CYBHWG Youth & Young Adult Continuum of Care (YYACC) subgroup

Thursday, September 23, 2021
4:00 – 5:30 p.m.

Agenda Items	Notes
Update SB 6560	**Kim Justice & Matt Davis,** Office of Homeless Youth & **Sazi Wald,** Health Care Authority (HCA) **SB 6560 Work Group (Kim)** Highlights • SB 6560 (2018) – Goal: Ensure that youth leaving systems of care would exit to safe and stable housing. • Resulting plan: Youth Exiting Systems of Care – developed by state agency staff in tandem with youth with lived experience. • No legislative direction or formal authority. Ad hoc group. • Meet biweekly; shepherding the implementation of things in that plan (those that have passed the Legislature). Most recently looked at a rapid response system for youth. Discussion / Q&A • Addressing youth exiting EDs? High incidence – high loss. Answered broadly. Collected from stakeholders, not specified what setting. Initial legislative direction – exit from inpatient settings. Agreed – EDs is important. **Report: Safe and supportive transition to housing (Sazi)** *See page 6 for slide deck.* Highlights • RDA: 2 out of 10 young people exiting inpatient treatment will be homeless within 12 mos. • A Way Home: 2 out of 3 homeless youth experiencing BH issues had been discharged from inpatient treatment. • Received feedback from 200+ people – 79 young people with lived experience; the rest were family members and providers. • See report findings, Executive Summary, starting on page 8. • See recommendations for agencies, providers, advocates, research – starting on page 29. Discussion / Q&A • A Way Home – youth placed in foster care did no better than those exiting inpatient care. • Young people discharging that have hit therapeutic threshold for inpatient care and discharging into homelessness. Is there an option or an idea? • Important to make sure we are supporting families and communities; that they have a linkage when they are being discharged. • How do we make sure, when talking about advocates, that parents are not blocked as they often are?

	• Systematic changes needed so discharge planner can give linkages and resources to parents. • Possibly to match with priorities that were presented in the Google survey results. Chat: • What ages does the bill identify as "youth who are protected? • Matt Davis – Youth Exiting Systems of Care report: https://www.commerce.wa.gov/wp-content/uploads/2020/Youth-Exiting-Systems-of-Care.pdf • Oxford House new to Grant County for "clean living" sobriety. • 144 beds and they now allow suboxone sobriety. • Housing for TAY needs to include options for young adults who need out of their family homes but shouldn't have to bounce through time on the streets before being eligible for supportive housing. • As parent advocates, we are sending families in crisis first to case managers; they are our strongest advocates for care.
Agency communications – new legislation	**Diana Cockrell**, Health Care Authority Highlights • When a bill is passed, generally, the division where the funding goes takes the work. • In DBHR, the work is organized by topic and the section that led the review and analysis during legislative session generally leads implementation. Typically, 3-5 people analyze each bill, including 2 or 3 other divisions if the legislation may affect their work. How does HCA implement new legislation? *There are nuances in the process depending on what the work is and how staffing is managed.* **1.** Hiring and onboarding the staff. **2.** Determine the work that needs to be done to implement. Review with fiscal staff. **3.** Develop a plan and a rough timeline for moving the work forward. Other details: • Lens: 3-legged stool: Impact on young person/child, parents, system partners/providers. • Look for ways to incorporate trauma-informed, diversity and inclusion. • Look at impacts/potential changes to contracts with MCOs and BH-ASOs. • Work within agency to coordinate between divisions. • Communications teams – uses listservs to communicate with the field. Discussion / Q&A • **Q:** How we get information to people that need it? *Currently we reach out to MCO's, BHO's, direct contracted providers, division list serves, agency list serves, webinars, and website. Social media is an area to explore further with our Communications team.* • Do staff spend time with the key legislators, legislative staff, and advocates to talk about what was intended with the law? *Unique to each piece of legislation. We can implement what's in the law, and our legal team will tell us what the law says. If that does not meet the spirit/intent of the legislation, we encourage people to work with legislators to change the law.*

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HB 1894 passed 2 years ago; it's not implemented across the board. SB 5412 – to support HB 1894. Timeline concerns me.
The core elements of what we are required to implement is out there; the training is out there. We are fielding questions regularly. Figuring out the legal nuances and fine-tuning language expanded the timeline beyond what we had hoped. Across the spectrum, BH entities' ability to think about it how to roll it out as the pandemic happened was challenged.
Legislative reports – what happens the next year with the findings?
Our section participates in producing 7-8 annual reports each year. We look at them to see where and how we might make internal recommendations. We use reports to inform policy recommendations and funding requests.

