandez	Amanda Shi
Darren Bosman	Bree Karger	Chanson Toyama
Xana Caillouet	Kaleb Lewis	Oscar Villagomez
Sierra Camacho	Desi Quenzer	Lillian Williamson
Sage Dews	Sol Rabinovich	
El Dolane	Casi Sepulveda	
Parent and Caregiver Members		
Tina Barnes	Rokea Jones	Rosemarie Patterson
Marta Bordeaux	Michelle Karnath	Liz Perez
Melissa Brooks	Karen Kelly	Jessica Russell
Christi Cook	Brandi Kingston	Jessica Schutz
Alyssa Cruz	Nicole Latson	Sharon Shadwell
Peggy Dolane	Starleen Lewis	Lamara Shakur
Jamie Elzea	Niki Lovitt	Tui Shelton
Heather Fourstar	Sarah McNew	Danna Summers
Amy Fumetti	Alexie Orr	Marcella Taylor
Melia Hughes	April Palmanteer	
System Partners		
Representative Carolyn Eslick *House of Representatives*	Summer Hammons *Tulalip Tribes*	Amber Leaders *Governor's Office*
Michele Roberts *Department of Health*	Steven Grilli *Through September 2023* *Department of Children, Youth and Families (DCYF)*	Vickie Ybarra *Beginning in October 2023* *DCYF*
Shelley Bogart *Department of Social and Health Services (DSHS), Developmental Disabilities Administration*	Byron Eagle *DSHS,* *Child Study Treatment Center*	Kim Justice *Department of Commerce – Office of Homeless Youth*
Delika Steele *Office of the Insurance Commissioner*	Bridget Underdahl *Office of Superintendent of Public Instruction*	Kelli Bohanon *or* Kristin Wiggins *Prenatal-5 subgroup* (shared position)
Jeannie Nist or Katherine Seibel *School-based Behavioral Health & Suicide Prevention* (shared position)	Hugh Ewart *or* Laurie Lippold *Workforce & Rates subgroup* (shared position)	Sarah Rafton *or* Kristin Houser *Behavioral Health Integration subgroup* (shared position)

Appendix B: Advisory Group charter

PN25 Behavioral Health Strategic Plan Advisory Group Charter

February 10, 2023

Purpose

During the 2022 legislative session, the Children and Youth Behavioral Health Work Group (CYBHWG) recommended the development of a statewide Prenatal through 25 (PN25) Behavioral Health Strategic Plan. This recommendation was passed by the Washington State legislature in Second Substitute House Bill 1890 (HB 1890).

The purpose of the PN25 Behavioral Health Strategic Plan Advisory Group is to oversee the development of longer-term, system-wide strategies to ensure access to high-quality equitable care and supports in behavioral health education and promotion, prevention, early intervention through crisis response, intensive treatment, postintervention and recovery, and ongoing well-being for families in the perinatal stage (pregnancy through the first year of life), children, young people transitioning to adulthood, and their caregivers. The development of these new system-wide strategies will be through a trauma-informed lens to reduce incidents of harm or trauma that may be experienced by families and instead, promote healing, recovery, and resiliency throughout the behavioral health system.

The Strategic Plan Advisory Group will provide guidance and oversight of the following activities:

- Strategic plan schedule and project scoping decisions
- Community engagement strategies
- Strategic plan development
- Submission of the strategic plan to the CYBHWG by August 15, 2024, and the Governor and legislature by November 1, 2024.

The Strategic Plan Advisory Group will report their progress and recommendations to the CYBHWG and its subgroups as needed. Similarly, the PN25 Advisory Group may engage the other CYBHWG subgroups to help fulfill the objectives of the strategic planning process.

Objectives

- Fulfill the requirements of HB 1890
- Use a strategy and approach that centers racial equity and elevates the voices of young people and family members with experience receiving behavioral health services in meetings and the statewide stakeholder process
- Develop a landscape analysis of the behavioral health system and services available to families
- Complete a gap analysis for the full Continuum of Care
- Complete best-practices research, including an analysis of peer-reviewed publications, and evidence-based practices addressing the delivery of behavioral health services to

families
- Develop a behavioral health future state vision
- Complete a comparison of the current behavioral health system for the identified population with the Behavioral health future vision
- Develop the strategic plan to be approved by the CYBHWG and delivered to the Governor legislature
- Oversee a state-wide stakeholder engagement process.
- Engage tribes as sovereign nations as part of the stakeholder engagement process.
- Address gaps and barriers related to lack of coordination and integration between systems and between types of providers

Guiding Principles

The following principles will guide the work of the Advisory Group: As individuals and a collective we:

- Are community-centered
- Engage in respectful engagement - we listen to the voices of children, youth, parents, and family support systems
- Foster trust, safety, and inclusivity for all members
- Commit to transparency in decision-making
- Embrace diversity
- Foster ideas and intentions to make innovative changes
- Embrace radical ideas and thinking
- Speak on personal experience, not for the group of people/population

Governance Structure

Children Youth Behavioral Health Workgroup (CYBHWG)

The CYBHWG provides recommendations to the Legislature to improve behavioral health services and strategies for children, youth, young adults, and their families. The group includes representatives from the Legislature, state agencies, health care providers, tribal governments, community health services, and other organizations, as well as parents and family support systems of children and youth who have received services.

Strategic Planning Advisory Group Co-Chairs

- Representative Lisa Callan
- Dr. Keri Waterland, Washington State Health Care Authority (HCA)

The PN25 Behavioral Health Advisory Group is one of 6 advisory groups to the CYBHWG (Figure 1). There is cross-cutting collaboration across the 6 groups. The co-chairs of the CYBHWG also serve as the co-chairs of the Strategic Plan Advisory Group. The advisory groups work will be informed by its own subcommittees both standing and ad hoc, which will be established as needed. The Advisory Group will also be informed by the 5 CYBHWG standing subgroups.

Decision Making

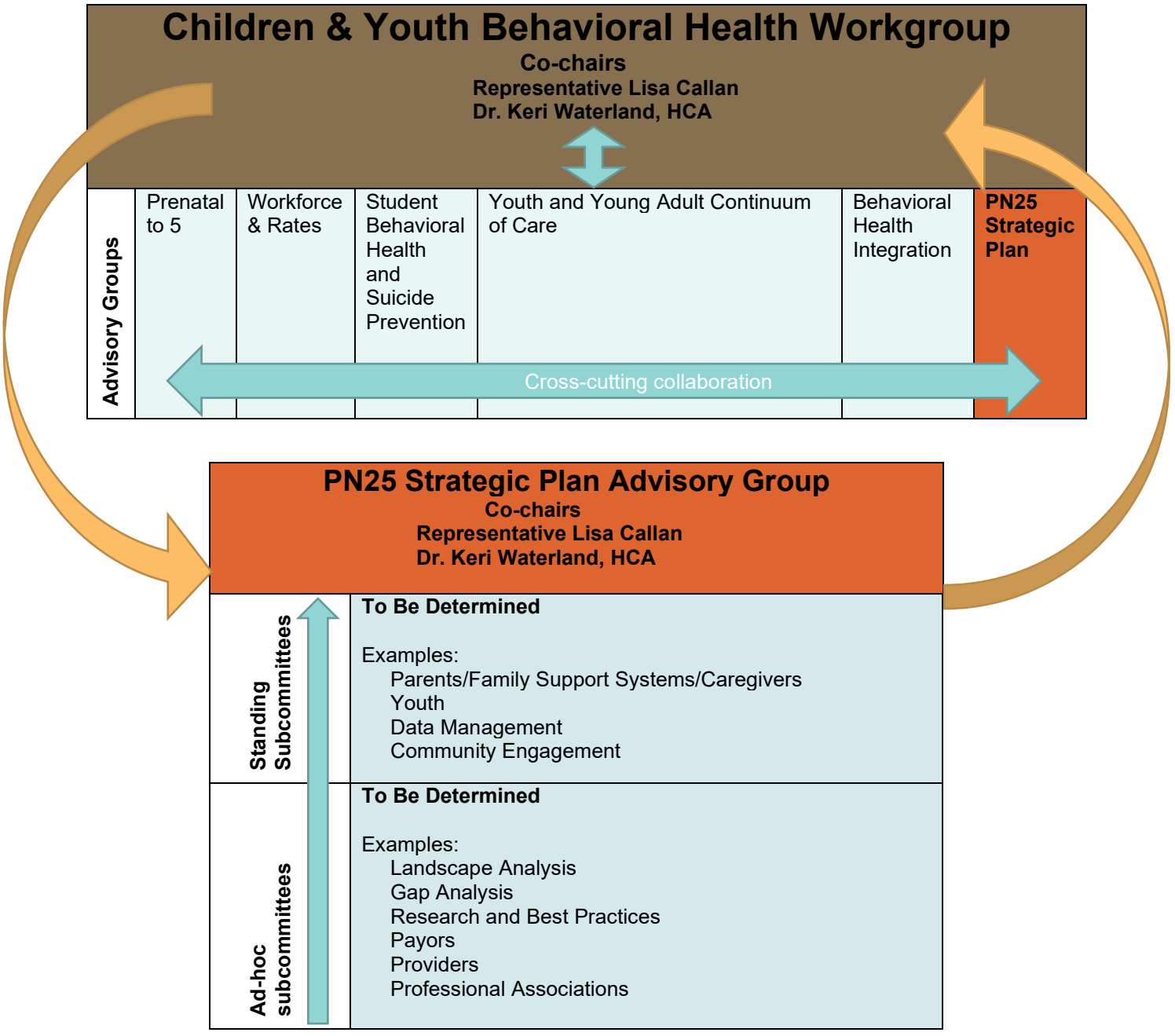
Decision making is done at the Advisory Group level. Decisions are informed by work done in standing subcommittees and ad hoc subcommittees. Decisions will be made by vote using electronic polling of the entire Strategic Planning Advisory group membership. We expect that any member who has a potential conflict of interest on a particular decision will abstain from voting.

Communication

All Advisory Group meetings are documented in meeting minutes which are distributed to Advisory Group members and posted on the CYBHWG website. In addition, all meetings are recorded on TVW.

Additional communication vehicles (email newsletters, social media, etc.) will be used to announce project updates and stakeholder engagement opportunities.

Figure 1


Children & Youth Behavioral Health Workgroup
Co-chairs
Representative Lisa Callan
Dr. Keri Waterland, HCA
Advisory Groups
Prenatal to 5
Workforce & Rates
Student Behavioral Health and Suicide Prevention
Youth and Young Adult Continuum of Care
Behavioral Health Integration
PN25 Strategic Plan
Cross-cutting collaboration
PN25 Strategic Plan Advisory Group
Co-chairs
Representative Lisa Callan
Dr. Keri Waterland, HCA
Standing Subcommittees
To Be Determined
Examples:
Parents/Family Support Systems/Caregivers
Youth
Data Management
Community Engagement
Ad-hoc subcommittees
To Be Determined
Examples:
Landscape Analysis
Gap Analysis
Research and Best Practices
Payors
Providers
Professional Associations

List of Advisory Committee Members

Appointees

Representative Lisa Callan, Co-Chair
Keri Waterland, Co-Chair (HCA) *or* Diana Cockrell (HCA)
Shelley Bogart (DSHS-DDA)
Lee Collyer (OSPI)
Byron Eagle (DSHS-Child Study Treatment Center)
Representative Carolyn Eslick
Steven Grilli (DCYF)
Kim Justice *or* Matt Davis (Commerce – Office of Homeless Youth)
Amber Leaders (Governor's Office)
Jane Beyer (OIC)
Michele Roberts (DOH)

Other Representatives

Hugh Ewart *or* Laurie Lippold (Workforce & Rates)
Summer Hammons (Tulalip Tribes)
Kristin Houser *or* Sarah Rafton (Behavioral Health Integration)
Kristin Wiggins *or* Kelli Bohanon (Prenatal through 5)
Jeannie Nist *or* Katherine Seibel (School Based BH and Suicide Prevention Subgroup)
Britni Dawson-Giles

Youth/Young Adults

Hannah Adira	Sage Dews	Desi Quenzer	Lillian Williamson
Darren Bosman	Eli Dolane	Sol Rabinovich	
Xana Caillouet	Tracey Hernandez	Casi Sepulveda	
Sierra Camacho	Bree Karger	Amanda Shi	
Amy Fumetti	Kaleb Lewis	Oscar Villagomez	

Parent/Caregivers

Tina Barnes	Melia Hughes	Sarah McNew	Lamara Shakur
Marta Bordeaux	Rokea Jones	Alexie Orr	Tui Shelton
Melissa Brooks	Michelle Karnath	April Palmanteer	Kimberly Slattery
Christi Cook	Karen Kelly	Rosemarie Patterson	Danna Summers
Alyssa Cruz	Brandi Kingston	Liz Perez	Marcella Taylor
Peggy Dolane	Nicole Latson	Jessica Russell	
Jamie Elzea	Starleen Lewis	Janice Schutz	
Heather Fourstar	Niki Lovitt	Sharon Shadwell	

Staff

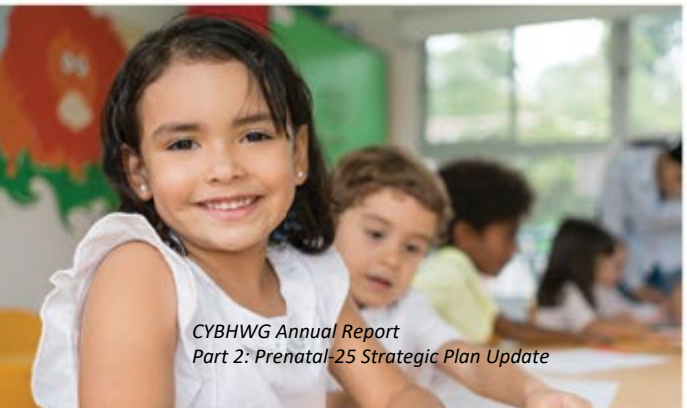
Jo Ann Kauffman (Kauffman & Associates)
Lisa Guzman (Kauffman & Associates)
Nicole Slowman (Kauffman & Associates)
Crystal Tetrick (Kauffman & Associates)
Nate Lewis (HCA)
Rachel Burke (HCA)
Erika Boyd (Rep. Callan's Aide)

2023 Meeting Schedule

Date	Time (PST)
January 12, 2023	4 to 6:30 p.m.
February 16, 2023	1 to 3 p.m.
March 13, 2023	3 to 5 p.m.
May 04, 2023	3 to 5 p.m.
July 06, 2023	3 to 5 p.m.
September 07, 2023	3 to 5 p.m.
November 02, 2023	3 to 5 p.m.

Appendix C: Qualitative Landscape Analysis, P-25 Strategic Plan Advisory Group

KAUFFMAN AND ASSOCIATES INCORPORATED



P-25 Behavioral Health Strategic Plan Advisory Committee

Qualitative Landscape Analysis

Table of Contents

Executive Summary

In 2022, the Washington State Health Care Authority engaged Kauffman and Associates, Inc. (KAI) to guide the development of a Prenatal through 25 (P-25) Behavioral Health Strategic Plan. This landscape analysis of behavioral health services in Washington state aimed to gain deep insights into the experiences, gaps, and access issues concerning behavioral health care. Through a series of focus groups and advisory group sessions, valuable qualitative data was captured to help shape the understanding of the current behavioral health landscape and inform the future vision of behavioral health as the first step in the strategic planning process.

1. **Advisory Group Landscape Analysis Qualitative Findings**: The top three findings from advisory group members centered around the high cost of care, difficulty navigating health insurance, and concerns about the delivery of behavioral health services. The high cost of services often forces individuals to choose between essential needs and mental health services. Health insurance, with its separate categorization for behavioral health and complex coverage policies, further exacerbates this situation. The delivery of behavioral health services lacks continuity and person-centered care, with an overly siloed approach that emphasizes diagnosis over holistic treatment.
2. **Gaps in Behavioral Health Services**: The significant gaps identified were geographical disparities in service access, an inadequate workforce, and capacity shortages within existing services. Rural areas were particularly underserved, and the demand for behavioral health professionals far exceeded the current supply, resulting in long wait times. Capacity shortages, evidenced by insufficient numbers of beds for young patients and overburdened staff, further compounded these issues.
3. **Access to Behavioral Health Prevention Services and Necessary Care**: Inequities in service access, affordability issues, and responsiveness of services emerged as top access issues. Disparities were observed in access to services based on location, socioeconomic status, and cultural background. Services were generally unaffordable due to high costs and complex health insurance policies. Service responsiveness varied, with cultural, linguistic, gender, and developmental appropriateness as key areas requiring improvement.

The findings warrant a need to delve deeper into the experiences of underrepresented groups, including Black, Indigenous, people of color, and LGBTQ2S+ (Lesbian, Gay, Bisexual, Transgender, Queer & Questioning, and Two Spirit[1]) communities. This will necessitate the expansion of the P-25 Strategic Plan Advisory Group to include a broader representation. The importance of diverse perspectives in enriching the understanding and ensuring the relevance and inclusivity of the P-25 Behavioral Health Strategic Plan cannot be overemphasized.

[1] LGBTQ2S stands for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, and Two Spirit. The term Two Spirit does not simply mean someone who is a Native American and/or Alaska Native (AI/AN) and gay. Traditionally, AI/AN Two Spirit people were male, female, and sometimes intersexed individuals who combined activities and traits of both men and women. *Source: https://www.samhsa.gov/sites/default/files/nc-lgbtq2s-resources.pdf*

The next steps involve incorporating quantitative findings into a comprehensive landscape analysis report to be shared with both advisory and focus groups. This report will guide the strategic planning, integrating not just the data, but also the voices and lived experiences of those most affected by behavioral health policies and practices. Ultimately, the goal is to use this work as a catalyst for change in the behavioral health landscape, promoting a future where behavioral health services are accessible, affordable, and effective for all.

Introduction

This report is the initial qualitative landscape analysis, as developed from the perspectives and experiences of the P-25 Strategic Plan Advisory Group members. It is the beginning of the story of the lived experiences of youth, young adults, parents, and families with the behavioral health system in Washington state. Further components of the qualitative landscape analysis will be forthcoming as the process of stakeholder engagement beyond the P-25 advisory group is involved. Simultaneously, a quantitative landscape analysis is being conducted by another contractor, McKinsey and Company. Once the information from the quantitative analysis is available, stakeholders will be able to further reflect on the information and express their experiences. Continuing the stories of their journeys with the state's behavioral health system will help them envision a better behavioral health system as the first step in creating a behavioral health strategic plan. This initial qualitative analysis will give the methodology taken to understand the findings, which is presented in the following sections:

- Experiences of Current Behavioral Health Services
- Gaps in Current Behavioral Health Services
- Accessing Behavioral Health Prevention Services and Necessary Care

A summary of the findings is provided along with recommended next steps.