Chat:
Registration link to training for families - https://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/family-initiated-treatment-fit
Registration link to training for providers – https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/family-initiated-treatment-fit
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<tr><td>Group Breakout Discussion(s)</td><td>
Highlights
Where did you think you would find resources and didn't?

Stayed on 211.
NAMI; family support group through NAMI may have local info.
Pediatricians – they don't know where to refer people?
People/youth don't know the resources, or where to find them.
Did not find information from providers.
I thought the school should have been able to direct me. Then I thought our doctor. Neither of those worked. It wasn't until I connected with other parents that I found resources.
Relying on word of mouth to find services causes trauma. Resource trauma – hours and hours of time.
MCO nurse coordinators - or whatever the role is called at that MCO – care coordinators, case managers - have been the best source.
Can we have a universal term?
Go to the MCO and say you need a care coordinator. Tell them to invite everyone to the table to develop a plan – HCA, DD, school, etc.
Moving into integrated care, there have been growing pains at HCA. There should be a creation of a care coordination team that pulls in all the people who need to be at the table.
That system does not exist if you're not on Medicaid

Where do you find information about behavioral health for children/youth?

Word of mouth.
Other parents/youth; in general, talking to others that are also trying to navigate the system.

Where should HCA be offering the information?

Offer info through schools, doctor offices, NAMI, and other related non-profits (PAVE among them).
Information provided online isn't enough – not equitable. Need physical resources/info in locations where families are. Homeless and women's shelters. Yes. bh ombuds.
Liaisons – exchange – for people who are remote.

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<tr><td>Group report out(s)</td><td>
Group 1 – Youth and young adults

Must use social media platforms that youth use frequently to try and increase communication.

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	• Social media, ads, schools, Crisis Connection. • Go to the youth with information, they are less likely to seek out. • Youth have a hard time finding resources. • Someone should know where to find resources without having to think about it. Just make it available everywhere! **Group 2 – Parents and caregivers** • Frustrating process when reaching out for services – unable to get what is needed. • Parents are doing the legwork / relying on word of mouth. • Would be nice to have a care coordinator or case manager. • MCO's to help with cross system collaboration. • What would be helpful? • Community liaison since every community is unique. **Group 3 – Providers/system partners** • Work force crisis - Providers are very busy and burdened. • Could use an increase in communication. • Put all new legislation on one webpage for one provider to go and see all bh information. • Make sure the word spreaders need to have the right info. Ensure end message is accurate for BHO's & MHO's. e.g., giving to a hospital and then trickling down. Multi-lingual flyers. • Several suggestions around media (paired with a personal story?). • How do we incorporate adult learning theory in how we are sharing information? Infographics. (Do this/don't do this) Use of video. **Action Items** • Reach out to the Spark Learning Center (Spark.ignite) for peer counselor, peer participation. (Lillian) • Others in the group invite youth contacts to increase youth participation.

Attendees

Jeanette Barnes
Rachel Burke, Health Care Authority (HCA)
David Callahan, Youth/Young adult
Dr. Phyllis Cavens, Child, and Adolescent Clinic
Jerri Clark, PAVE
Diana Cockrell, HCA
Mary Cole
Thalia Cronin, Community Health Plan of Washington
Matt Davis, Office of Homeless Youth
Kaila Epperly, Lutheran Community Services NW
Sydney Forrester, Washington State Governor's Staff
Ann Gray, Office of Superintendent of Public Instruction (OSPI)
Libby Hein, Molina Healthcare
Andrew Hill, Excelsior Wellness Center
Charlotte Janovyak, Legislative staff
Kim Justice, Office of Homeless Youth
Michelle Karnath, Clark County Juvenile Court, Statewide FYSPRT tri-lead, Parent
Annette Klinefelter, AKI
Richelle Madigan
Taku Mineshita, Department of Children, Youth and Families (DCYF)
Carey Morris
Cammie Perretta, HCA
Deborah Pineda
Penny Quist, Parent Advocate
Representative Carolyn Eslick, Washington Legislature
Jana Robinson
Chan Saelee
Janice Schutz, Washington State Community Connectors (WSCC)
Liz Troutman
Megan Veith, Building Changes
Liz Venuto, HCA
Sazi Wald, HCA
Cindi Wiek, HCA
Greg Williamson, DCYF
Lillian Williamson, Youth/Young adult

Washington State Health Care Authority

Safe and supportive transition to stable housing for youth ages 16-25

Best practice recommendations for strong supportive communities

[July/2021]

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Executive summary

Overview

HCA is exploring best practices to transition youth and young adults ages 16-25 who experience homelessness from inpatient to outpatient behavioral care and stable housing.[1] The 2018 A Way Home Washington reports two out of three 13 to 24-year-olds experienced homelessness after they had discharged from a public system of care from inpatient behavioral health treatment.[2] The Office of Homeless Youth (OHY) presented 2017 data from Research and Data Analysis illustrating that within 12 months of exiting inpatient behavioral health treatment, one in five young people ages 13-24 would be homeless. 82-84% of these young people were between the ages of 18-24.[3,4]

SSB 6560 aims to prevent young people from experiencing homelessness after being discharged from a systems of care.[5] The bill was codified into RCWs 43.330.700 and 46.20.117. The bill asks that statewide programs coordinate with the Department of Commerce and support youth to get identification cards after leaving detention centers.[6,7]

Transition into the community

HCA works in partnership with the Department of Commerce's Office of Homeless Youth (OHY) with a position both funded and supported by the Raikes Foundation and Schultz Family Foundation. HCA explored best practices for transitioning homeless transition age youth (TAY) from inpatient treatment into the community. HCA used literature review and lived expert stakeholder feedback to create five levels of recommendation:

- Value-based purchasing packages
- Technical assistance and education
- Policy recommendations
- Practice recommendations
- Research recommendations

Four important foci

Four vital aspects of comprehensive recovery support for TAY were identified and will be referenced throughout this document. Stigma, which is the first vital aspect, is called out specifically here but is integrated throughout the report because it influences aspects of best-practice and transformative comprehensive care. Stigma and anti-oppressive care should be integrated into recommendation implementation.

1. Stigma and anti-oppressive care: The ways that our identities influence the types of care we receive and access.
2. Basic Needs: things like housing, food, money, education, employment, ID cards, and other daily necessities.
3. Relational Health: Family, friends, and other things that impact social well-being.
4. Access to TAY appropriate Behavioral Health Care: Enrollment in behavioral health care, staff training, behavioral health interventions.

Current practice

- Discharge planners attempt to link TAY with:
    - Follow up care
    - Housing vouchers
    - Stable Housing
    - Natural supports
    - Employment supports
    - Education supports
    - Legal supports
    - Other community supports
- Managed Care Organizations (MCOs) support care coordination for health care services.
- HCA contracts to ensure these supports are provided.

Cost savings

- Safe and stable housing is highly cost-effective for people with behavioral health needs who experience homelessness. Several cost-saving analyses indicate a cost reduction between 40% and 55%. [12–15]

Best Practice

Best practice for discharging TAY includes:

- Living skills
- Stable housing
- Continuous care and consistent care providers
- Developmentally appropriate policy considerations
- Supportive housing, employment, & educations
- Transitional living and independent living
- Warm handoffs
- Stable natural supports
- Peer-driven programming

Recommendations

For more details see the recommendations in section 5, page 23.