Background

During the 2022 Washington State legislative session, the Children and Youth Behavioral Health Work Group (CYBHWG) recommended the development of a statewide P-25 Behavioral Health Strategic Plan. The recommendation was passed in the Second Substitute House Bill 1890 (HB 1890).

The purpose of the P-25 Behavioral Health Strategic Plan Advisory Group is to oversee the development of longer term, systemwide strategies. Doing so will ensure access to:

- High-quality equitable care and supports in behavioral health education
- Promotion and prevention
- Early intervention through crisis response
- Intensive treatment
- Postintervention and recovery
- Ongoing well-being for families in the perinatal stage (pregnancy through the first year of life), children, young people transitioning to adulthood, and their caregivers.

The development of these new systemwide strategies will be through a trauma-informed lens to reduce incidents of harm or trauma that may be experienced by families and instead, promote healing, recovery, and resiliency throughout the behavioral health system.

Washington Health Care Authority (WA HCA) contracted KAI to coordinate stakeholder outreach and engagement to facilitate the strategic plan. KAI used the same framework for the qualitative analysis that will be used for the quantitative analysis. The landscape analysis

defined in HB 1890 as the current landscape of behavioral health services for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth will outline the following:

> (A) The current service continuum including the cost of care, delivery service models, and state oversight for behavioral health services covered by Medicaid and private insurance,
>
> (B) current gaps in the service continuum, areas without access to services, workforce demand, and capacity shortages; and
>
> (C) barriers to accessing preventative services and necessary care including inequities in service access, affordability, cultural responsiveness, linguistic responsiveness, gender responsiveness, and developmentally appropriate service availability.

Methods and Framework

Between April 19–26, 2023, six 90-minute Zoom virtual focus groups were scheduled with one session for behavioral health providers, two sessions with youth and young adult advisory group members, and three sessions with parents and/or caregivers of children and youth, prenatal through age 25, who were also advisory group members.[2] The purpose of these focused conversations was to gain valuable insight and unique perspectives as a youth or young adult, a parent or caregiver of a child, or a provider working with youth who have received or are receiving behavioral health and/or drug and alcohol treatment services. These groups were facilitated using a focus group guide, (Appendix A). The sessions were recorded for note keeping purposes only, and the guide provided a script for the facilitators to conduct the focus group sessions.

Population

Families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth in Washington are the population served by this initial qualitative landscape analysis. The youth, young adults, parents, and care givers are members of the P-25 Behavioral Health Strategic Plan Advisory Group. A small number of providers who work with children, youth, and families were also included..

Recruitment process

An email was sent to all advisory group members and providers. Those members who were interested agreed to participate and were provided information and a Zoom link to join a scheduled session.

[2] 13 parents and 4 youth/young adults participated in the focus groups. There were 4 providers in the provider focus group: 2 from schools, 1 psychiatrist, and 1 physician.

Analysis

The qualitative analysis of focus groups involved a two-level analysis process, first to identify themes, sub-themes, and explore interrelationships, and second to analyze the findings through a behavioral health subject matter expertise (SME) lens. The first- and second-level analyses are detailed in the next section.

First-Layer Analysis

A systematic analysis of the transcripts and notes was conducted. Analysis of focus group findings were conducted to identify themes and sub-themes. Next, themes and sub-themes were reviewed to better understand and learn about the participants' behavioral health experiences.

Second-Layer Analysis

Second layer analysis incorporated the lens of a behavioral health SME to provide a nuanced interpretation and understanding of the data from both focus groups and advisory groups. The family-systems and person-in-environment framework provided a structure for capturing meaningful insights from the stories shared in a dynamic manner. The background informing the SME analysis encompasses several behavioral health domains including health care; state and federal administrations with a strong focus on improving access to quality care; addressing health disparities; and creating strategic plans grounded in both research and the lived experiences of diverse populations.

A systematic and iterative framework was employed to conduct a second-layer analysis of the data which is detailed here:

1. **Thematic Analysis:** Thematic analysis was used to identify, analyze, and interpret patterns of meaning within the qualitative data. The confirmation of the initial thematic review was completed with cross analysis to the original coding. The themes were grouped according to topics related to experiences, gaps, and access issues, providing a comprehensive understanding of the present behavioral health landscape.
2. **Triangulation:** To ensure the reliability and validity of the findings, data from both focus and advisory groups were cross verified. This ensured that the themes and patterns identified were consistent experiences or views shared across various groups and sessions. This was done using transcripts, notes, video, and audio data.
3. **Integration of In-Depth Qualitative Data:** The goal was to capture the meaningful stories and depth of the experiences shared within the process for this analysis. The experiences of those who participated matter greatly, and their sharing is appreciated. By doing so, a perspective was presented that is rich in detail and comprehensive in terms of data, scope, and depth.
4. **Incorporation of Diverse Perspectives:** Understanding the importance of representation, there was an emphasis on the need to expand participation in the advisory and focus groups. The goal is to include voices from black, indigenous, people of color, and LGBTQ2S+, and other underrepresented communities among users of behavioral health services.

Preliminary findings from the focus groups were presented to the advisory group during the May 4 P-25 Strategic Plan Advisory Group virtual meeting. A breakout session was held where all meeting participants could give their input on two questions: 1) how they would define behavioral health; and 2) where they see gaps in the behavioral health system. Ten breakout groups of four to five participants were given 30 minutes to address the two questions. One of the groups had youth and young adult participants. The other groups were a mix of parents, providers and others working in behavioral health services, programs, and agencies. The same two-layered coding that was used on the focus group data was applied to the breakout session of the P-25 meeting. The process is displayed in Figure 1.

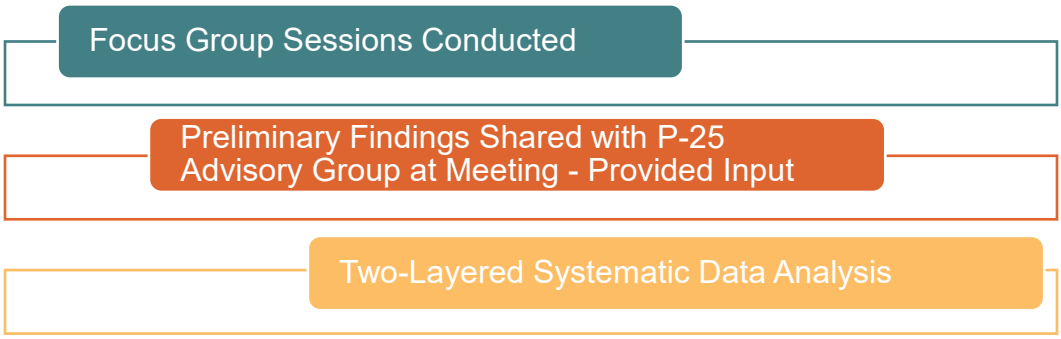


Figure 1 Qualitative Coding Process of Analysis

Qualitative Landscape Analysis Findings

This section reports on the landscape analysis findings from the focus groups. This section is organized to provide a summary of focus group findings including experiences, gaps, and access to services as described below. Focus group findings are further expanded upon to elicit greater meaning to participants' experiences and identify key themes, sub-themes, and behavioral health insights across the focus group findings.

Experiences: The behavioral health landscape, as revealed by the perspectives and experiences of the P-25 Strategic Plan Advisory Group members, highlights challenges such as limited access to early intervention services, shortage of trained mental health professionals, stigma, and inadequate health insurance coverage. Participants emphasized the need for comprehensive definitions of behavioral health that consider diverse identities and experiences, the importance of person-centered language to reduce stigma, and the necessity for culturally competent care.

Gaps: This analysis revealed significant gaps in the behavioral health landscape, including limited access to early intervention services, a shortage of trained providers, inadequate health insurance coverage, and pervasive structural stigma. To address these gaps, recommendations include increased funding for early intervention, enhanced provider training, improved insurance coverage, and anti-stigma initiatives.

Access: Key barriers identified included limited availability of providers, long wait times, lack of insurance coverage, stigma, and inadequate coordination of care. To address these gaps, recommendations included enhancing provider capacity, expanding telehealth options, improving care coordination, increasing public awareness and education, and advocating for policy changes to ensure equitable access to behavioral health services for all individuals and communities.

Experiences of Current Behavioral Health Services

In the focus group discussions, participants shared their experiences with current behavioral health services in Washington state. One of the most pressing concerns raised was the long wait times for appointments and lack of timely access to care. Participants across various focus groups reported facing significant delays in getting the help they needed, which can have detrimental effects on their mental health.

The advisory group echoed participants' testimonials, recognizing the formidable challenges people face when interacting with the system. High costs of care often deter individuals from seeking help or force them to choose between basic needs and mental health services. This aligns with concerns expressed by individuals in the May 4 focus group, who described the struggle of paying for medication and therapy alongside everyday expenses.

Cost of Care

Throughout the focus group discussions, the cost of behavioral health care was a significant concern for many families. For instance, one participant shared, "I had to pay for services out-of-pocket because insurance didn't cover them." High costs present barriers to accessing needed care, even for those with insurance coverage. According to one study, Walker et al. (2018),[3] financial barriers and limited insurance coverage often hinder individuals from accessing necessary behavioral health services. Such barriers have several implications, including delayed care, worsening of symptoms, and increased reliance on crisis services like emergency departments. An important insight from this issue is the potential impact on the mental health of individuals and communities if cost barriers remain unaddressed.

Across the board, the cost of care emerged as a considerable barrier to accessing behavioral health services, often driving individuals to choose between essential needs and mental health services.

The advisory group highlighted a poignant reality—individuals and families have to make decisions between affording meals and rent, or mental health services. This stark reality underscores the economic strain individuals and families face when seeking these essential services. Participants not only talked about the unaffordable prices of the services themselves, but also the hidden costs that come with it such as lost work hours, transportation expenses, childcare while attending therapy sessions, and more. These additional expenditures

[3] Walker, E. R., Cummings, J. R., Hockenberry, J. M., & Druss, B. G. (2018). Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatric Services, 69(6)*, 623-628.

exacerbate the financial burden and often get overlooked when considering the affordability of care.

Health Insurance

Focus group participants highlighted the role of health insurance and its influence on access to behavioral health services. They mentioned the difficulties faced by uninsured and underinsured individuals in accessing mental health care. Research demonstrates that health insurance coverage significantly impacts mental health service use, and individuals without adequate coverage face more barriers to accessing care.[4] Additionally, participants reported that even with insurance, the out-of-pocket costs associated with mental health services can still be prohibitive for many individuals. Health insurance complexities represent another significant roadblock in individuals' experiences with the behavioral health system. A notable issue is the perceived separation of behavioral health from physical health in insurance coverage, as expressed in the Group 1 of the advisory group May 4. This dichotomy is not only semantically confusing, but also structurally inconvenient, as it requires patients to navigate two seemingly different systems to access comprehensive health care.

The labyrinth of insurance policy details, including understanding what services are covered and dealing with out-of-network care intricacies, presents a significant challenge for many. Coverage limitations often lead to high out-of-pocket costs for services, and for those requiring out-of-network care, expenses can become prohibitive. These experiences underscore the need for clearer, more integrated, and accessible coverage for behavioral health services in insurance policies.

Delivery of Behavioral Health Services

The focus group discussions touched upon various aspects of the delivery of behavioral health services, emphasizing the importance of integrating primary care and behavioral health services. Participants expressed concerns about the fragmented nature of the current system and the challenges in navigating it. For example, one participant mentioned the need for better coordination and communication among providers, schools, families, and other supports for children and adolescents.

> *Because insurance companies who make the rules for how services are paid for have decided that it's in their best interest long term financially, for preventive services to be paid for so that people go in and things get caught early and addressed before they become more serious and expensive. And yet in the behavioral health field, there's not that parallel, right of like, preventive services aren't paid for, you know, like, you can't go oh, I'm starting to see an emerging challenge with my five-year-old, you know, oh, no, they have to have a diagnosis. It has to be medically necessary for them to get treatment for it to be paid for. And so why is there that discrepancy? —Focus group participant*

[4] Bishop, T. F., Seirup, J. K., Pincus, H. A., & Ross, J. S. (2020). Population of US Practicing Psychiatrists Declined, 2003–13, Which May Help Explain Poor Access to Mental Health Care. *Health Affairs, 35*(7), 1271-1277. doi.org/10.1377/hlthaff.2015.1653

Research supports the importance of integrating behavioral health services into primary care settings, as it leads to improved outcomes and can help address access issues.[5] Also, some participants discussed the use of telehealth services, which increased during the COVID-19 pandemic and could improve access to care, particularly in rural and underserved areas.[6]

The current delivery of behavioral health services raises concerns about the lack of continuity of care, the overly siloed approach, and the limited focus on person-centered care. Advisory group participants pointed to instances where treatment felt impersonal, detached, and driven primarily by the clinician's understanding of their diagnosis rather than their holistic needs.

The system often felt fractured, with different services operating in isolation, leading to individuals having to navigate multiple providers and services on their own. Participants also echoed the sentiment that treatments were often heavily diagnosis-focused, with less emphasis on their personal experiences, contexts, and needs. They expressed a desire for more empathetic, personalized, and continuous care that extends beyond labels and diagnoses.

Gaps in Current Behavioral Health Services

A comprehensive evaluation of both the focus group and advisory group data reveals three main gaps in behavioral health services: The lack of accessibility in certain regions, a shortage of skilled professionals, and insufficient capacity within existing services.

Areas Without Access to Services

Focus group participants recounted several distressing stories that highlighted the challenges faced by families trying to access behavioral health services, especially in rural and remote areas. A particularly poignant story involved a parent who lost their child to suicide after they were unable to access the appropriate services. The child, who had been diagnosed with fetal alcohol spectrum disorder (FASD) presented in the emergency department with suicidal ideation, plan, and intent, yet no effective intervention was offered by the emergency department and the designated crisis responders. Given the cognitive and behavioral challenges associated with FASD, it may have made it more difficult for the child to articulate their feelings, understand the severity of their situation, and engage with the treatment process effectively.[7] Additionally, it could have complicated the assessment and intervention process for providers who may not have been adequately trained to recognize and respond to the specific needs of individuals with FASD or other Intellectual and Developmental Disabilities (IDD).[8]

[5] Heath, B., Wise Romero, P., & Reynolds, K. A. (2021). A review and a proposed research and practice agenda for the integration of behavioral health and primary care. *Families, Systems, & Health, 39*(1), 123-138.

[6] Druss, B. G. (2021). Addressing the COVID-19 pandemic in populations with serious mental illness. *JAMA Psychiatry, 78*(9), 929-930.

[7] Paley, B., & O'Connor, M. J. (2011). Behavioral interventions for children and adolescents with fetal alcohol spectrum disorders. *Alcohol research & health: the journal of the National Institute on Alcohol Abuse and Alcoholism*, *34*(1), 64–75.

[8] Thanh, N. X., & Jonsson, E. (2018). LIFE EXPECTANCY OF PEOPLE WITH FETAL ALCOHOL SYNDROME. *Journal of Population Therapeutics and Clinical Pharmacology*, *23*(1). Retrieved from jptcp.com/index.php/jptcp/article/view/240

The lack of capacity for interventions and specialized services for individuals with IDDs, particularly during a crisis, can pose a significant barrier to accessing appropriate and effective care. This story reiterates the need for more specialized training for health care providers and the integration of services that consider the unique needs of individuals with conditions such as FASD. It is also worth noting that the lack of resources for parents and caregivers of children with IDDs can create more strain. Comprehensive support services for these families, including specialized therapy and counseling, parent training programs, and respite care, are essential components of an effective, robust behavioral health system.

Expanding on this challenging situation, a variety of services that could have been beneficial were notably absent. First and foremost, comprehensive crisis intervention services that are adept at handling situations where the individual is unable to provide consent due to incapacitation would have been instrumental. As highlighted by the participant's experience, the lack of these services in the emergency department context was a crucial gap. The emergency department is often the first point of contact for those in acute crisis, and it should be equipped with personnel trained to assess and manage behavioral health crises effectively.

Another key missing element was family advocacy. Parental and familial input can be vital in managing behavioral health crises, especially in cases involving minors or dependent adults. Having family advocates to support and guide the parents through the process, ensuring their voices and concerns are heard, could provide a critical buffer in these stressful situations. In addition, the availability of locally accessible, specialized mental health services, especially in rural areas of Washington, was identified as another key gap. Many participants noted the difficulty of navigating complex systems, which could be further complicated in rural settings due to geographic dispersion and limited resources.

Lastly, it is evident that there are overarching gaps in understanding the legal complexities of behavioral health crisis management. The consent laws, especially in the case of someone who is incapacitated and in crisis, can be hard to comprehend for families navigating the system, further exacerbating an already stressful situation.

This incident underscores the importance of integrating an array of services within the emergency department, facilitating legal understanding, and enhancing the overall behavioral health infrastructure, particularly in Washington's rural and remote regions. This comprehensive approach would significantly improve the behavioral health landscape, providing robust support for families navigating behavioral health crises. The sad narrative also emphasizes the need to continue advocating for policy changes and strategic engagement to ensure such tragedies are averted in the future.

The advisory group acknowledged systemic gaps, particularly the service vacuum in certain geographical areas and the need for a larger, more capable workforce. Participants from rural areas often face long travel times to access services, an issue noted in the qualitative behavioral health landscape breakout group. Furthermore, there's a substantial workforce shortage, resulting in prohibitive waiting times.

These situations reveal the dire consequences that can result from inadequate access to services. Research shows that rural populations face significant barriers in accessing mental

health services due to a variety of factors. These include distance to travel to providers, limited public transportation, and the scarcity of available services.[9] These disparities contribute to worsen outcomes for those in need of behavioral health interventions, and the focus group discussions demonstrate the real-life impact of these disparities on individuals and families. It is crucial to address the gaps in service access in both rural and urban areas to make sure all individuals can access the care they need, regardless of their geographic location. This may require innovative strategies, such as telehealth and mobile mental health clinics, to reach underserved populations and provide the necessary support.[9]

Levels of Care in the Environment

Focus group participants identified various gaps in behavioral health services, echoing concerns raised in research about the availability and adequacy of services. For example, A participant stated, "For the work I'm doing with community and school, certainly behavioral health promotion, primary prevention, early intervention, and referral services aren't where I live." This concern aligns with research findings suggesting that early intervention and prevention are crucial for improving mental health outcome.[10]

One parent shared the tragic story of their family friend whose child died by suicide after being unable to access appropriate care. This highlights the severe consequences that can result from service gaps. Research supports these concerns, whereby gaps in services can lead to adverse outcomes, including increased risk for suicide and psychiatric hospitalizations.[11]

A participant also mentioned the importance of intermediate levels of care and the need to involve schools, families, and other supports for children and adolescents, a sentiment echoed in research by Estrada-Martínez et al.[12] The integration of these support systems is vital for addressing disparities and improving mental health outcomes. The groups also mentioned the need for services tailored to different developmental stages, such as infant/early childhood, school-age children, and emerging adults ages 18–25.