HCA:

- Track referrals post-discharge including linkage to stable housing 12 months post-discharge
- Purchase for in-reach to inpatient substance use disorder (SUD) and mental health (MH) treatment and ongoing follow up care after discharge
- Continue to coordinate for rule adjustment
- Collaborate with agencies to form and deliver trainings on developmentally appropriate care

Providers:

- Assess for homelessness and link TAY with safe and stable housing
- Warm handoff to other providers
- Provide living skills support including supportive housing, education, and employment
- Provide in reach and peer support
- Integrate client voice and choice
- Provide couple and family counseling and reconciliation
- Ensure there is follow up with clients up to 12-months post discharge

Advocates:

- Increase housing inventory of low barrier safe and stable housing first options
- Explore state-wide policies that preclude TAY experiencing homelessness from housing
- Support SUD and MH case management
- Support funding for community activities and engagement for TAY
- Explore paid lived-expert voice across the system (agency to state-level)

Researchers:

- Form evidence based practiced to discharge homeless TAY
- Create empirically based value-based purchasing packages or other payment structures for TAY experiencing homelessness
- Develop empirically based data collection for tracking TAY transitions into stable housing

Grant Partners

Raikes Foundation and Schultz Family Foundation funded the position that completed this work.

Grant timeline

January 2020-June 2021

Key partners

The Department of Commerce—Office of Homeless Youth, Mockingbird society, A Way Home Washington, Raikes Foundation, Schultz Family Foundation.

Contact information

Sazi Wald, MSW, LSWAIC, SUDPT

Behavioral Health Transition Age Youth Stable Housing Policy Lead

sazi.wald@hca.wa.gov

360-790-4560

Section 1.0 overview

Young people across the state need stable housing and support when they exit behavioral health settings. In order to better understand this opportunity, we identified best practice behavioral health supports needed to ensure that TAY are appropriately linked with basic needs, behavioral health care, and strong community. Inpatient transition planning presents a clear avenue to support this process.

Throughout the project we sought to use a co-design, collaborative approach with information from both stakeholders and literature to better understand the current state of transition planning.

The rest of this section will outline current data on TAY homelessness. Subsequent sections will explore what stakeholders reported, the literature review, and the resulting best practices. Finally, we will outline recommendations for HCA, the broader system, advocates, and researchers to continue this project and make improvements.

Section 1.1 current available data

Homelessness was defined as any situation where housing is nonexistent or unstable. Such as when someone is unsure where they will sleep at night, when they are living on the street or in a car, reside in temporary situations, are couch surfing, etc.[2]

Info graphic showing current available data on teen homelessness.

According to housing and urban development (HUD) data, **across all ages** as of 2019, Washington had an overlapping total of:

- 4,415 Transitional Housing beds
- 5,111 Rapid Resourcing beds
- 11,454 Permanent Supportive Housing beds
- 4,241 Permanent Housing beds

Yet we were still left with a **shortage of 8,538** beds.[30]

1,911 of these individuals needing beds are unaccompanied and **unsheltered** youth under the age of 25 compared to the total of **2,089** homeless youth.[31]

Based on Washington's most recent data regarding exits from public systems from 2017, 1,441 youth ages 12-24 experienced homelessness within a year of leaving the care setting. 19% of those were from behavioral health inpatient services which is close to **2 out of every 10** young people that go into treatment systems. 83% were between the ages of 18-24 (more than **8 out of 10)**.[4]

A Way Home Washington's report found significantly higher results from RDA's 2015 data. **2 out of 3** youth experiencing homelessness had been discharged from inpatient behavioral health treatment.[2,32]

A Way Home Washington also reports that there are **13,000** unaccompanied youth throughout the state utilizing homelessness services.[33]

Section 2.0 stakeholder solutions

During this report, we sought out both stakeholders and literature to inform best practices. While the next section explores in detail both findings, we led with the voices of those with lived experience.

During the stakeholder process, we sought to better understand what Washingtonians were experiencing firsthand regarding transitions for TAY experiencing homelessness.

This section will outline the state of Washington’s discharge planning straight from those who experience it.

Anonymous surveys and interviews were conducted by the project lead throughout the state.

Combined we met with and surveyed:

- **42**—18-25-Year-old lived experts
- **37**—26-35-Year-old lived experts
- **26**—Families of young lived experts
- **111**—Service Providers and Administrators

Youth and adult lived expert groups were often combined into “TAY lived experts” during data analysis owing to similar reported experiences and will be identified as “lived experts;” caregivers and services providers were still separated. When comparing TAY lived expert groups the age range will be used ex. 18- to 25-year-olds or (age 18-25).

Survey and Interview Result Overview:

Demographics

The Western side of the state saw more adult lived experts and caregivers, with a quarter located in the Eastern part of the state. Provider location was not captured.

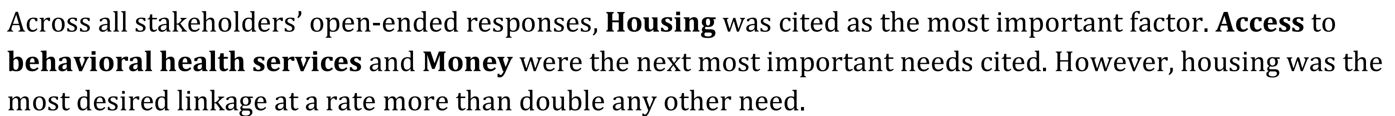
Across all respondents: 28% identified as Mixed race and/or people of color. Within providers, however, 96% identified as Mixed race and/or people of color.

Across all respondent reports: 66% were female, 23% were male, 1% were intersex, and 9% identified as transgender (including non-binary).

Across provider types: 32% of respondents were in some form of leadership, 16% were peer support staff, 16% were master-level counselors, and 13% worked in case management.

Of the TAY (age 18-25) lived experts: 32% were experiencing homelessness. 51% were stably housed while 17% were in a temporary living situation.

Primary themes to inform best practice



Across all stakeholders' open-ended responses, **Housing** was cited as the most important factor. **Access** to **behavioral health services** and **Money** were the next most important needs cited. However, housing was the most desired linkage at a rate more than double any other need.

Section 2.1 the current state of discharges according to stakeholders

The state of discharges currently shows drastic need for change. When it comes to the support that TAY received after discharge, **39%** received **no support at all**. Caregivers **unanimously** reported that there was not enough support for their TAY after discharge, with **54%** reporting that there was no support and **46%** reporting very little.

Together, **52%** of TAY respondents reported that their **discharge plans were completely different, while 29%** reported that their discharge plans played out as intended.

26% of TAY felt that they received the support that they needed after leaving inpatient treatment, while only **14%** of 18- to 25-year-olds felt adequately supported. **46%** of TAY of the respondents received some but not enough support. The feedback clearly shows that **stakeholders need follow up support after discharge.**

31% of TAY lived experts report meaningful involvement in their discharge planning process. Only **14%** of 18–25-year-old reported meaningful discharge planning involvement. Across all TAY, **35%** reported they were **not involved in their discharge plans**, which shows a significant opportunity and desire for client voice.

Lived experts often cited **integrity** as an issue regarding the services they received. During their transition, they would often be encouraged to pursue or be promised opportunities and services that fell through or were not what they had agreed upon. TAY cited **stigma** and **cultural insensitivity** as significant factors during these experiences.

Throughout the discharge process, **27%** of TAY reported that they received culturally and developmentally appropriate services, while only **14%** of caregivers felt the same. **43%** of TAY felt that some of these needs were met, compared with only **29%** of caregivers. **36%** of TAY and **57%** of caregivers reported that these services were **not culturally responsive and developmentally appropriate.**

Both subtle and blatant oppression around the areas of race, gender identity, sexual orientation, class, religion, ability status, looks, and legal background were cited as significant barriers. These were placed under the theme of the stigma the **4th most frequently cited barrier and action item** making up **15%** of total responses from TAY and **18%** among all stakeholders. Systems and services must take action to meet the unique healing needs of stakeholders through training, self-growth, and representation.

Communication was another common theme across **all stakeholders**. Breakdowns in communication during the transition process were significant. A common experience reported was evolving discharge information. For example, some caregivers received information that their youth would be held for a certain amount of time, but they found out that their youth had been discharged early. As previously mentioned, many TAY were not linked with support after discharge. Follow-up care was deemed essential by not just TAY and caregivers but also echoed by providers. Many providers felt frustrated by the lack of communication among their peers, while also feeling

bogged down by paperwork, high caseloads, time constraints, and the overwhelming lack of sufficient resources available.