Another gap highlighted by a participant is the lack of environmental strategies related to behavioral health: "There's no infrastructure for this. We need strategic parent engagement, education, and policy changes." Research by Castillo et al. (2019)[13] suggests that community-

[9] Andrilla, C. H., Patterson, D. G., Garberson, L. A., Coulthard, C., & Larson, E. H. (2018). Geographic variation in the supply of selected behavioral health providers. *American Journal of Preventive Medicine, 54*(6S3), S199-S207.

[10] Hoagwood, K., Burns, B., & Olin, S. (2019). Evidence-based practice implementation strategies: Importance of mixed-methods research in implementation and services. *The Journal of Behavioral Health Services & Research, 46*(3), 366-371.

[11] Walker, E. R., Cummings, J. R., Hockenberry, J. M., & Druss, B. G. (2018). Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatric Services, 69(6)*, 623-628.

[12] Estrada-Martínez, L. M., Caldwell, C. H., Bauermeister, J. A., & Zimmerman, M. A. (2018). Stressors in multiple life-domains and the risk for externalizing and internalizing behaviors among African Americans during emerging adulthood. *Journal of Youth and Adolescence, 47*(1), 46-59.

[13] Castillo, E. G., Ijadi-Maghsoodi, R., Shadravan, S., Moore, E., Mensah, M. O., 3rd, Docherty, M., Aguilera Nunez, M. G., Barcelo, N., Goodsmith, N., Halpin, L. E., Morton, I., Mango, J., Montero, A. E., Rahmanian Koushkaki, S., Bromley, E., Chung, B., Jones, F., Gabrielian, S., Gelberg, L., Greenberg, J. M., … Wells, K. B. (2019). Community Interventions to Promote Mental Health and Social Equity. *Current psychiatry reports*, *21*(5), 35.

based interventions, parent engagement, and environmental strategies are essential for promoting mental health in various populations.

In summary, participants' concerns about the gaps in behavioral health services emphasize the need for targeted improvements in prevention, early intervention, and support systems, as well as the importance of environmental strategies and community involvement. By addressing these gaps, policymakers and service providers can help to enhance the overall quality and accessibility of behavioral health services for diverse populations.

Workforce Demand

The focus group discussions brought attention to the high demand for behavioral health providers, which often results in long wait times for services and insufficient care for those in need. A story shared by a parent involved their struggle to secure resources for their child, who was endangering others in the home. This family experienced a heartbreaking dilemma. Leaving their child in the hospital led to reports to Child Protective Services, but they were unable to find appropriate resources for their child otherwise. A lack of available providers and resources highlights the severity of workforce shortages in the field.

Another crucial gap is the mismatch between the supply and demand of behavioral health professionals. Advisory group discussions revealed long waiting times for appointments, a symptom of the workforce shortage. This problem is even more pronounced for specialized services and for those requiring immediate attention, such as people in crisis or at-risk youth. These experiences corroborate the focus group data, wherein participants highlighted instances of having to wait weeks to months for a consultation.

Workforce shortages are a major concern in behavioral health care, as it can lead to delays in accessing services, lower quality of care, and increased patient burden.[14] Factors contributing to workforce shortages include an aging provider workforce, high rates of provider burnout, and inadequate reimbursement rates for services.[15] Additionally, research indicates that the distribution of behavioral health providers is uneven across geographic areas, with rural areas having a lower supply of providers compared to urban areas.[16]

Addressing the workforce shortages in behavioral health care will require concerted efforts to attract and retain qualified providers, provide adequate support and resources to reduce burnout, and ensure that reimbursement rates are competitive and sustainable. Furthermore, policy and educational initiatives can be implemented to increase the pipeline of future behavioral health providers, as well as to support the use of telehealth and other innovative strategies to mitigate workforce shortages.[14]

[14] Davis, M., Gersen, A., & Gahlon, G. (2020). Telepsychiatry Use in US Mental Health Facilities, 2010–2017. *Psychiatric Services, 71(2)*, 121-127.

[15] Han, X., Luo, Q., & Ku, L. (2017). Medicaid expansion and grant funding increases helped improve community health center capacity. *Health Affairs, 36*(1), 49-56.

[16] Andrilla, C. H., Patterson, D. G., Garberson, L. A., Coulthard, C., & Larson, E. H. (2018). Geographic variation in the supply of selected behavioral health providers. *American Journal of Preventive Medicine, 54*(6S3), S199-S207.

Capacity Shortages

In addition to the issue of workforce shortages, capacity shortages in existing services were another substantial issue identified. In a small group discussion on May 4, there was mention of the lack of beds for youth under 13, indicating the gap in in-patient services for this age group. Another compounding issue is the workforce being underpaid and overstressed, contributing to high turnover rates and further exacerbating service availability. Focus group participants echoed these concerns, mentioning instances where their appointments were rushed due to the clinicians' overwhelming workload (focus group, participant). This includes limited bed availability in inpatient and residential treatment settings and a lack of specialized programs for individuals with complex behavioral health needs.

Capacity shortages can lead to prolonged wait times for services, forcing individuals and families to make difficult choices about where to seek care, as shown by the heartbreaking story of the parent who had to leave their child in the emergency room to ensure they received appropriate treatment. Research suggests that factors contributing to capacity shortages in behavioral health care include inadequate funding for public mental health services, high rates of uninsured individuals, and the increasing demand for services.[3] Moreover, capacity shortages may disproportionately affect certain populations, such as children and adolescents, who require specialized care and support that are often in short supply. Addressing capacity shortages in behavioral health care will require targeted investments in the expansion and development of services, as well as strategic planning to ensure that resources are allocated effectively to meet the diverse needs of the population.

Accessing Behavioral Health Prevention Services and Necessary Care

Access issues take several forms in the behavioral health landscape. Through focus groups, the following inequities emerged, including inequities in service access, unaffordability of services, and a lack of responsiveness to diverse patient needs.

Inequities of Service Access

Inequities in access to behavioral health services are a persistent concern, as evidenced by the focus group discussions and advisory group reiteration. Both the focus group and advisory group data pointed toward significant disparities in service access. Factors such as location, socioeconomic status, and ethnicity can lead to vast differences in the ability to obtain necessary behavioral health services. For instance, rural residents often struggle with finding nearby services, and low-income individuals may lack the resources to travel to better-served areas. Additionally, Black, Indigenous, people of color and LGBTQ2S+ individuals reported feeling less understood or accepted by their providers, impacting their willingness to seek services.

The issue of access is multifaceted, encompassing concerns related to inequitable service distribution, high costs, and service responsiveness. A lack of culturally, linguistically, and developmentally appropriate services often results in barriers to access for diverse groups. This results in significant disparities in service use among minorities, individuals with different

linguistic backgrounds, varying age groups, and those with unique developmental needs. Moreover, the high costs associated with care make behavioral health services unaffordable for many, deterring them from seeking necessary help.

Research demonstrates that disparities in access to mental health services often result in lower-quality care and poorer outcomes for marginalized populations.[17] Moreover, affordability is a significant barrier to care for many families, as the excessive cost of services can prevent them from accessing the necessary support and treatment they need. The focus group discussions emphasize the need for addressing these barriers to care, as well as the importance of creating a more responsive and equitable behavioral health system that meets the needs of all individuals and families, regardless of their background or circumstances. Factors such as language barriers, cultural beliefs, and stigma can further exacerbate disparities in service access for racial and ethnic minority populations.[18]

Addressing these inequities in access to care will require targeted efforts to identify and eliminate barriers, as well as the development and implementation of culturally responsive interventions that recognize and address the unique needs of diverse populations. This may include increasing the cultural competency of providers, implementing linguistically appropriate services, and addressing stigma and other barriers to care within specific communities.[18]

Affordability of Services

Affordability of behavioral health services is a crucial issue for many families, as highlighted by the focus group discussions. Even when services are available, excessive costs or inadequate insurance coverage can create significant barriers to accessing needed care. Focus group discussions highlighted the prohibitive cost of care as a significant barrier. Participants shared anecdotes of having to choose between basic necessities and mental health services due to financial constraints.

These observations were echoed in the advisory group discussions, where it was noted that out-of-pocket expenses, even with insurance, are often too high for many individuals. Research indicates that the high cost of behavioral health services, coupled with the rising prevalence of high-deductible health plans, has made it increasingly difficult for many families to access care.[19] Furthermore, the focus group discussions revealed that many families struggle to navigate the complex insurance landscape, which can lead to confusion and frustration when trying to access care.

Addressing the affordability of behavioral health services will require concerted efforts to make sure that families have access to comprehensive, affordable insurance coverage that includes the necessary supports and treatments for behavioral health concerns. Additionally, policy and programmatic initiatives aimed at reducing the cost of care, such as value-based payment

[17] Cook, B. L., Hou, S. S., Lee-Tauler, S. Y., Progovac, A. M., Samson, F., & Sanchez, M. J. (2019). A review of mental health and mental health care disparities research: 2011-2014. *Medical care research and review, 76*(6), 683–710.

[18] Cabassa, L. J., Stefancic, A., O'Hara, K., El-Bassel, N., Lewis-Fernández, R., Luchsinger, J. A., ... & Blanco, C. (2019). Peer-led healthy lifestyle program for preventing diabetes among low-income Latinos: A randomized controlled trial. *American Journal of Preventive Medicine, 57*(5), e143-e151.

models and increased funding for public mental health services, can help to make services more accessible and affordable for all individuals and families.[19]

Responsiveness of Services

The focus group participants voiced concerns about the behavioral health system's responsiveness, both in addressing individual and community needs. This includes the need for more culturally responsive care that recognizes and addresses the diverse needs of patients from different cultural backgrounds. Research supports the value of culturally competent care in improving mental health outcomes for diverse populations.[20] Culturally responsive care involves understanding the cultural beliefs, values, and practices of patients and tailoring interventions to align with their specific needs and preferences. Strategies for improving cultural responsiveness in behavioral health care include increasing the diversity of the provider workforce, offering cultural competency training for providers, and developing and implementing culturally tailored interventions that have been shown to be effective for specific populations.[20] Incorporating these strategies into the behavioral health system, will create a more responsive, equitable, and effective system of care for all individuals and families, regardless of their background or circumstances.

Cultural Responsiveness

Participants across the board highlighted a need for more culturally responsive care. People from different ethnic and cultural backgrounds often reported feeling misunderstood or invalidated by their providers. This was further underscored by the advisory group, which emphasized the importance of understanding cultural nuances in care delivery. One participant shared, "I felt like my provider didn't understand my cultural background." This experience highlights the need for providers to be sensitive to and knowledgeable about the cultural values, beliefs, and practices of their clients. Sue et al. (2019)[21] emphasizes the importance of cultural competence in reducing disparities in mental health care and improving outcomes for diverse populations. By incorporating cultural competence training for providers, culturally responsive services can be offered that address the unique needs and experiences of clients from diverse backgrounds.[21]

Linguistic Responsiveness

A lack of language-congruent services was identified as a significant barrier. Non-English speakers reported struggles in communicating their needs, leading to frustrations and, in many cases, discontinuation of services. The advisory group affirmed this, emphasizing the need for more multilingual providers (Advisory group, participant). One participant shared, "My family couldn't find a therapist who spoke our language." This highlights the importance of linguistic

[19] Han, X., Luo, Q., & Ku, L. (2017). Medicaid Expansion And Grant Funding Increases Helped Improve Community Health Center Capacity. *Health Affairs, 36*(1), 49–56. *doi.org/10.1377/hlthaff.2016.0929*

[20] Gone, J. P., & Kirmayer, L. J. (2020). Advancing Indigenous Mental Health Research: Ethical, conceptual and methodological challenges. *Transcultural psychiatry*, *57*(2), 235–249. https://doi.org/10.1177/1363461520923151

[21] Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the Culturally Diverse: Theory and Practice*. (8 ed.) Wiley.

responsiveness in providing quality care. Research by Sentell et al. (2018)[22] demonstrates that language barriers can contribute to disparities in care and hinder access to mental health services. By ensuring access to providers who speak the client's language, or offering interpretation services, the behavioral health system can better accommodate the needs of linguistically diverse populations.[22]

Gender Responsiveness

Focus group participants also discussed the importance of gender-responsive care. One participant mentioned, "My daughter didn't feel comfortable talking to a male therapist." This highlights the need for providers to be sensitive to gender-specific issues and make sure clients feel comfortable discussing their experiences. Issues surrounding gender inclusivity and sensitivity also emerged in the discussions. Transgender and nonbinary individuals often faced hurdles in finding providers who understand their specific needs and struggles. The advisory group identified the need for more gender-responsive services to address this gap. A review by Lanctot (2018)[23] suggests that gender-responsive care can lead to better treatment outcomes and increased satisfaction with services. This may involve offering clients the option to choose a provider of the same gender, or ensuring providers receive training on gender-specific issues and concerns.[23]

Developmentally Appropriate Service Availability

The focus group participants emphasized the need for developmentally appropriate services in the behavioral health landscape. There were concerns about the lack of developmentally appropriate services, particularly for young children and adolescents. Parents and caregivers expressed difficulties finding suitable services for their children, often resulting in delayed care. The advisory group also noted this gap, advocating for age-appropriate services to be more widely available. One participant shared, "My teenager needed a therapist who understood adolescent issues." Research by McGorry et al. (2022)[24] highlights the importance of developmentally tailored interventions that consider the unique needs of children and adolescents at various stages of development. Providing developmentally appropriate care can enhance the effectiveness of interventions, reduce barriers to care, and improve overall client satisfaction.[24]

[22] Sentell, T., Sentell, T., Pitt, R., Okan, O., Manganello, J., Massey, P., Davis, J & Davis, T. (2018). Social health literacy: Existing evidence, research gaps, and future directions. *European Journal of Public Health*, *28*(suppl_4), cky213-071

[23] Lanctot, N. (2018). Gender-responsive programs and services for girls in residential centers: Meeting different profiles of rehabilitation needs. *Criminal Justice and Behavior*, *45*(1), 101-120.

[24] McGorry, P. D., Mei, C., Chanen, A., Hodges, C., Alvarez-Jimenez, M., & Killackey, E. (2022). Designing and scaling up integrated youth mental health care. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *21*(1), 61–76. https://doi.org/10.1002/wps.20938

Summary

The advisory group behavioral health landscape analysis revealed significant insights into experiences, gaps, and access issues related to behavioral health services, informed by rich data from focus groups and advisory group discussions.

Experiences: The high cost of care was frequently noted as a barrier to receiving behavioral health services, as was the complexity of navigating health insurance. Participants called for more person-centered care and a move away from solely diagnosis-focused treatment, highlighting the need for a more integrated and patient-focused approach (Focus group; Advisory group).

Gaps: Key gaps included geographical areas without service access, a workforce unable to meet the growing demand, and capacity shortages within existing services. Particular concerns were raised about underserved rural areas and the scarcity of specialized services (Focus group; Advisory group).

Access: The analysis also revealed notable issues with access to behavioral health prevention services and necessary care. These included inequities in service access, long wait times for appointments, unaffordability of services, and a lack of responsiveness to diverse patient needs. Furthermore, issues of cultural, linguistic, gender, and developmental responsiveness in services were underscored (Focus group; Advisory group).

Thematic elements observed include the following:

Barriers to accessing behavioral health services: Participants from all three focus groups (youth, parents, and providers) identified significant barriers to accessing services, such as prohibitive costs, limited insurance coverage, inadequate reimbursement rates, long waiting lists, and a lack of culturally and linguistically responsive providers. Moreover, transportation issues and a shortage of providers, especially in rural areas, were noted as major challenges.

Quality of providers: All focus groups raised concerns about the quality of behavioral health providers. Issues ranged from inexperienced practitioners, such as students in training, to overworked professionals working long hours, which can compromise the quality of care.

Gaps in the Continuum of Care (CoC) Model: Participants from all focus groups mentioned gaps in the CoC model, including a lack of infrastructure, insufficient support for school-based services, and the need to better leverage existing resources like collaborative care models. Furthermore, they highlighted the importance of addressing social determinants of health and incorporating environmental strategies and parent engagement at all levels.

Accessibility and availability of services: All focus groups emphasized the need for more accessible and available services, both in terms of location and operating hours.

The groups also mentioned the need for services tailored to different developmental stages, such as infant/early childhood, school-age children, and emerging adults ages 18–25. Additionally, they stressed the importance of offering services that cater to various demographic groups, including race, ethnicity, culture, and community.

Prevention and early intervention: Participants from all focus and advisory groups underscored the importance of prevention and early intervention efforts in addressing behavioral health issues among children and their families. They suggested empowering primary care providers to assess psychiatric symptoms in young children and emphasized the need for funding to support whole family systems.

Desired services and improvements: All focus groups expressed the need for more comprehensive and diverse services for children and their families, such as culturally responsive care, gender-sensitive services, and linguistically appropriate support. Advisory groups affirmed this. The importance of addressing generational trauma and implementing strategic parent engagement and education initiatives was also discussed.

This qualitative analysis of the behavioral health landscape in Washington state is a first step in understanding the behavioral health system as part of the strategic planning process. The first phase of analysis has laid a robust foundation, but a broader representation is needed to accurately portray the complete behavioral health landscape and further inform strategic plan visioning.

It is recommended that the advisory group expand its representation to include more diverse voices, particularly from the Black, Indigenous, people of color, and LGBTQ2S+ communities. This will provide a more complete understanding of the lived experiences of different demographic groups, which will in turn provide more equitable solutions.

Simultaneously, the advisory group will be asked to aid in this expansion, leveraging their networks to ensure a diverse representation of advisory group participants. Diverse perspectives within the advisory group will ensure a more balanced representation of lived experiences and perspectives. An inclusive approach is crucial in shaping a strategic plan that will drive meaningful and lasting change in the behavioral health system.

The next step in this process will involve synthesizing the quantitative findings with these rich qualitative findings to create a comprehensive report. This report will provide clear visual representations of the statistical descriptive data, along with the voices and lived experiences captured through this work. This report will then be shared with both the advisory group and the focus groups. The intention for this sharing is to be a dialogue rather than a one-way communication. The intention for these groups is to interact with the findings, ask questions, offer interpretations, and contribute to deepening and broadening our understanding of the behavioral health system, and start envisioning a new and improved system.

This approach allows the integration of participants directly into the analysis process, turning focus group participants and advisory group members into co-analysts. They have lived these experiences; their further involvement will bring all engaged in this process closer to the truth of the behavioral health landscape and generate richer insights for strategic planning.

The landscape analysis report will thus form a cornerstone in the strategic planning process for the project. By offering clear insights into the current state of the behavioral health landscape and potential areas for improvement, the report will guide discussions on strategy development. The strategic plan will then reflect not only the data but also the voices and perspectives of those most affected by behavioral health policies and practices, enhancing its relevance and impact.

Ultimately, the aspiration is to use this report and subsequent strategic planning as the catalyst for real and sustainable change in the behavioral health landscape. The ultimate goal is a future where behavioral health services are accessible, affordable, and effective for all who need them, irrespective of their background or circumstances.

Appendices

Appendix A: Focus Group Guides

WA Children and Youth BH Work Group Strategic Plan—Focus Group: Parent

Part I. Logistics (At time of zoom registration)

- Parents must be:
  - A parent/guardian/caregiver of youth with lived BH experience
  - A member of the WA Children and Youth BH Work Group

- Set up Zoom registration for the group, with name and consent to participate.

Part II. Introduction (5 minutes)

[Focus Group Moderator] Thank you for agreeing to talk to us today and joining us on zoom. Introduce self, with Kauffman and Associates, Inc. (KAI). The purpose of today's focus group session is to gain your valuable insight and unique perspective as a parent of a child who has or is receiving behavioral health and/or drug and alcohol treatment services.

Over the past few years, many voices have been raised about the crisis in mental health, particularly for children and young people, and the inability of the system and services to meet children, youth, and families' needs.

The Washington Legislature has directed the Children and Youth Work Group to develop a strategic plan for people from birth through age 25 to better meet their needs.

Your experiences and perceptions will help give an accurate view of what's happening to young people now and will help us develop a plan to improve these services in the future.

[Focus Group Moderator] I will be asking you some questions which you are free to answer in any way you wish. Please elaborate on any of your points as you see fit. And if a question is unclear, please ask me to explain. Also, know that your participation is voluntary, and you may pass on any questions you do not want to answer. If you change your mind about participating in this focus group, you may leave the zoom session at any time.

This session is being recorded for note taking purposes only. Your answers will be kept confidential. Recordings will be held securely at KAI and destroyed after analysis. None of the

data will be stored in the State of Washington. Your identity will be protected; no names will appear, and information will be aggregated for a summary report. There are no known risks from taking part in this focus group. There is a benefit to your participation in the focus group which is to give input and feedback to help the CYBH Work Group develop a strategic plan addressing behavioral health care services, programming, facilities, and support. There is no cost to participate in this focus group with the exception of your time.

Part III. Questions and Feedback (75 Minutes)

[Focus Group Moderator] will share a bit about themself and introduce [Note Taker]. [Note Taker] will introduce themselves. [Focus Group Moderator] Can we please go around the room and share your first name and a hobby.

Let us begin.

[Put up slide of BH [FGM] introduce and describe slides, ask for questions. Leave slide up.

Use next slide if they are unsure or don't know.

[FGM]

1. How would you define behavioral health? What does behavioral health mean to you?
    a. Define for all youth ages (infant/early childhood, school-age children, emerging adults ages 18-25)?
    b. How would you define for youth and their families in geographic locations (rural, city, around state)?
    c. How does it serve different demographics (including race/ethnicity/culture/community)?

[Put up slide of BH [FGM] Share next slide of definitions if not used above.

2. Were your definitions of behavior health similar to these? Different?

[Put up slide of BH services [FGM] introduce and describe slides, ask for questions. Ask for other services not covered. Leave slide up.

3. Describe your experiences with these BH services? What services have you, your children or your family used? [FGM] Ask if anyone would like to comment or choose a person-make sure to allow time for all to contribute.
   Make sure they address the following:

a. What BH and/or drug and alcohol and/or prevention services have you used or are using? Ask about schools, boys & girls clubs, cultural & prevention activities/events?
b. How did you, your children or your family get connected with these activities & services? Who did you, your children, or your family talk to (school, counselor, friend, family, etc.)?
c. What about services for the different age and developmental stages (infant/early childhood, school-age children, emerging adults ages 18-25).
d. What about services for geographic locations-rural, etc.
e. What services serve what demographics (including race/ethnicity/culture/community)?

4. Are there any other BH services and/or drug and alcohol and/or prevention services you think should be offered? Look at services-give examples of other services not mentioned.

    a. What types of services did you wish you, your children or your family had gotten that you couldn't? Ask age group of children, geographic location, demographic information (including race/ethnicity/culture/community).

    b. Do you feel there are enough BH services and/or drug and alcohol treatment providers, such as counselors?

        i. Do you feel that there are enough providers, that look like you, your children, or your family, or come from your communities or your cultures?

            1. Are there enough providers that serve children at different ages and developmental stages (infant/early childhood, school-age children, emerging adults ages 18-25).

            2. Do the providers serve geographic locations where children are located, and demographic information (including race/ethnicity/culture/community).

    c. Do you feel that more or other services are needed? For example, are there adequate prevention services that are culturally relevant.

ii. Are there other serves that serve children at different ages and developmental stages (infant/early childhood, school-age children, emerging adults ages 18-25).

iii. Are there other services to serve geographic locations where children are located, and demographic information (including race/ethnicity/culture/community).

Additional Prompts

f. Do you think that the majority of the providers are culturally informed of the individuals they work with (including race/ethnicity/culture/community)?

   a. Do they speak the languages of the individuals they work with?

   b. Do you feel that there are sufficient genders represented in providers, that are like the clients they serve?

g. Do you feel that the services you, your children or your family received met you, your children, or your family where you are at for your ages (infant/early childhood, school-age children, emerging adults ages 18-25), or life stages?

5. Where did you, your children or your family get BH and/or drug and alcohol services? Did people come to your home? Did you, your children or your family see someone someplace else, such as at school/work? At an activity/event?

   d. How far did you, your children or your family have to travel to get these services? Did you, your children or your family get to these services in an area close to your home/school? Did they have days/times to fit around your school/jobs? Activities/events offered at good times?

   e. Were the locations welcoming to you, your children, or your family? Did you, your children or your family feel safe? why-colors on walls, posters, languages used, made you, your children or your family feel valued? Met you, your children, or your family where you are at for your ages, or life stages?

6. Did you experience any problems or issues to receive services? Prevention services, accessing necessary care? Resources or supports?

   a. What are the barriers to accessing preventative services?

b. What are the barriers to accessing necessary care?

7. What behavioral health services would you like to have available for you, and/or your family?
    a. For all youth ages (infant/early childhood, school-age children, emerging adults ages 18-25)?
    b. In geographic locations (rural, city, around state)?
    c. Services in different demographics (including race/ethnicity/culture/community)?

Part IV. Conclusion (10 Minutes)

[Focus Group Moderator] We have reached the end of the focus group questions. Given everything that we discussed, is there anything we have not asked that you would like to share?

Thank you for attending and agreeing to talk to us today.

Children and Youth BH Work Group Strategic Plan—Focus Group: Youth

Part I. Logistics (At time of zoom registration)

- Youth must be:
    - Between the ages 15-25 years old
    - Members of the WA Children and Youth BH Work Group
- Set up Zoom registration for the group, with name and consent form of parent/guardian for those under 18 years old and consent for those youth 18-25 years old.

Part II. Introduction (5 minutes)

[Focus Group Moderator] Thank you for agreeing to talk to us today and joining us on zoom. Introduce self, with Kauffman and Associates, Inc. (KAI). The purpose of today's focus group session is to gain your valuable insight and unique perspective as a youth/young adult who has or are receiving behavioral health and/or drug and alcohol treatment services.

Over the past few years, many voices have been raised about the crisis in mental health, particularly for children and young people, and the inability of the system and services to meet children, youth, and families' needs.

The Washington Legislature has directed the Children and Youth Work Group to develop a strategic plan for people from birth through age 25 to better meet their needs.

Your experiences and perceptions will help give an accurate view of what's happening for young people now and will help us develop a plan to improve these services in the future.

[Focus Group Moderator] I will be asking you some questions which you are free to answer in any way you wish. Please elaborate on any of your points as you see fit. And if a question is unclear, please ask me to explain. Also, know that your participation is voluntary, and you may pass on any questions you do not want to answer. If you change your mind about participating in this focus group, you may leave the zoom session at any time.

This session is being recorded for note taking purposes only. Your answers will be kept confidential. Recordings will be held securely at KAI and destroyed after analysis. None of the data will be stored at the State of Washington. Your identity will be protected; no names will appear, and information will be aggregated for a summary report. There are no known risks from taking part in this focus group. There is a benefit to your participation in the focus group which is to give input and feedback to help the CYBH Work Group develop a strategic plan addressing behavioral health care services, programming, facilities, and support. There is no cost to participate in this focus group with the exception of your time.

Part III. Questions and Feedback (75 Minutes)

[Focus Group Moderator] will share a bit about themself and introduce [Note Taker]. [Note Taker] will introduce themselves(s). [Focus Group Moderator] Can we please go around the room and share your first name and a hobby you enjoy.

Let us begin.

[Put up slide of BH [FGM] introduce and describe slides, ask for questions. Leave slide up.

Use next slide if they are unsure or don't know.

[FGM]

8. How would you define behavioral health? What does behavioral health mean to you?
    a. Define for all youth ages (infant/early childhood, school-age children, emerging adults ages 18-25)?
    b. How would you define for youth and their families in geographic locations (rural, city, around state)?
    c. How does it serve different demographics (including race/ethnicity/culture/community)?

[Put up slide of BH [FGM] Share next slide of definitions if not used above.

9. Were your definitions of behavior health similar to these? Different?

[Put up slide of BH services [FGM] introduce and describe slides, ask for questions. Ask for other services not covered. Leave slide up.

10. Describe your experiences with these BH services? What services have you, your children or your family used? [FGM] Ask if anyone would like to comment or choose a person-make sure to allow time for all to contribute.
    Make sure they address the following:
    a. What BH and/or drug and alcohol and/or prevention services have you used or are using? Ask about schools, boys & girls clubs, cultural & prevention activities/events?
       How did you get connected with these activities & services? Who did you talk to (school, counselor, friend, family, etc.)?

11. Are there any other BH services and/or drug and alcohol and/or prevention services you think should be offered? Look at slides-give examples of other services not mentioned.
    a. What types of services did you wish you had gotten that you couldn't?
    b. Do you feel there are enough BH services and/or drug and alcohol treatment providers, such as counselors?
        i. Do you feel that there are enough providers that look like you, or come from your communities or your cultures?
            1. That serves your age groups, how about other age groups (infant/early childhood, school-age children, emerging adults ages 18-25).
            2. Do the providers serve geographic locations where you are located and serve your demographics (including race/ethnicity/culture/community).

    c. Do you feel that there are areas that need more or other services? For example, are there adequate prevention services that are culturally relevant.

    Additional Prompts

    d. Do you think that the majority of the providers are culturally informed about the individuals they work with?
        c. Do they speak the languages of the individuals they work with?
        d. Do you feel that there are sufficient genders represented in providers?

e. Do you feel that the services you received met you where you are at as a teenager or young adult?

12. Where did you get BH and/or drug and alcohol services? Did people come to your home? Did you see someone at school? At an activity/event?

    a. How far did you have to travel to get these services? Did you get these services in an area close to your home/school? Did they have days/times to fit around your school/jobs? Activities/events offered at good times?

    b. Were the locations welcoming to you? Did you feel safe? why-colors on walls, posters, languages used, made you feel valued? Met you where you are as a teenager/young adult?

13. Did you experience any problems or issues to receive services? Prevention services, accessing necessary care? Resources or supports?
    a. What are the barriers to accessing preventative services?

    b. What are the barriers to accessing necessary care?

14. What behavioral health services would you like to have available for you, and/or your family?
    a. For all youth ages (infant/early childhood, school-age children, emerging adults ages 18-25)?
    b. In geographic locations (rural, city, around state)?
    c. Services in different demographics (including race/ethnicity/culture/community)?

Part IV. Conclusion (10 minutes)

[Focus Group Moderator] We have reached the end of the focus group questions. Given everything that we discussed, is there anything we have not asked that you would like to share?

Thank you for attending and agreeing to talk to us today.

WA Children and Youth BH Work Group Strategic Plan—Focus Group: Providers

Part I. Logistics (At time of zoom registration)

Set up Zoom registration for the group, with name and consent to participate.

Part II. Introduction (5 minutes)

[Focus Group Moderator-FGM] Thank you agreeing to talk to us today and joining us on zoom. Introduce self, with Kauffman and Associates, Inc. (KAI). The purpose of today's focus group session is to gain your valuable insight and unique perspective as behavioral health care service providers.

Over the past few years, many voices have been raised about the crisis in mental health, particularly for children and young people, and the inability of the system and services to meet children, youth, and families' needs.

The Washington Legislature has directed the Children and Youth Work Group to develop a strategic plan for people from birth through age 25 to better meet their needs.

Your experiences and perceptions will help give an accurate view of what's happening for young people now and will help us develop a plan to improve these services in the future.

[Focus Group Moderator] I will be asking you some questions which you are free to answer in any way you wish. Please elaborate on any of your points as you see fit. And if a question is unclear, please ask me to explain. Also, know that your participation is voluntary, and you may pass on any questions you do not want to answer. If you change your mind about participating in this focus group, you may leave the zoom session at any time.

This session is being recorded for note taking purposes only. Your answers will be kept confidential. Recordings will be held securely at KAI and destroyed after analysis. None of the data will be stored at the State of Washington. Your identity will be protected; no names will appear, and information will be aggregated for a summary report. There are no known risks from taking part in this focus group. There is a benefit to your participation in the focus group which is to give input and feedback to help the CYBH Work Group develop a strategic plan addressing behavioral health care services, programming, facilities, and support. There is no cost to participate in this focus group with the exception of your time.

Part III. Questions and Feedback (75 Minutes)

[FGM] will share a bit about themself and introduce [Note Taker]. [Note Taker] will introduce themselves. [FGM] Can we please go around the room and share your first name and your role in supporting behavioral health care services for children and their families.

Let us begin.

[Put up slides of BH care continuum [FGM] introduce and describe slide, ask for questions. Leave slide up.

[FGM]

15. Does this model fit your services? What stands out to you about these services and models? How would the CoC be better defined based upon your experiences? What is not included in this CoC model? Can we start with you (ask if anyone would like to start, or choose a person-make sure to allow time for all to contribute).
    a. What behavioral health services have you assisted in providing to children and their families? Ask about outside of clinics-such as schools/activities/events.
    b. How do children and their families access the behavioral health services that you offer?
    h. What about services for the different age and developmental stages (infant/early childhood, school-age children, emerging adults ages 18-25).
    i. What about services for geographic locations-rural, etc.
    j. What services serve what demographics (including race/ethnicity/culture/community)?

16. What gaps exist within the current service continuum?
    a. What areas lack access to services?
    b. What areas lack workers/providers?
        i. Do you feel there are enough behavioral health services?
        ii. Do you feel that there are enough behavioral health service providers, that look like, or come from their client's communities.
    c. What areas on the care continuum lack capacity? For example, are there adequate prevention services that are culturally relevant?

    Additional Prompts
    a. Do you feel that BH service providers culturally informed of their clients?
    b. Are behavioral health service providers gender and linguistic responsiveness?
    c. Are there behavioral health service providers that serve youth at all ages/developmental stages (infant/early childhood, school-age children, emerging adults ages 18-25)?
    d. What services serve what demographics (including race/ethnicity/culture/community)?

17. Do you feel there are enough behavioral health services facilities available?

a. Are behavioral health service facilities accessible? (e.g., Operating times, location)
b. Are behavioral health service facilities gender and linguistic responsiveness?
c. Are there behavioral health service facilities that serve youth development stages?

18. What are the barriers for children to receive behavioral health services?
    a. What are the barriers to accessing preventative services?
    b. What are the barriers to accessing necessary care?
    c. For all youth ages (infant/early childhood, school-age children, emerging adults ages 18-25)?
    d. In geographic locations (rural, city, around state)?
    e. Services in different demographics (including race/ethnicity/culture/community)?

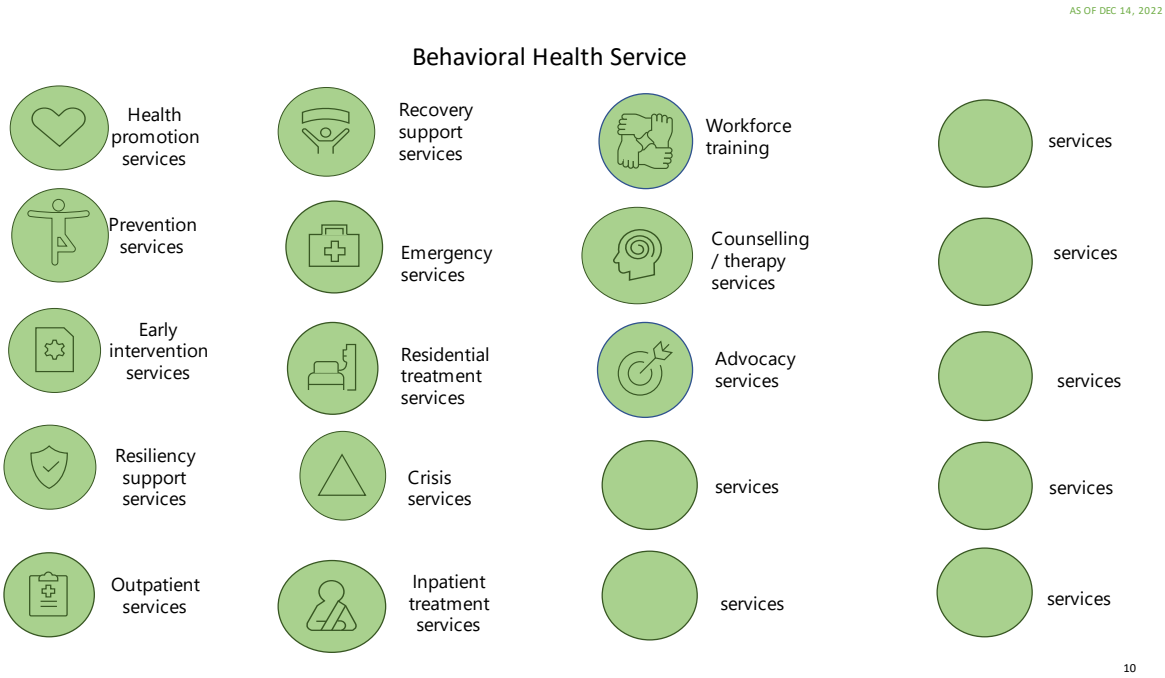
19. What behavioral health services would you like to see available for children and their families?
    a. For all youth ages (infant/early childhood, school-age children, emerging adults ages 18-25)?
    b. In geographic locations (rural, city, around state)?
    c. Services in different demographics (including race/ethnicity/culture/community)?

Part IV. Conclusion (10 minutes)

[Focus Group Moderator] We have reached the end of the focus group questions. Given everything that we discussed, is there anything we have not asked that you would like to share?

Thank you for attending and agreeing to talk to us today.

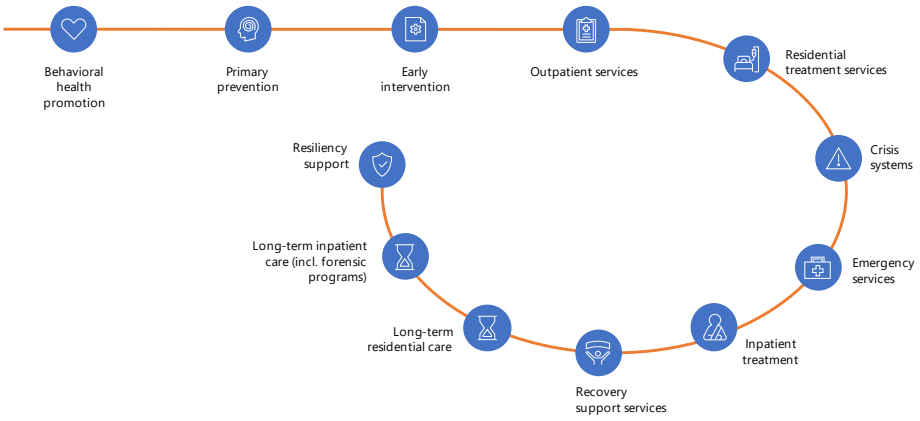
Appendix B: Behavior Health Services Slide for Parent and Youth Groups



Appendix C: Continuum of Care Slide for Provider Group

AS OF DEC 14, 2022

The continuum of behavioral health care



Source: McKinsey Health Institute, as adapted by WA HCA; interviews conducted with WA DCYF, DOH, DSHS, and HCA in September 2022

7

Focus Group Sessions Conducted

Focus Group Data Preliminary Analysis

Preliminary Findings Shared at P-25 Advisory Group Meeting

Identification of Common Themes

P-25 Strategic Plan Advisory Group Provided Input

Identification of Common Themes and Second Layer Data Analysis

Appendix D: Consultations with subject matter experts

Name	Description
Kashi Arora	External Affairs Manager, Seattle Children's Hospital – focused on pediatric mental and behavioral health.
Eric Bruns	Professor of Psychiatry and Behavioral Sciences, University of Washington School of Medicine. Dr. Bruns's research focuses on public child-serving systems, and how to maximize their positive effects on youth with behavioral health needs and their families.
Lee Collyer	Director, Student Health & Safety, Washington State Office of Superintendent of Public Instruction.
Trevor Covington	Mental and Behavioral Health Domain Manager, Pediatric Pandemic Network, and Washington State Coordinator, Western Regional Alliance for Pediatric Emergency Management.
Hugh Ewart	Senior Director for State and Federal Government Relations, Seattle Children's Hospital.
Suzanne Fields	Senior Advisor for Health Care Policy & Financing, University of Maryland School of Social Work's Institute for Innovation and Implementation.
Elizabeth Koschmann	Faculty, University of Michigan Department of Psychiatry and Director of TRAILS (Transforming Research into Action to Improve the Lives of Students), a program that works to disseminate evidence-based mental health practices to K-12 schools.
Elizabeth Manley	Faculty and Senior Advisor for Health and Behavioral Health Policy at Innovations Institute and a nationally recognized expert in children's behavioral health, intellectual/developmental disabilities, and substance use systems design.
Tim Marshall	Director of Community Mental Health, Connecticut Department of Children and Families. Led the development of statewide youth mobile crisis intervention services from 2009-2022.
Jessica McClure	Staff psychologist and Medical Director of Population Behavioral Health, Cincinnati Children's Hospital, with a special expertise in the effective use of cognitive-behavioral therapy with children and adolescents.
Joan Miller	CEO for the Washington Council for Behavioral Health and widely knowledgeable about behavioral health in Washington State.
Melissa Saladonis	Vice President of Government Relations, Cincinnati Children's Hospital, with expertise in building coalitions to support legislative reform efforts.
Denise Sulzbach	Faculty and Director of the TA Network at the University of Connecticut's Innovations Institute, which advances research-based, inclusive, culturally responsive, and transformative solutions for child-, youth-and family-serving public systems, and supports the workforce within these systems.
Jim Theofelis	Extensive history as a mental health practitioner and advocate for young people with a particular focus on those who are homeless or at risk of homelessness in the state of Washington.
Sarah Walker	Associate Professor, Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine. Founder of the CoLab for Community and Behavioral Health Policy and director of the Evidence-Based Practice Institute, a center founded by the Washington state legislature focused on promoting effective children's mental health treatment.
Mark Weist	Faculty at the University of South Carolina's Department of Psychology. Co-lead of the Southeastern School Behavioral Health community and lead of multiple studies on strategies to improve school-based behavioral health effectiveness and scalability.

Appendix E: Emerging state strategies report

Prenatal through 25 BH Strategic Planning

DRAFT Overview of emerging state approaches and practices

June 27, 2023

How to use this document

Purpose: This document provides an initial overview of emerging approaches from other states focused on behavioral health (BH) to inform the future state vision of BH for the prenatal through 25 population in the state of Washington. The examples included in this document are not directly transferrable – further analysis is required on relevance and applicability for Washington. Additionally, this document is not a comprehensive list of emerging state BH approaches and efforts – the initiatives included in the initial overview are meant to serve as an illustrative sample.

What is included: This document includes a range of state BH initiatives, from system-level efforts to more focused interventions and initiatives, with differing funding levels; state BH initiatives included in the initial overview were suggested by subject matter experts (SMEs) identified by Children and Youth Behavioral Health Work Group (CYBHWG) staff as well as identified through outside-in initial scan of examples across states. As directed by WA HCA, the document includes three sections: (1) Initial overview mapping of all included initiatives across ages, populations of focus, and goals along the continuum of care, as well as a variety of cross-cutting goals; (2) One-page summary descriptions with information on goals, implementation, and results for each initiative included in the overview; (3) Deep dive analyses on several select initiatives based on interviews with SMEs and initiative leads.

Context: This effort is part of the Prenatal through 25 Behavioral Health Strategic Plan development led by the CYBHWG and staffed by the Health Care Authority (HCA). This document has been created at the request of the CYBHWG. The approaches and considerations included in this document may be further developed based on additional inputs from CYBHWG and Strategic Plan Advisory Group members, staff, and SMEs.

Executive summary (1/2)

States are pursuing a wide range of efforts focused on BH for children and youth, from system level change to more focused interventions. Across these efforts, several themes emerge:

Cross-sector collaboration, specifically between healthcare and education, is being pursued across many state approaches and initiatives. Many state initiatives identify schools as a primary site of wellness promotion and service delivery; collaboration between healthcare and education (including data sharing) enhances positive outcomes from these efforts and ensure effective utilization of available resources

Digitization is a growing method of BH service delivery. States have invested in tech-enabled services to make it more convenient for youth and families to access care. Examples include developing apps and websites that support access to trained BH professionals, digitally-enabled BH promotion and education resources, and e-consult solutions for providers

Tech enablement to support performance infrastructure may help bring about quality improvement, effective resource allocation, and informed decision-making. Several states have invested in robust tech platforms (e.g., data collection and sharing), which have helped support continuous monitoring of service delivery and improve outcomes

Statewide BH programs are found to be effective when resourced with sustainable funding and dedicated approaches to workforce. States have enhanced funding in a variety of ways, such as creating grant pools earmarked for children and youth and expanding the utilization of Medicaid funding for BH services and supports. For workforce development, states have found success by exposing young people to BH careers, instituting loan repayment programs, enabling attractive career development, among other approaches

While there is no one universal recipe for successful governance models, clear stakeholder roles (including decision-making) and intentional design are important for effective governance. To coordinate actions and meaningfully engage stakeholders (e.g., local community organizations, managed care organizations, parents), state efforts pursue a variety of governance models with different structures, levels of (de)centralization, and key stakeholder roles

Source: Based on discussions with CYBHWG staff in May - June 2023; informed by initiative overviews that follow in this document; sources for each individual initiative are included on profile pages that follow

Executive summary (2/2)

While this document does not provide a comprehensive overview of state-led efforts aimed at improving children and youth behavioral health, the following areas emerge as potential priorities and focus areas for future initiatives, as gleaned from qualitative insights from expert interviews regarding the overall BH landscape:

Goals along continuum of care: Potential opportunity in the overall BH landscape for scaling wraparound services for individuals with complex needs and co-occurring conditions (e.g., intellectual and developmental disabilities, serious mental illness), as well as further enhancing prevention and promotion efforts across age groups and populations

Demographics of focus: While initiatives exist to improve access to BH services for underserved or vulnerable populations – e.g., rural settings, tribal communities, incarcerated and homeless individuals – there remains an opportunity to scale these programs to increase scope of impact and further tailor services to meet unique needs

Age: Potential opportunity in overall BH landscape for services specifically tailored for transitional age youth (TAY), age 19-25 years old, as well as the early childhood period, age 0-5 years old

Cross-cutting goals: Potential opportunity in the overall BH landscape to achieve sustainable funding mechanisms, as opposed to one-time or periodic funding (most commonly for prevention and promotion initiatives)

Source: Based on discussions with CYBHWG staff in May - June 2023; informed by initiative overviews that follow in this document; sources for each individual initiative are included on profile pages that follow

Overview of state BH initiatives

1. Overview mapping of initiatives

2. Initiative summaries

3. Initiative deep dives

State BH initiatives focused on Prenatal through 25 populations and included in the initial overview

NON-EXHAUSTIVE

AK	Adult Home Care
AZ	Differential Adjusted Payments (DAP)
CA	Behavioral Health Continuum Infrastructure Program (BHCIP)
CA	Behavioral Health Virtual Services Platform
CA	CalHOPE Student Services
CA	Statewide All-Payer Fee Schedule for School-Linked BH Services
CA	Wellness Coach Workforce
CA	Youth drop-in centers
CO	Children and Youth Mental Health Treatment Act
CO	Early Childhood Mental Health support line
CO	I Matter
CT	Mobile Response and Stabilization Services*
GA	Intensive Customized Care Coordination (IC3)
IL	Universal mental health screenings
MA	Community Behavioral Health Centers
MD	Coordinated community supports
MI	Caring for Students (C4S)
MI	Michigan Child Collaborative Care (MC3)
MI	MI Kids Now Loan Repayment Program
MI	TRAILS to Wellness*
MN	School-Linked Behavioral Health Grants
NE	Behavioral Health Education Center
NH	Systemic, Therapeutic, Assessment, Resources & Treatment (START)
NJ	Children's System of Care*
NM	Project ECHO
NY	NYC Well
OH	OhioRISE
OR	Treatment Foster Care Oregon
SC	Center for Excellence in Evidence-Based Intervention
UT	Safe UT

* Deep dive analysis included in final section

Source: Preliminary web search of examples across states, interviews with SMEs identified by HCA conducted in May - June 2023

Overview: Demographics addressed of state BH initiatives reviewed (1/3)

NON-EXHAUSTIVE

✓ Covers 18+ adults, but not transitional age (19-25) specifically

		Age groups					Populations of focus	
		< 0 Prenatal	0-5 Early Childhood	6-12 Childhood	13-18 Adolescent	19-25 TAY[1]		
State	**Program**						**Specific demographics of focus**	**Source[2]**
AK	**Adult Home Care**					✓	Individuals in foster care with severe disabilities (including intellectual disabilities) who are moving into adulthood	Office of Governor, Alaska
AZ	**Differential Adjusted Payments**			✓	✓		Students	Arizona Health Care Cost Containment System (AHCCCS)
CA	**BH Continuum Infrastructure Program**	✓	✓	✓	✓	✓	Vulnerable populations at risk of institutionalization – experiencing incarceration, hospitalization, or homelessness	California Department of Healthcare Services
	BH Virtual Services Platform		✓	✓	✓	✓	Black, Indigenous, People of Color, LGBTQIA+, rural communities, families experiencing homelessness, justice-involved individuals, and foster youth	California Department of Healthcare Services
	CalHOPE Student Services			✓	✓	✓	African American/Black, Asian and Pacific Islanders, Latino/Latinx, LGBTQ+ community, parents/caregivers, veterans, young adults	CalHOPE
	Statewide All-Payer Fee Schedule for School-Linked BH Services		✓	✓	✓	✓	Children and youth aged 0-25	California Department of Healthcare Services
	Wellness Coach Workforce		✓	✓	✓	✓	Children and youth aged 0-25	California Department of Health Care Access and Information
	Youth drop-in centers			✓	✓	✓	Vulnerable and marginalized youth populations including, but not limited to, LGBTQ+, homeless, and Indigenous youth	Mental Health Services Oversight & Accountability Commission
CO	**Children and Youth Mental Health Treatment Act**		✓	✓	✓	✓	Children or youth at risk of out-of-home placement and ineligible for Medicaid	California Behavioral Health Administration
	Early Childhood Mental Health support line		✓				Parents and caregivers	Colorado Department of Human Services

1. TAY = Transitional Age Youth (19-25) | 2. Demographics of focus as defined in initiative descriptions, specific sources for each initiative included on profile pages that follow
Source: Program and state agency websites (details follow on initiative profile pages), interviews with SMEs identified by HCA conducted in May - June 2023

Overview: Demographics addressed of state BH initiatives reviewed (2/3)

NON-EXHAUSTIVE

✓ Covers 18+ adults, but not transitional age (19-25) specifically

		Age groups					Populations of focus	
		< 0 Prenatal	0-5 Early Childhood	6-12 Childhood	13-18 Adolescent	19-25 TAY		
State	**Program**						**Specific demographics of focus**	**Source[1]**
CO	**I Matter**		✓	✓	✓	✓	All youth, including those receiving special education services	I Matter
CT	**Mobile Response and Stabilization Services**		✓	✓	✓		Available across child welfare, juvenile justice, prevention and behavioral health systems	Connecticut Department of Children and Families
GA	**Intensive Customized Care Coordination (IC3)**		✓	✓	✓	✓	At risk of being placed in an intensive program in an out-of-home setting due to behavioral, emotional and functional concerns that cannot be addressed safely and adequately in the home	Center of Excellence for Children's Behavioral Health Georgia Health Policy Center
IL	**Universal mental health screenings**			✓	✓		Students in primary and secondary school	Illinois General Assembly
MA	**Community Behavioral Health Centers**		✓	✓	✓	✓	MassHealth members (MA's state Medicaid program)	Massachusetts Executive Office of Health and Human Services
MD	**Coordinated community supports**			✓	✓		Students	Maryland Department of Health, Community Health Resources Commission
MI	**Caring for Students**			✓	✓		All Medicaid-enrolled students	National Academy for State Health Policy
	Michigan Child Collaborative Care	✓	✓	✓	✓	✓	Primary care providers in Michigan who are managing patients with behavioral health problems	University of Michigan
	MI Kids Now Loan Repayment Program		✓	✓	✓		Underserved areas	Michigan Department of Health and Human Services
	TRAILS to Wellness			✓	✓		Schools where at least 40% of students have been identified as low-income	TRAILS to Wellness

1. Demographics of focus as defined in initiative descriptions, specific sources for each initiative included on profile pages that follow.
Source: Program and state agency websites (details follow on initiative profile pages), interviews with SMEs identified by HCA conducted in May - June 2023

Overview: Demographics addressed of state BH initiatives reviewed (3/3)

NON-EXHAUSTIVE

✓ Covers 18+ adults, but not transitional age (19-25) specifically

		Age groups					Populations of focus	
		< 0 Prenatal	0-5 Early Childhood	6-12 Childhood	13-18 Adolescent	19-25 TAY		
State	**Program**						**Specific demographics of focus**	**Source[1]**
MN	**School-Linked Behavioral Health Grants**			✓	✓		Students	Minnesota Office of the Revisor of Statutes
NE	**Behavioral Health Education Center[2]**	✓	✓	✓	✓	✓	Mental Health Profession Shortage Areas: population to provider ratio higher than 30,000 to 1[3]	University of Nebraska Medical Center
NH	**START**			✓	✓	✓	Individuals with intellectual and developmental disabilities (IDD)	START
NJ	**Children's System of Care**		✓	✓	✓	✓	Children and youth with intellectual and developmental disabilities	New Jersey Department of Children and Families
NM	**Project ECHO**	✓	✓	✓	✓	✓	Rural health care providers	Project ECHO
NY	**NYC Well**		✓	✓	✓	✓	Underserved communities	NYC Mayor's Office
OH	**OhioRISE**	✓	✓	✓	✓	✓	Youth with complex behavioral health and multisystem needs	Ohio Medicaid Managed Care
OR	**Treatment Foster Care Oregon**			✓	✓		Adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency	National Gang Center
SC	**Center for Excellence for Evidence-Based Intervention**		✓	✓	✓	✓		
UT	**Safe UT**		✓	✓	✓	✓	K-12 and higher ed students, parents/guardians, and educators	Safe UT

1. Demographics of focus as defined in initiative descriptions, specific sources for each initiative included on profile pages that follow | 2. Serves range of populations across age groups | 3. Kaiser Family Foundation
Source: Program and state agency websites (details follow on initiative profile pages), interviews with SMEs identified by HCA conducted in May - June 2023

Example goals for state BH initiatives focused on Prenatal through 25 populations[1]

NON-EXHAUSTIVE

Potential goals along continuum of care

- Improve promotion, prevention & wellness
- Increase capacity for BH treatment
- Expand crisis treatment services
- Strengthen rehabilitation and re-integration (esp. focusing on populations with complex needs)
- Enhance wraparound services

Potential cross-cutting focus areas

- Establish new digital access channels
- Expand BH workforce / capability for care
- Provide equitable access to BH services across settings
- Expand eligibility and coverage
- Scale evidence-based and evidence-informed practices
- Enhance funding mechanisms

1. Definitions of goals included in appendix.

Source: Synthesis of goals across state initiatives included in the initial overview; interviews with experts identified by HCA conducted in May - June 2023

Overview: Mapping of state BH initiatives reviewed (1/3)

NON-EXHAUSTIVE

State	Program	Goals along continuum of care: Improve promotion, prevention & wellness	Expand capacity of BH treatment	Expand crisis treatment services	Strengthen rehab. and re-integration	Enhance wrap-around services	Cross-cutting goals: Establish new digital access channels	Expand BH workforce / capability for care	Provide equitable access to BH services across settings	Expand eligibility and coverage	Scale evidence-based/informed practices	Enhance funding mechanisms	Funding level	Impact[1]
AK	Adult Home Care	✓	✓		✓				✓	✓			Funding not available	
AZ	Differential Adjusted Payments	✓	✓					✓	✓	✓		✓	Less than $10M funding	
CA	BH Continuum Infrastructure Program		✓						✓				More than $100M funding	54 total projects funded, 75% for low-income communities
	BH Virtual Services Platform	✓					✓		✓				More than $100M funding	Implementation in progress
	CalHOPE Student Services	✓						✓	✓		✓		Between $10M - $100M funding	6,000 staff engaged in Community of Practice
	Statewide All-Payer Fee Schedule for School-Linked BH Services[2]	✓								✓		✓	Less than $10M funding	Implementation in progress
	Wellness Coach Workforce	✓						✓	✓				More than $100M funding	Implementation in progress
	Youth drop-in centers	✓	✓						✓				Between $10M - $100M funding	
CO	Children and Youth Mental Health Treatment Act	✓		✓						✓			Funding not available	271 children served
	Early Childhood Mental Health support line	✓					✓		✓				Between $10M - $100M funding	

Source: Interviews with SMEs identified by HCA conducted in May - June 2023; Prioritizing Health: A Prescription for Prosperity | 1. Impact included if publicly available | 2. Funding does not include cost of services to be covered by fee schedule

Overview: Mapping of state BH initiatives reviewed (2/3)

NON-EXHAUSTIVE

State	Program	Goals along continuum of care: Improve promotion, prevention & wellness	Expand capacity of BH treatment	Expand crisis treatment services	Strengthen rehab. and re-integration	Enhance wrap-around services	Cross-cutting goals: Establish new digital access channels	Expand BH workforce / capability for care	Provide equitable access to BH services across settings	Expand eligibility and coverage	Scale evidence-based/informed practices	Enhance funding mechanisms	Funding level	Impact[1]
CO	I Matter	✓	✓				✓		✓				Between $10M - $100M funding	2,600 Colorado youth served
CT	Mobile Response and Stabilization Services			✓			✓		✓		✓		Between $10M - $100M funding	25% reduction in ED visits among youth
GA	Intensive Customized Care Coordination (IC3)				✓	✓					✓		Funding not available	1,000 youth served annually
IL	Universal mental health screenings	✓							✓				Less than $10M funding	
MA	Community Behavioral Health Centers	✓	✓	✓	✓	✓			✓				More than $100M funding	
MD	Coordinated community supports	✓							✓				Less than $10M funding	
MI	Caring for Students	✓								✓		✓	Funding not available	
	Michigan Child Collaborative Care	✓					✓	✓					Funding not available	15,000+ youth served over 10 years
	MI Kids Now Loan Repayment Program	Workforce development trains workers across the continuum						✓	✓				Less than $10M funding	84 total recipients of loan repayments in 2019
	TRAILS to Wellness	✓						✓	✓	✓	✓		Between $10M - $100M funding	10,000 staff trained

Source: Interviews with SMEs identified by HCA conducted in May - June 2023; Prioritizing Health: A Prescription for Prosperity, McKinsey Global Institute, July 2020 | 1. Impact included if publicly available

Overview: Mapping of state BH initiatives reviewed (3/3)

NON-EXHAUSTIVE

State	Program	Goals along continuum of care: Improve promotion, prevention & wellness	Expand capacity of BH treatment	Expand crisis treatment services	Strengthen rehab. and re-integration	Enhance wrap-around services	Cross-cutting goals: Establish new digital access channels	Expand BH workforce / capability for care	Provide equitable access to BH services across settings	Expand eligibility and coverage	Scale evidence-based/informed practices	Enhance funding mechanisms	Funding level	Impact[1]
MN	School-Linked Behavioral Health Grants	✓	✓						✓	✓		✓	◔	60% of school districts covered by grant program
NE	Behavioral Health Education Center[2]	Workforce development trains workers across the continuum						✓	✓				◑	5,189 students exposed to BH careers
NH	START	✓			✓	✓	✓	✓	✓		✓		○	4,029 individuals served in 2021
NJ	Children's System of Care			✓	✓	✓	✓	✓	✓	✓	✓	✓	●	70% reduction in child out-of-home placement
NM	Project ECHO	✓					✓	✓	✓		✓		○	
NY	NYC Well	✓					✓		✓				◑	1M calls answered
OH	OhioRISE			✓	✓	✓			✓	✓	✓		◑	21,000+ total enrolled children and youth
OR	Treatment Foster Care Oregon	✓			✓	✓		✓	✓		✓		○	½ number of arrests for boy participants
SC	Center for Excellence for Evidence-Based Intervention	✓						✓			✓		◔	
UT	Safe UT	✓		✓			✓						◔	30,000 unique users

◔ Less than $10M funding
◑ Between $10M - $100M funding
● More than $100M funding
○ Funding not available

Source: Interviews with SMEs identified by CYBHWG leaders and staff conducted in May - June 2023; Prioritizing Health: A Prescription for Prosperity, McKinsey Global Institute, July 2020 | 1. Impact included if publicly available

Overview of state BH initiatives

1. Overview mapping of initiatives

2. Initiative summaries

3. Initiative deep dives

AK: Adult Home Care

In 2023, Alaska passed legislation establishing a new alternative for individuals with disabilities in foster care when they age out of the foster care system, allowing them to stay in a familiar surrounding while transitioning to adulthood and receiving care

Population of focus: TAY[1] in foster care system

Description

- Part of Alaska's Healthy Families Initiative, HB58 establishes **adult home care as a new service type** and adult care home as a new residential license type
- Enables someone caring for an adult foster child at home to license their **home as an adult daycare**, allowing them to **receive Medicaid payments to cover the cost of care**
- Provides incentives for caregivers to continue to offer support for **individuals in foster care with severe disabilities (including intellectual disabilities) who are moving into adulthood** and would like to continue to **reside in their familiar home setting**
- The new service would be **reimbursed through a 50/50 federal Medicaid match**

Initiative goals

"This legislation [provides] … a new option for home care for … people with disabilities, with fewer administrative burdens than existing options. This legislation will keep families together, provide critical in-home support to Alaskans who need it and simplify the state bureaucracy that helps support all Alaskans through every stage of their life."

- Heidi Hedberg
Commissioner at Alaska Department of Health

December 20, 2023

Source: Office of Governor, Alaska, Alaska House Bill No.58, Alaska Behavioral Health (Image)

AZ: Differential Adjusted Payments (DAP)

In 2020, Arizona implemented a differential payment rate for selected providers that have committed to partner with schools to provide behavioral health services

Population of focus: Students in primary / secondary school

Description

- Arizona's Health Care Cost Containment System **increased differential adjusted payments (DAP) by 1%** for all providers that meet one of the following milestones:
  - Have accepted **at least 10 referrals from a school** that led to subsequent service provision for the student
  - Have provided **services on a school campus**
- Part of initiative to improve patients' care experience and members' health while reducing growth in cost of care
- Enabled by legislation that created the **Children's Behavioral Health Services Fund**, allocating **$8M of funding** toward the coverage of BH services for uninsured and underinsured students through

Initiative goals

Enlist enough providers so that services are available at least to the same extent that they are available to the general population

Incentivize providers that **improve patients' care experience and members' health**

Distinguish providers that have committed to **reducing cost of care growth**

December 20, 2023

Source: AZ DAP Increase, AZ Children's Behavioral Health Services Fund, Jake's Law

CA: Behavioral Health Continuum Infrastructure Program (BHCIP)[1]

In 2021, California Department of Health Care Services (DHCS) launched BHCIP to help youth access care without delay by building up sites where they can receive BH services and expanding the community continuum of behavioral health treatment resources

Population of focus: Children and youth at risk of institutionalization

Description

- Invest in the expansion of beds, units, or rooms by building new behavioral health continuum infrastructure and expanding capacity
- Address historic gaps in healthcare delivery by enhancing and establishing a wide range of options including community wellness/youth prevention centers, outpatient treatment for substance use disorders, school-linked health centers and outpatient community mental health clinics
- Provide alternatives to incarceration, hospitalization, homelessness and institutionalization by better meeting the needs of vulnerable populations who face the greatest barriers to access
- **Total funding of $2.2B**, with **$480.5M of funding specific to children and youth**

Results to date

Utilization	Targeted populations	Project examples
54 total projects funded in Round 4 of 6 total grant rounds	**75%** of projects for Medi-Cal (low income) services	**$57.4M** for psychiatric acute care hospital in Los Angeles with 36 beds
16 county projects awarded	**4** projects granted to tribal entities	**$27.6M** for adolescent SUD treatment facilities in Orange County with 32 beds and 2,626 slots

TAY Transitional age youth (19-25 yro.)

Source: CYBHI 101, CYBHI January 2023 Progress Report, BHCIP Data Dashboard, Office of Governor

CA: BH Virtual Services Platform[1]

California Department of Health Care Services (DHCS) will launch the Behavioral Health Virtual Services Platform, a new technology-enabled services solution for all children, youth, and families in California starting in 2024

Population of focus: Youth aged 0 - 25

Description

- Key functions include **screening** for mental health or substance use disorders; **pre-clinical coaching** services available by chat, text, video, phone; and **connecting users to off-platform clinical services**
- Offerings also include interactive digital education, self-monitoring tools, application-based games, mindfulness exercises, and access to free, **on-demand one-on-one coaching and counseling supports**
- Available as a downloadable smart phone application and via a website portal and telephone
- **$632.7M in funding total**, with **target launch in January 2024**
- Announced **external vendor Kooth** to launch the new platform; announced **$75M contract with The Child Mind Institute (CMI) to implement Next-Generation Digital Supports**, which supports accessibility

Initiative goals

"This platform will increase access to early, upstream supports that over time will reduce the overall need for services delivered in emergency departments and psychiatric hospitals, as well as through crisis services, by providing young people with an outlet to address loneliness, sadness, anxiety, school and family stressors, and other issues affecting children, youth, and young adults."

- Dr. Mark Ghaly
Secretary of the California Health & Human Services Agency

Source: CYBHI 101, CYBHI January 2023 Progress Report, California MAT Expansion Project, State of Reform

CA: CalHOPE Student Services[1]

Begun in 2022, CalHOPE Student Services establishes a statewide Social Emotional Learning Community of Practice (SEL CoP) that builds the SEL capacity of school districts, preparing educators to be first-line responders to enrich the psychological well-being of children and youth

Population of focus: Students enrolled in K-12

Description

- Convenes leaders from all 58 County Offices of Education (COEs) in a **Community of Practice to share SEL training, evidence-based practices, and cultural adaptations** which address opportunity gaps and disproportionality; COEs then disseminate these learnings to school districts to build capacity and a common language of the importance of **positioning schools as "Centers of Wellness"**
- **$45M in funding total** with $6.8M provided by Federal Emergency Management Agency (FEMA); more than **80% of funds directly passed to 58 COEs**
- Implemented through partnership between Department of Health Care Services (DHCS), Sacramento County Office of Education (SCOE), Orange County Department of Education (OCDE), UC Berkeley, and FEMA

Initiative goals

Building a statewide network/infrastructure that allows COEs to share SEL best practices and build collective capacity

6,000 school staff have already participated in SEL CoP

Source: CYBHI 101, CYBHI January 2023 Progress Report, CalHOPE Student Support, CalHOPE About the Project

CA: Statewide All-Payer Fee Schedule for School-Linked BH Services[1]

DHCS and the Department of Managed Health Care (DMHC) will maintain a school-linked statewide all-payer fee schedule to allow students (25 years or younger) to receive outpatient mental health and substance use disorder services at or near school sites starting in 2024

Population of focus: Students aged 0 - 25

Description

- Initiative aims to bring together the healthcare and education sectors to **reimburse for a predefined set of services for all children, regardless of payer status, in a school-linked setting**
- The supporting workgroup is composed of partners representing K-12 education, institutions of higher education, Medi-Cal managed care plans, commercial health plans, county behavioral health departments, behavioral health providers, associations, advocates, youth and parents/caregivers
- Plan to **launch in January of 2024**

Initiative goals

Create a more **approachable billing model for schools** and local educational agencies

Ease burdens related to contracting, rate negotiation, and navigation across delivery systems

Reduce uncertainty around students' coverage

Source: CYBHI 101, CYBHI January 2023 Progress Report, CYBHI Fee Schedule Working Group Session 3

CA: Wellness Coach Workforce[1]

California Department of Health Care Access and Information (HCAI) is creating a new certified position of Wellness Coach in 2024-2025 to help support the behavioral health needs of California youth in a wide variety of settings

Population of focus: Youth aged 0 - 25

Description

- Wellness Coaches will offer **non-clinical services** that support youth behavioral health, such as wellness promotion and education, screening, care coordination, individual and group support, and crisis referral
- Wellness Coaches will serve youth aged 0 - 25 as part of a care team in a **wide variety of school, health, and community settings**
- Wellness Coaches will earn either a **Wellness Coach I or II certification**, which each require completion of 52 hours of classroom education, 400 hours of on-the-job training, and either an AS or BS degree, respectively
- HCAI received **$338M in funding** to design and build the Wellness Coach workforce
- Training of Wellness Coaches is expected to begin in 2024 with coaches in the field in 2025

Initiative goals

Build a diverse BH workforce with lived experience to serve vulnerable populations

Fill gaps in BH workforce – currently few roles cater to professionals with 1-4 years of education

Ensure the role is both a **desirable occupation** in and of itself and a stepping-stone to more advanced BH roles

Source: CYBHI January 2023 Progress Report, CYBHI December 2022 Update, HCAI Wellness Coaches Model

CA: Youth drop-in centers

Launched in 2018, California's allcove™ youth drop-in centers aim to increase accessibility to affordable mental health and wellness services for youth aged 12 - 25, including behavioral health, physical health, housing, education, and employment support, and linkage to other services

Population of focus: Youth aged 12 - 25

Description

- Helps detect, prevent, and treat **mild to moderate mental health needs**, and connect young people to their local community behavioral health system for more intensive interventions; **services are free or low cost**
- Provides **culturally competent and relevant services for vulnerable and marginalized youth populations** including, but not limited to, LGBTQ+, homeless, and Indigenous youth
- Engages youth through **direct-to-youth marketing strategies**
- Developed by **Stanford's Center for Youth Mental Health and Wellbeing**
- **Received $15M in funding over 4 years** to launch
- Two prototype centers already implemented, with five more centers already receiving seed funding

Initiative goals

Educate the public about the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness

Implement **evidence-based programs** that promote healthy development, support children, youth, and their families

Address the unique mental health **needs of at-risk youth**, such as racial minorities, LGBTQ+ youth, and youth with disabilities

Source: Allcove white paper, Mental Health Services Oversight & Accountability Commission

CO: Children and Youth Mental Health Treatment Act

In 2018, CO passed the Children and Youth Mental Health Treatment Act (CYMHTA) to help families access residential treatment for children with mental illness and avoid out-of-home placement

Population of focus: Low-income families with youth up to age 21

Description

- CYMHTA assists families who are uninsured or underinsured to **pay for residential treatment, community-based treatment, and transitional services for youth up to age 21** with a mental illness
- Under CYMHTA, **families only pay for 7% of the cost** of mental health treatment for their children
- CO's Behavioral Health Administration contracts with four Mental Health Agencies, to operationalize CYMHTA: Signal Behavioral Health Network, Rocky Mountain Health Partners, Beacon Health Options and Beacon Health Options on behalf of Health Colorado, Inc.
- In SFY22, **total funding for CYHMTA was $6.9M**

Results to date

Utilization	Growth	Outcomes
271 children and youth served in SFY22	**10%** growth in children and youth served from SFY21	**83%** of youth discharged had reduced risk of out-of-home placement
97 children served were new to CYMHTA in SFY22		

Source: CYMHTA SFY22 Annual Report

CO: Early Childhood Mental Health support line

In 2022, the Colorado Department of Human Services announced a new Early Childhood Mental Health (ECMH) Support Line to connect parents and caregivers of children under age 6 with the mental health resources they need

Population of focus: Parents and caregivers of children under age 6

Description

- The support line enables parents and caregivers, including early childhood professionals, to **speak with an early childhood mental health consultant**
- Consultation available through the support line can help families and caregivers to better understand and support the emotional well-being of young children in their care by discussing needs, brainstorming appropriate support resources, and connecting parents and caregivers to local community resources
- The support line is a **no-cost, confidential service** that is available statewide M-F from 10:30am to 5:30pm
- Funding is allocated through a **three-year $33.5M grant** from the state to improve children's preparedness for kindergarten

Initiative goals

"All families may benefit from reaching out to the Early Childhood Mental Health Support Line … The support line aims to increase the knowledge and confidence of caregivers in a way that supports positive mental health early and creates a foundation for lifelong health and well-being."

- Lisa Schlueter
Preschool Development Grant Birth through Five ECMH strategy lead

Source: Colorado Department of Human Services

CO: I Matter

In 2021, Colorado State Legislature launched the I Matter program to provide access to mental health and substance use disorder services for youth, including addressing needs that may have resulted from the COVID-19 pandemic

Population of focus: Youth ages 0-18 or 21

Description

- Provides up to **six free mental health sessions with a licensed provider** for youth 18 years of age or younger or 21 years of age or younger if receiving special education services
- Partners with Signal BH as a primary provider, which also has a **provider-friendly subcontracting mechanism** for independent providers
- Implements statewide public awareness and outreach campaign that includes **digital ads on social media platforms**, and **on-the-ground outreach to schools and youth organizations**
- Pilot **initial funding of $10M** (catalyzed by federal COVID funding); received **$6M in additional funding** to extend services until at least June 2024

Results to date

Utilization

2,600 Colorado youth have participated in at least one therapy session

7,500 therapy sessions have been completed or are upcoming

Feasibility

$10-50M of funding necessary to implement including extension rounds of support

<2 years to impact and address

Source: I Matter, Colorado Department of Human Services

CT: Mobile Response and Stabilization Services

Connecticut's nationally recognized Mobile Response and Stabilization Services (MRSS) program, launched in 2009, provides 24/7 mobile children's mental health crisis services free of charge to all children in the state

Population of focus: Children and youth under 18

Description

- Serve children in their homes and communities, **diverting children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative**
- Trained mental health clinicians are deployed to homes, schools and community locations to provide in-person crisis stabilization services and linkage to ongoing care for children in Connecticut
- **Call center: Centralized, toll-free phone number serves as point of entry** and to provide person-to-person assistance and connection to crisis services; **accessible 24/7, 365 days per year**
- Receives grant-funding from Department of Children and Families (DCF) – **$10.7M in funding in 2016**
- Mobile Crisis Performance Improvement Center (PIC) delivers **strong continuous quality improvement**

Results to date

Utilization	Outcomes
16,776 total calls fielded by the Call Center in 2016	**25%** reduction in ED visits among youth who utilize the service
90% rate of face-to-face contact with families that request services	**8.5%** decline in child problem severity following mobile crisis involvement

Source: CT Mirror, Child Health and Development Institute, SFY 2016 EMPS Report Card, Child Health and Development Institute

GA: Intensive Customized Care Coordination (IC3)

In 2017, Georgia launched Intensive Customized Care Coordination (IC3) as a provider-based High Fidelity Wraparound model intervention designed for youth ages 4-21 with complex needs

Population of focus: Youth ages 4-21 with complex needs

Description

- Wraparound[1] is facilitated through **two state-contracted Care Management Entities (CMEs)**, which engage team members to identify resources for youth with Severe Emotional Disturbance (SED)
- Goals of the CME include assisting families with developing formal and natural supports, **minimizing out-of-home placements** and assisting with the **transition from institutional to community-based care**
- Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), Medicaid, and federal grants support Wraparound for youth who are at-risk for institutional level of care (LOC)
- Deemed by Substance Abuse and Mental Health Services Administration (SAMHSA) as achieving "maintenance of fidelity and program standards and established markers of competency"

Results to date

Source: SAMHSA ICC State and Community Profiles, Georgia State University High Fidelity Wraparound

Utilization	Services	Outcomes
1,000 youth served through IC3 / Wraparound annually	**1:10** care coordinator to child/family ratio	**90%** of caregivers reported positive responses for cultural sensitivity
	12-18 months of average service duration	**56%** of youth demonstrated improved levels of functioning

Wraparound is a process building on the collective action of a team to mobilize resources from a variety of sources to support families in their communities

IL: Universal mental health screenings

In 2017, Illinois passed legislation integrating mental health screenings into K-12 school physicals statewide

Population of focus: Students in primary and secondary school

Description

- Requires **social and emotional screenings** for children as part of their school entry examinations
- The standards for the screenings are to be **developed in the Office of Women's Health and Family Services** in consultation with statewide organizations representing school boards, pediatricians, and educators along with mental health experts, state education and healthcare officials, and others
- Aims to cultivate the most up-to-date, evidence-based screening formats to identify potential issues early on and help students receive the support they need
- Currently exploring ways to fund these screenings—including grants legislated this year which provide funding for mental well-being checks

Initiative goals

"[The effort is] aimed at identifying potential mental health problems in school-age children, removing the stigma of mental illness and reducing teen suicide by identifying their needs and providing early intervention"

- Kimberly A. Lightford
Assistant Majority Leader and Vice Chair of the Illinois Senate's Education Committee

Source: The Kennedy Forum, Illinois Department of Human Services

MA: Community Behavioral Health Centers

Launched in 2023, Community Behavioral Health Centers (CBHCs) are one-stop shops for a wide range of mental health and substance use treatment programs, offering immediate care, both in crisis situations and the day-to-day

Population of focus: Medicaid recipients

Description

- The statewide network includes 25 CBHCs in communities across Massachusetts
- **Team model of care**: **teams that specialize in serving children and adolescents**; involves a clinician, care coordinator; peer specialist or family supporter
- **Bundled billing**: For those who are covered for care at a CBHC, there is just one rate for their combined services, compared to typically when insurance companies bill for every individual service a patient receives
- **Services are insurance-blind**, meaning anyone can access services, no insurance needed
- **$200M in funding** for implementation

Initiative goals

Expanded access, including **same-day access to assessment/referral** and crisis/urgent treatment

Community-based crisis intervention integrated with full OP continuum of services

Focus on equity through **culturally competent, accessible treatment**

December 20, 2023

Source: Mass.gov, Western Massachusetts News, WGBH News, Massachusetts Behavioral Health Partnership

MD: Coordinated community supports

The Maryland Consortium on Coordinated Community Supports, established in 2022, is a 24-member entity responsible for developing a statewide framework to expand access to comprehensive behavior health services for Maryland students

Population of focus: Students

Description

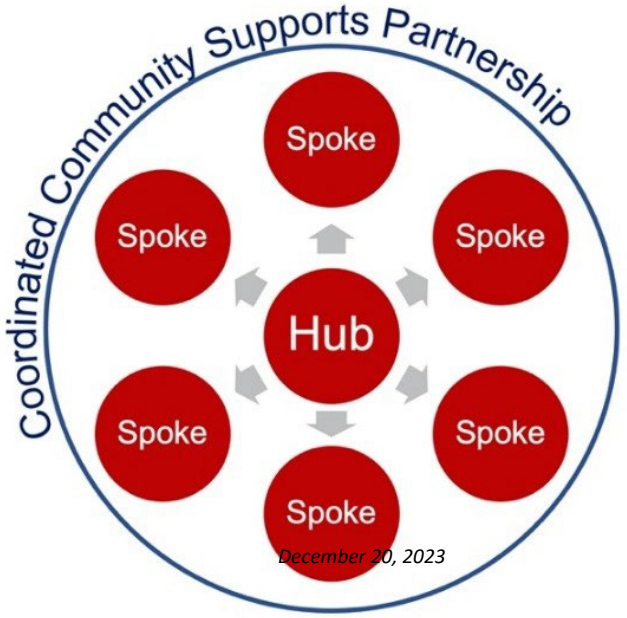
- The Consortium was created by the Maryland General Assembly as part of the Blueprint for Maryland's Future
- Uses a **Hub and Spoke framework** for local Community Support Partnerships:
  - **Spokes**: Providers of BH services to students and their families – may be existing providers of school-based services, or providers not currently operating in schools.
  - **Hubs**: Responsible for tasks including coordinating service providers, distributing Partnership grant funds to Spokes as subgrantees, and collecting and reporting data.
- **$50M in total grant funding** in 2023, $85M in funding in 2024
- Future **grants will go to Hubs only**, who will distribute funding to Spokes as subgrantees.

Initiative goals

Expand access to high-quality behavioral health and related services for students and families

Improve student wellbeing and readiness to learn; foster positive classroom environments

Promote sustainability through revenues from Medicaid, commercial insurance, hospital community benefit, and other **funding sources**



Source: Maryland Community Health Resources Commission, Consortium April 2023 Presentation

MI: Caring for Students (C4S)

In 2019, Michigan expanded its school-based Medicaid program in an effort called Caring for Students (C4S), which enabled the State to seek federal Medicaid match funding for all Medicaid-enrolled students

Population of focus: Medicaid-enrolled students

Description

- Allowed MI to seek Medicaid **reimbursement for services provided to all Medicaid-enrolled students**
- **Expanded the types of providers who can bill for Medicaid services in school-based settings** (and for all Medicaid-enrolled students) to include physician assistants, certified nurse specialists, marriage and family therapists, behavior analysts, school social workers and school psychologists
- During implementation, the **state health agency supported schools** by:
  - Updating the State Medicaid Provider Manual
  - Holding site visits and webinars to educate school staff about the newly approved providers

Results to date

Financial investment: The State legislation dedicated funding to support the planning and implementation of C4S. Over time, due to new federal investment through Medicaid, the C4S program will have a dedicated revenue stream to sustain it

Strong collaboration: The State team included key partners from Medicaid, education and intermediate school districts (ISDs) which led to buy-in and resulted in concrete, workable policy solutions

Source: Case Study: Expanding Michigan's School-based Medicaid Program, Healthy Students, Promising Futures

MI: Michigan Child Collaborative Care (MC3)

Only 1 county in Michigan has an adequate number of pediatric and perinatal psychiatrists. In response, the state launched the Michigan Child Collaborative Care (MC3) in 2012 as a statewide telepsychiatry consultation program to support primary care providers

Population of focus: Prenatal mothers, children / youth under age 26

Description

- Through the MC3 program, psychiatrists are available to offer **guidance on diagnoses, medications and psychotherapy interventions** so that primary care providers can better manage patients in their practices
- The treating provider initiates the consult with a call to the Behavioral Health Consultant (BHC), a master's-level mental health professional based locally, or submits a consultation request through a secure web-based form
- The BHC triages the referral, responds to any questions that are within the scope of his/her expertise, and forwards appropriate cases to the MC3 psychiatrist for **same-day phone consultation**
- **Written summary of the consultation is sent to the provider along with local resources**
- **Funded by the Michigan Department of Health and Human Services**

Results to date

Utilization	Outcomes
18,000+ services provided over 10 years **15,000+** patients served over 10 years	"This program has been a lifesaver. I can call and get help with behavioral health issues within a day. MC3 providers have enabled me to better care for patients that would otherwise be somewhat outside of my practice 'comfort zone'; unfortunately, these children have no easy access to pediatric psychiatric services and we primary care providers are 'it' in rural Northern Michigan." - Pediatrician in Michigan's Northern Lower Peninsula

December 20, 2023

Source: Psychiatric Services Journal, MC3, MC3 (2), Western Michigan University, University of Michigan

MI: MI Kids Now Loan Repayment Program

Begun in 2022, the MI Kids Now Loan Repayment Program (MKN LRP) is a debt repayment program focused on incentivizing behavioral healthcare providers to practice in underserved areas across the state

Population of focus: Students in professional school

Description

- MKN LRP funds loan repayment of up to $300,000 to those who agree to **provide mental health services in eligible nonprofit practice sites or public school-based systems for at least 2 years**
- MKN LRP partners with local orgs to gain access to unique communication channels to market the program
- Loan repayment agreements are funded by a **federal/state/local partnership:** 40% funded by federal dollars, 40% funded by state dollars, 20% funded by employer contribution
- Federal funds awarded by National Health Services Corps (NHSC)
- **$3M in total funds** obligated in FY 2019

Results to date

Utilization	Growth	Retention
185 applications received in 2019	**236%** increase in applications from 2013 to 2019	**55%** retention rate following fulfillment of service obligation
84 total recipients of loan repayments in 2019	**2nd** largest state loan repayment program in 2019	

Source: MKN LRP FY 2023 Program Guidance, MSLRP FY 2018-2019 Report

MI: TRAILS to Wellness

Launched in 2013, Transforming Research into Action to Improve the Lives of Students – TRAILS to Wellness – aims to bring proven mental health strategies to the school setting, helping staff provide the support students need

Population of focus: Students in K-12

Description

- TRAILS offers the **training, materials, and implementation support** schools need to provide their students with evidence-based mental health supports that are appropriate for the school setting; **$50M funding** in 2023
- TRAILS offers **3 tiers of programming** that correspond to differing levels of student need:
  - **Tier 1, Universal Education and Awareness:** Social and emotional learning (SEL) for all students to promote resiliency and build self regulation skills; self-care strategies for staff to prevent stress and burnout
  - **Tier 2, Targeted Intervention:** CBT and mindfulness for students with symptoms of depression / anxiety
  - **Tier 3, Suicide Risk Management:** Accurate, timely identification of students at risk of suicide
- Currently operating in Michigan, Colorado, and Massachusetts – goal of expanding to 10 states by 2040

Results to date and initiative goals

Results	Goals
10,000 school staff and mental health professionals have accessed TRAILS trainings and resources	**50%** of Title I designated schools (where at least 40% of students have been identified as low-income) have access to TRAILS resources in at least 10 states by 2040

Source: TRAILS to Wellness, TRAILS Program Overview, Our Impact, University of Michigan

MN: School-Linked Behavioral Health Grants

Established in 2022, Minnesota's School-Linked Behavioral Health program helps schools and families identify and treat BH needs by providing assessments, counseling sessions, and tools for teachers to help support students – all while keeping students close to home and in school

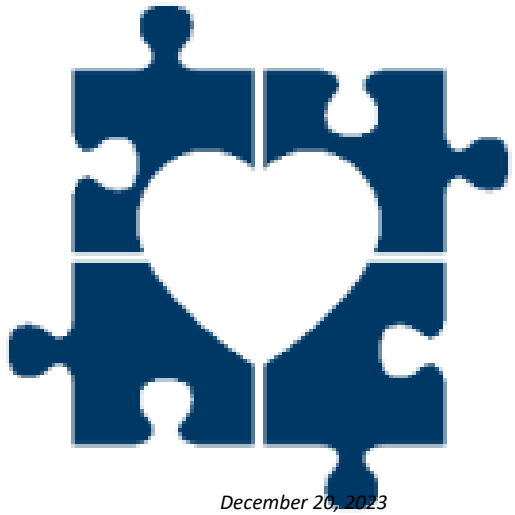
Population of focus: Students in K-12

Description

- School-linked behavioral health grants are issued through a Request for Proposal (RFP) process to licensed **behavioral health providers who are embedded in or located close to schools** to screen for behavioral health concerns, deliver services to students and build capacity of school personnel
- Providers offer behavioral health services to **all students, regardless of insurance status**
- The school-linked **grant program funds approximately 20-30% of the total costs** of comprehensive school behavioral health services
- **$6M in annual investment** proposed by Governor and Lieutenant's Governor

Results to date

Utilization	Goals
60% of school districts in the state covered by grant program	**~50%** of youth served through the grant program received behavioral health care for the first time
1,000+ schools participate in the school-linked grant program	



Source: Minnesota School Boards Association, PolicyLab

NE: Behavioral Health Education Center

88 of 93 counties in NE are designated Mental Health Profession Shortage Areas. In 2009, the Behavioral Health Education Center of Nebraska (BHECN) was established to address the shortage of BH professionals in rural and underserved areas of the state

Population of focus: Students in high school, college, and professional school

Description

- BHECN is a partnership among the NE state legislature, academic institutions, and community organizations dedicated to improving access to BH care across the state by developing a skilled and passionate workforce:
  - **Engage & Recruit**: BHECN's Ambassador Program aims to engage interest in BH careers for students, especially those in rural and underserved areas
  - **Prepare & Train**: BHECN connects students to training for psychiatric residents, psychiatric nursing, psychology, counseling, social work, marriage & family therapy, and addiction counseling
  - **Retain & Support**: BHECN provides professional development, training opportunities, and connectivity
- **$25M in funding** in 2022 by the Nebraska Legislature using funding from the American Rescue Plan Act

Results to date

Engage & Recruit	Prepare & Train	Retain & Support
5,189 students exposed to careers in BH	**1,439** students completed interprofessional training in rural sites	**327k+** hits on free BH jobs website
13 of 20 psychiatry residents stayed in NE	**139** students completed BHECN supported internships and clinical rotations	**4,914** people participated in BHECN live and online training programs

Source: University of Nebraska Medical Center, BHECN 2021-2022 FY Legislative Report

NH: Systemic, Therapeutic, Assessment, Resources & Treatment (START)

In 2009, The National Center for START services was established to implement an evidence-based, community crisis prevention and intervention service model for individuals aged 6 and older with intellectual and developmental disabilities (IDD) and mental health needs (IDD-MH)

Population of focus: Individuals 6+ with IDD

Description

- The National Center for START Services develops innovative training, conducting research, and implementing the START model in communities across North America
- START program implementation follows a **three to four-year development process** of ongoing support in the form of **START model tools, training, strategic planning, consultation, and technical assistance**
- The local START teams provide: 24-hour case coordination to improve supports and service outcomes, whole-person assessment, individualized map of individual's connections to others/systems, cross-system linkage, community education, and family/staff/provider support and education (in-home therapeutic coaching)
- All START programs work together as a **national community of practice** facilitated by the National Center

Results to date

Utilization	Outcomes
4,029 people with IDD and mental health needs served in 2021	**71%** of individuals had a reduction in mental health symptoms as measured by Aberrant Behavior Checklist
2,650 crisis calls received in 2021	**73%** of crisis contacts in 2019 resulted in individuals remaining in their current community-based setting, avoiding potential ED visits / psychiatric inpatient admissions

Source: START Model, START 2021 Annual Report, CA Department of Developmental Services, The Center for START Services, Institute on Disability (Image)

NJ: Children's System of Care

In 2000, New Jersey redesigned its children's mental health system to ensure services are available regardless of a child's insurance status and without involving the child welfare or juvenile justice systems

Population of focus: Youth under 21

Description

- NJ adopted a "system of care" — a framework that aims to make a wide array of culturally competent services available in a coordinated, easy-to-navigate way
- **Reduces use of institutional-based care** by providing children at risk of out-of-home placements with services in their homes / communities: reserves residential placements for the children who truly needed them
- **Services go beyond medical intervention** – offers peer support groups for kids and parents; access to sports, clubs and other activities that provide opportunities for positive social interactions and mentorship
- PerformCare is the single portal for access to care available 24/7/365
- Investment of over $100 million from 2020-2022

Results to date

Outcomes

70% reduction in number of children living in out-of-home settings between 2006 and 2022 (10,000 to 3,000)

9,700 fewer youth in juvenile detention from 2003 to 2008 (12,000 to 2,300 a year)

297 fewer youth in out-of-state behavioral care from 2007 to 2012

DIVISION OF CHILDREN'S SYSTEM OF CARE

Source: New Jersey Department of Children and Families, WBUR, New Jersey's Children's System of Care

NM: Project ECHO

Created in 2003 to empower rural health care providers with expert knowledge and best practices, Project ECHO (Extension for Community Healthcare Outcomes) uses videoconferencing to build virtual communities of practice

Population of focus: Children and youth in rural / under-served communities

Description

- Project ECHO is a **hub-and-spokes and learning collaborative model** that uses telehealth technologies to build a virtual collaboration between Primary Care Physicians (PCPs) and multidisciplinary specialists
- Participants attend **virtual case-based sessions with subject-matter experts**, empowering them to lead positive, sustainable change in their communities
- Project ECHO fosters growth in PCPs' abilities to provide care for children with **mild to moderate mental health disorders** while extending the reach of Child and Adolescent Psychiatrists for more seriously ill youth
- Currently helping early childhood educators learn how to be culturally responsive to their students' unique needs through **social-emotional learning awareness and strategies**

Initiative goals

Use technology to leverage scarce resources

Share best practices to reduce disparities

Apply case-based learning to master complexity

Evaluate and monitor outcomes

Source: New Jersey Department of Children and Families, WBUR, New Jersey's Children's System of Care
Source: Project ECHO 2022 Annual Report, Project ECHO Explainer, American Psychiatric Association

NY: NYC Well

Launched in October 2016, NYC Well is a free and confidential mental health pipeline offering phone, text, and online chat-based support; expanded service offerings also include crisis counseling, peer support, information and referral, and follow-up services for BH concerns

Population of focus: All NYC residents

Description

- Launched as part of ThriveNYC, a citywide behavioral health initiative overseen by the Mayor's Office of New York City; operated by Vibrant Emotional Health
- Aims to provide a **single point of entry** to individuals seeking access to behavioral health support and treatment
- Services provided include suicide prevention and crisis counseling; peer support and short-term counseling via telephone, text and web; referrals and warm transfer to other services; follow-up to check on care
- The service is available in **over 200 other languages at all times, 24/7/365**

Results to date

Utilization	Outcomes
1M calls, texts, and chats answered as of August 2020	**90%** of participants say the service helped them at least a little, with nearly two thirds saying the service helped them a lot
74% of users are repeat contacts	**20%** of participants say they may have utilized emergency services if NYC well did not exist

Source: New Jersey Department of Children and Families, WBUR, New Jersey's Children's System of Care
Source: Evaluation of NYC Well, NYC Well Evaluation

OH: OhioRISE

In 2022, Ohio's Department of Medicaid launched OhioRISE (Resilience through Integrated Systems and Excellence), a specialized managed care program for youth with complex behavioral health and multisystem needs

Population of focus: Children and youth ages 0 - 20

Description

- OhioRISE aims to shift the system of care and keep more kids and families together by creating **new access to in-home and community-based services – e.g., Intensive Home-Based Treatment (IHBT)**
- Primarily designed for children and youth with **significant BH treatment needs**, as measured by the Ohio Child and Adolescent Needs and Strengths (CANS) assessment
- **Aetna Better Health** of Ohio serves as the **single statewide specialized managed care plan**
- Features multi-agency governance to drive towards improving cross-system outcomes
- Serves the most in need and vulnerable families and children to **prevent custody relinquishment**

Results to date

Tech Enablement	Applications	Utilization
2,600+ Ohio assessors registered in CANS IT system	**36,000+** CANS assessments submitted in CANS IT system as of May 2023	**21,000+** total children and youth enrolled in OhioRISE as of May 2023

Source: Ohio Medicaid Managed Care, OhioRISE Launch Report (May 30, 2023)

OR: Treatment Foster Care Oregon

In 1983, Treatment Foster Care Oregon (TFCO) was developed as an alternative to institutional, residential, and group care placements for children and youth with severe emotional and behavioral disorders

Population of focus: Children ages 7-17

Description

- The two main goals of TFCO are to **create opportunities for youth to successfully live in a family setting** and to simultaneously **help parents provide effective parenting**
- Adolescents are placed in a **family setting for nine months**; community families are recruited, trained, and supported to provide well-supervised placements and treatment
- Youth in TFCO receive weekly support to navigate the program, practice of problem-solving and coping skills along with other skills individualized for their particular needs
- TFCO is currently implemented throughout the United States, Australia, Sweden, Norway, Denmark, The Netherlands, United Kingdom, and New Zealand

Results to date

Outcomes

½ the number of arrests for boy participants

3x less likely to run away from foster care

⅔ fewer days incarcerated for boy participants

$3.15 in benefit for every $1.00 spent on TFCO when considering child welfare and criminal justice involvement

December 20, 2023

Source: TFCO About, TFCO Evidence, National Gang Center

SC: Center for Excellence in Evidence-Based Intervention

Since 2020, South Carolina's Center of Excellence in Evidence-Based Intervention has helped identify and support the use of evidence-based practices for children, youth, and families

Population of focus: Children, youth, and families

Description

- Mission is to support agencies and organizations in the **selection and implementation of evidence-based interventions to promote youth and family well-being** and to address challenges related to behavioral health problems and substance use
- Serves as an intermediary organization
  - Create **training and technical assistance** plans for identified evidence-based interventions
  - Support **high quality implementation** of evidence-based interventions with fidelity
  - Establish mechanisms for **data collection and feedback**

Initiative goals

Make evidence-based support and intervention available when and where youth and families need them

Promote excellence and accountability in service provision

Encourage BH workforce readiness

Source: South Carolina Center of Excellen ce in Evidence-Based Intervention – Homepage, Presentation

UT: Safe UT

Youth suicide was the leading cause of death for young people aged 10-24 in Utah. In response, the state commission launched the Safe UT app in early 2016 as a way for youth to access help with any sized problem at any time

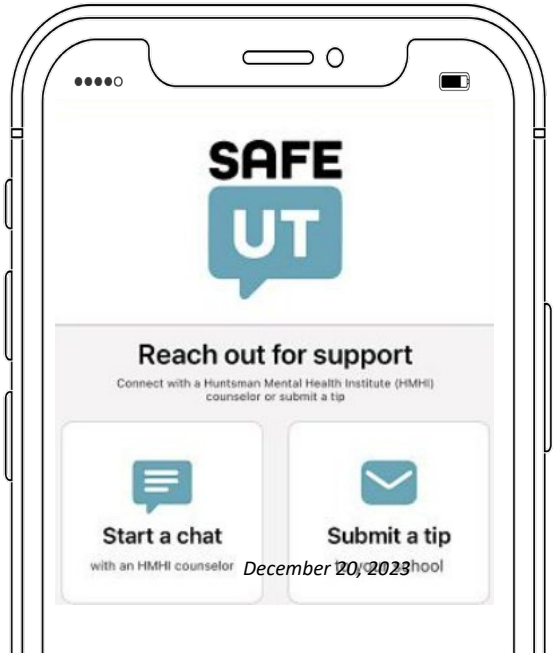
Population of focus: Students K-12 & higher ed

Description

- Safe UT is a mobile app that provides a way for students, parents/guardians, and educators to confidentially connect to a licensed counselor **24/7, 365 days a year**
- Users start a **real-time, two-way messaging exchange** with master's level counselors via chat or call
- **Use is confidential**, and crisis counselors do not inquire about identifying information except in emergencies
- Users can submit a tip on behalf of someone else for concerns regarding bullying, self-harm, and school safety
- **$1.2M of funding** requested in FY 2023
- Commissioned by Safe UT & School Safety Commission, services provided by Huntsman Mental Health Institute

Results to date

Access	Utilization	Outcomes
96% of school districts enrolled	**30,000** unique users	**85%** of administrators agree that mental health stigma has improved since enrolling in Safe UT
882k+ students with access	**12%** projected growth in FY 2023	**349** lifesaving interventions



Source: 2022 Safe UT Annual Report, Safe UT FY23 Funding Letter of Support

Overview of state BH initiatives

1. Overview mapping of initiatives
2. Initiative summaries
3. **Initiative deep dives**

Potential lessons in BH service delivery from selected initiatives

Initiatives included in deep-dives, based on guidance from interviewed SMEs: CT's Mobile Crisis and Stabilization Services, MI's TRAILS to Wellness, NJ's Children's System of Care

Considerations from initiatives included in deep-dives

Deep community involvement: CT, MI, and NJ involved community agents (e.g., parents, principals) and individuals with lived experience in program design to craft services that appropriately meet the needs of those who need it

Robust workforce: NJ has extended the total BH workforce by rethinking roles for Bachelor's level staff and peer support. CT has also discovered that providing training can help make workers feel prepared for their roles and reduce attrition

Easy-to-navigate user experience: Both CT and NJ have found that establishing a single point of entry may increase navigability of services for youth and families with complex needs. Moreover, adopting a "just go" mentality for crisis response in CT has helped states win credibility and legitimacy among families

Tech enablement & infrastructure: Both CT and NJ have highlighted the importance of establishing a data-sharing platform across organizations to support continuous monitoring and process improvement

Sustainable funding: NJ has experienced that leveraging Medicaid for its Children's System of Care (CSOC) may help to make funding more predictable. Reinvesting cost savings have also helped NJ and CT support program sustainability

Questions for discussion

How has WA thought about engaging community stakeholders and individuals with lived experience to create a strategic plan that is most reflective of needs?

How has WA contemplated expanding BH roles to accommodate non-clinicians (e.g., Bachelor's level staff, peer support)? In what ways might WA support the training of clinicians, especially in underserved communities (e.g., rural, tribal settings)?

How has WA thought about the prospect of establishing a single point of entry for BH services (e.g., similar to NJ's System of Care for individuals with complex needs)? In case of multiple points of entry, how might WA ensure that youth and families have the support they need to navigate the system effectively (e.g., "no wrong door" approach)?

How has WA thought about establishing the underlying data capabilities to support a robust performance infrastructure for continuous tracking and improvement of service delivery?

How has WA thought about the role of Medicaid in funding BH services? What other sources of funding may the working group consider to support the strategic plan?

Source: Based on discussions with HCA in May - June 2023; summarized from initiative overviews contained in this document

Deep Dive: Mobile Response and Stabilization Services (CT)

Key system elements

Workforce strategies: To increase exposure, CT offers internship experience to 2nd year clinical Master's students. CT also maintains a training program with full toolkit of treatment skills to reduce uncertainty and burnout; every year, a training plan and assessment of gaps is conducted to assess areas of need. Individuals who stay for 2-3 years are typically retained long-term from past experience in CT

Funding mechanism: CT mainly leverages funding from state general fund for its MRSS program; achieves sustainable funding by demonstrating ROI metrics to state – e.g., CT calculates cost savings from diverted inpatient beds from community care being used instead

Governance and collaboration: CT is divided into six regions, each with its own contractor; each contractor is broken down into smaller subgroups – must know every school in district and track every referral from every school building. Legislation has also been instrumental for CT – each school has a Memorandum of Agreement (MOA) with mobile crisis provider to report student crises

Source: Based on expert interview in June 2023, Child Health and Development Institute

Potential takeaways for WA as shared in SME interviews

Cross-applicable principles:

1. "Just go" mentality: Minimize time on phone and send someone immediately for face-to-face contact with crisis caller
2. Rapid response: Guarantee face-to-face contact within 60 minutes of call
3. User-centric approach: Minimize screening out of calls, assure caller that crisis is important
4. High-touch assistance: Stay involved with family until handoff to stabilization service

State-specific considerations:

1. Sizing and staffing: Adequate staff capacity within a region to achieve face-to-face interactions on a reliable basis – gives parents confidence, increases credibility of the system
2. Remote geographies: Difficult to provide coverage for large areas with little population; may require telehealth that is rapid and reassuring to parents

Deep Dive: TRAILS to Wellness (MI)

Key system elements

Equity-focused services: TRAILS engages underserved communities with higher touch implementation support. Recognizing that schools in these areas demonstrate higher workforce turnover, TRAILS focuses on building long-term protocols to ensure continuity of training. TRAILS also develops culturally sensitive materials for its training curriculum designed to be reflective of lived experiences in communities

Funding mechanisms: TRAILS uses combined funding from multiple sources: funding from philanthropies and social impact funds, state appropriated dollars, revenue from direct service contracts; initially partnered with University of Michigan to receive matched Medicaid funding – spun out from University of Michigan in 2022

Community engagement: TRAILS hires teachers to partner with clinical team and design program structure. TRAILS also regularly convenes student groups to gather feedback on curriculum content

Source: Based on expert interview in June 2023, University of Michigan Medicine

Potential takeaways for WA as shared in SME interviews

Cross-applicable principles:

1. Implementation science: Training that goes beyond one-time demonstrations – including collaborative partnership with local districts, on-the-ground champions, and long-term consultation

2. Community engagement: Continuously engaging communities to ensure BH service delivery is tailored to unique cultural needs and reflective of lived experience

State-specific considerations:

TRAILS is actively considering additional states for expansion – looking for several criteria:

1. Funding – States with capacity and willingness to earmark funding from state budget to support BH training efforts (e.g., Michigan allocated $50M in state funding to TRAILS in 2022)

2. Workforce – States with workforce capacity necessary to support TRAILS school-based training program

Deep Dive: Children's System of Care (NJ)

Key system elements

Workforce strategies: NJ extends its BH workforce by employing Bachelor's level workers and peer support; roles for non-clinicians include mobile responders, care managers within care management organizations, and behavioral assistance providers. NJ also contracts Rutgers University Behavioral Health Care as a center to provide training, technical assistance, and coaching – 30 courses per month, free of charge

Funding mechanism: Funding for NJ's Children's System of Care (CSOC) is built into Medicaid. Specific funds are earmarked for individuals with IDD – CSOC covers the full array of services for this population segment

Governance and collaboration: PerformCare functions as Administrative Service Organization (ASO) that coordinates services. Care management entities (CMEs) function as independent non-profit organizations to implement high fidelity wraparound in communities – actively engage community stakeholders, such as parents, principals, judges, and Boys & Girls Clubs

Source: Based on expert interview in June 2023, Children's Initiative Concept Paper, CSOC Presentation, Rutgers

Potential takeaways for WA as shared in SME interviews

Cross-applicable principles:

1. Single point of access: Serves as convenient way for parents to access care and navigate services
2. Mobile response and stabilization system: Meets parents' and schools' needs in cases of crisis
3. Intensive care coordination by CMEs: Having entity embedded into the community allows for local accountability
4. Community engagement: Involving parents in the conversation, running support groups, and conducting education sessions for the community facilitates appropriate service design

State-specific considerations:

1. Degree of service decentralization: Differing level of siloes and fragmentation in different states
2. Community organizational infrastructure: Differing level of presence of nonprofits owned by communities to facilitate service delivery

Appendix

Unique stakeholders engaged to support overview of state initiatives

Name	State	Role
Elizabeth Koschmann	MI	Executive Director, TRAILS to Wellness
Deb Pinals	MI	Medical Director for Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services
Denise Sulzbach	CT	Director, University of Connecticut Innovations Institute
Eric Bruns	WA	Associate Director, School Mental Health Assessment, Research, and Training (SMART) Center
Hugh Ewart	WA	Senior Director of State and Federal Relations, Seattle Children's Hospital
Jessica McClure	OH	Medical Director of Behavioral Health, Cincinnati Children's Hospital
Jill Fragos	IL	Vice President of Government Relations, Lurie Children's Hospital of Chicago
Jim Theofelis	WA	Founder, NorthStar Advocates
Kashi Arora	WA	Mental and Behavioral Health Program Manager, Seattle Children's Hospital
Liz Manley	NJ	Assistant Commissioner (Former), New Jersey Children's System of Care
Melissa Saladonis	OH	Vice President Government Relations, Cincinnati Children's Hospital
Sarah Walker	WA	Director, CoLab for Community and Behavioral Health Policy
Sharon Hoover	MD	Co-Director, National Center for School Mental Health
Susan Hayes Gordon	IL	Senior Vice President and Chief External Affairs Officer, Lurie Children's Hospital of Chicago
Suzanne Fields	MA	Senior Advisor for Health Care Policy and Financing, University of Maryland's Institute for Innovation and Implementation
Tim Marshall	CT	Director of Community Mental Health, Connecticut Department of Children and Families

Subject matter experts to consider for additional interviews

Potential contacts identified by interviewed SMEs for future connection

NON-EXHAUSTIVE

Name	State	Role
Cindy Beane	WV	Commissioner for the West Virginia Bureau of Medical Services
Dana Weiner	IL	Senior Policy Fellow, Chapin Hall of University of Chicago
Marisa Weisel	OH	Deputy Director, Ohio Department of Medicaid
Michelle Zabel	MD	Executive Director, University of Maryland's Institute for Innovation and Implementation
Mollie Greene	NJ	Assistant Commissioner (Current), New Jersey Children's System of Care
Kelly English	MA	Deputy Commissioner, Massachusetts Child Youth & Family Services
Robert Putnam	MA	Executive Vice President of Positive Behavioral Interventions and Supports, May Institute
Sheamekah Williams	OK	Director, Children, Youth, and Family Services at Oklahoma Department of Mental Health and Substance Abuse Services

Source: Expert interviews with SMEs identified by CYBHWG leaders and staff in May – June 2023

Perspectives on the current state of BH services in WA as shared by SMEs

While SME interviews were primarily conducted to gather examples of emerging BH initiatives from other states, several qualitative insights were shared regarding the current state of BH services for children/youth in WA. Below is a list of perspectives on the current state of the BH system in WA as shared by SMEs

NON-EXHAUSTIVE

Age-specific opportunities:

- Early childhood: Potential opportunity to strengthen care services for young children under the age of 5
- Transitional age youth (TAY): Potential opportunity to strengthen developmentally appropriate resources for TAY population (19-25 years old). As one SME shared, "Right now, Washington puts 18-year-old's and 50-year-old's in the same treatment program, even though they navigate the system very differently"

Culturally responsive opportunities:

- Potential opportunity to strengthen services in languages other than English
- Potential opportunity to recruit more BH workers whose life experience reflects the populations they serve (e.g., LGBTQ+ youth, youth of color, individuals who have experienced homelessness)

Care continuum opportunities:

- Potential opportunity to develop capacity for intensive care serving individuals with more complex needs
- Potential opportunity to fortify support and resources for individuals returning to their communities following inpatient BH treatment – e.g., community building, workforce training, well maintained discharge facilities

Cross agency collaboration:

- Potential opportunity to improve coordination mechanisms across agencies. As one SME shared, "It's easy for HCA to fall into project-based work because of its structure – when in reality the focus should be on system level reform"

Source: Expert interviews with SMEs identified by CYBHWG leaders and staff in May – June 2023

Potential methodological considerations as shared by SMEs

While SME interviews were primarily conducted to gather examples of emerging BH initiatives from other states, several methodological considerations were also shared regarding exercises that may enrich the strategic planning process:

NON-EXHAUSTIVE

Quotes shared from SMEs

Data investment

My hope is that the Strategic Plan makes recommendations to invest in robust data systems so we can see what's happening. Right now, we cobble together a lot of anecdotal reports to make a case to the State

Fund and eligibility mapping

Children and youth served by public systems are a shared population – they are not receiving services from just one location. Where we see states making inroads is in recognizing this sharing of dollars and accountability to understand how each system contributes to a single plan of care and a holistic view of what each family needs

Integrated care planning

There is more work to be done with integrated managed care plans to ensure consistency in approach across multiple health plan partners … People change between health plans – sometimes families are in multiple health plans, or children are moving in and out of foster care – so there isn't a long-term ownership of wellbeing of child. The question is: How do we think about that continuity for individuals in these situations?

Care pathways

I always recommend starting with identifying the care pathway for children and families - what are their current experiences? Where are there missed opportunities? You could have existing services but might not be offering at the right time or place … This can then point to system level responsibilities

Source: Expert interviews with SMEs identified by CYBHWG leaders and staff in May – June 2023

States pursue a broad range of behavioral health (BH) initiatives focused on several goals (1/2)

NON-EXHAUSTIVE

Goals along continuum of care

Improve promotion, prevention & wellness	Proactively reduce risk factors for BH conditions and improve general mental health and wellbeing
Increase capacity for BH treatment	Increase the total infrastructure available to provide clinical treatment to individuals with BH conditions
Expand crisis treatment services	Assess, triage, and provide real-time support to individuals experiencing acute crises, including crisis prevention, response and stabilization
Strengthen rehabilitation and re-integration	Assist with holistic support, especially for populations with complex needs and co-occurring intellectual and developmental disability (IDD) and BH needs
Enhance wraparound services	Expand suite of services that assist individuals and families to initiate, stabilize and maintain long-term recovery from mental and substance use disorders

Source: McKinsey Health Institute

States pursue a broad range of behavioral health (BH) initiatives focused on several goals (2/2)

NON-EXHAUSTIVE

Cross-cutting goals

Establish new digital access channels	Utilize technology to create virtual entry points for children and youth to use along all stages of the BH spectrum
Expand BH workforce / capability for care	Build a sustained, sufficient, and diverse BH workforce by expanding workforce recruitment, retention, training, and other initiatives
Provide equitable access to BH services across settings	Enhance BH infrastructure across settings such as schools and community organizations to improve coverage for populations with challenges to access
Expand eligibility and coverage	Address gaps in eligibility and coverage across the BH care continuum
Scale evidence-based and evidence-informed practices	Create mechanisms for consistently identifying and scaling across different settings and populations empirically proven interventions and interventions with emerging evidence
Enhance funding mechanisms	Effectively utilize federal funding, identify alternative funding sources, and ensure funding availability over time

Source: McKinsey Health Institute