Section 2.2 housing availability after discharge

Housing

When it comes to housing, **80% of 18- to 25-year-old lived experts reported wanting a place of their own. 24% reporting that they wanted to live with their families.** “Families” include their biological family, chosen family, and their offspring. This number increased to **51%** when accounting for all TAY lived experts who primarily highlighted their children as their family preference.

Overall, before entering inpatient treatment settings **77%** of TAY respondents were unstably housed or homeless.

After leaving inpatient settings**, three out of four respondents** were unstably housed or homeless and **26%** were connected to stable housing.

Across all groups, behavioral health access and housing resource linkage for those leaving inpatient settings were unanimous.

Housing options must respect the desire for young people to live on their own. **Transitional housing** was a persistent request by providers and families, while **outreach support and wrap-around services** with **individual housing arrangements** were requested by TAY lived experts. **Across all groups,** easy access and **“all in one” spaces** were popular recommendations.

These recommendations included:

- Transitional supportive housing model
- Outreach workers who could **link young people with:**
  - **basic needs**
  - **social supports**
  - **recovery supports.**

TAY are proud of their **recovery** with **49%** reporting that it was their greatest strength. Their **parenting** was the second highest at **16%**, and maintaining **housing** came in third at **14%.**

TAY are not the only individuals who need services to support their goals. Caregiver stakeholders want services to help them support their children. **21%** of caregivers reported that their **families** were among their greatest strengths, with **16%** reporting that their families’ **recovery** was another huge source of light. Caregiver strength data was complex. 32% of respondents reported **persistence** in the face of the challenges they experienced. 11% of the 32% of respondents reported stigma as the largest barrier. **16% of caregivers reported no strengths** due to the loss of their children. Culturally responsive outreach, follow-up care, and communication were the most frequently cited solutions to mitigate the immense challenges and prevent future loss.

Section 2.3 if we had a magic wand

Stakeholders were asked to create their ideal transition situations if there were no boundaries.

Transition Age Youth

TAY lived expert stakeholders sought flexible independent stable housing with easily accessible behavioral health programming. They would like to have the money to access food, clothing, transportation, pay child support, and other things that they need to live. They would like outreach and case management so that they can stay up to date with what they need.

Ideally, **they would like to have their own apartment** and to **access a counselor, peer, or case manager when they needed**. They would like a peer counselor to be available during the process of accessing behavioral health services. For example, if they need to go to the emergency department, a **peer** or other professional could stay with them to be supportive while they are going through that experience, rather than sitting alone on a gurney.

They want to be **integrated into their communities without feeling stigmatized** and shamed for their behavioral health and homelessness experience. Support could be **TAY-specific programming** with their peers and housing placements in communities that are welcoming and supportive. Where staff and neighbors take a trauma-informed and developmental approach to help TAY integrate into the community.

TAY want to have their children and loved ones (including animals) with them. To support this, they ask for parenting and relationship support to not only heal unhealthy internalized family patterns, but to also stop the cycle of abuse.

Within behavioral health settings, TAY want to be a **part of the treatment process**, be **fully educated** on their **options**, and have **leadership opportunities** available that help them improve programming. They want to be placed in a **safe environment** that they co-define, as each person's safe placement may look different.

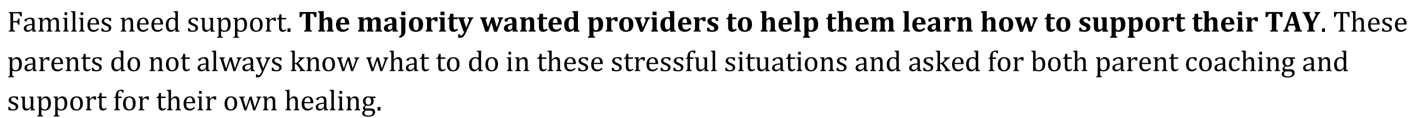
Of note, was the observation that **these desires encompass basic needs**. This population experiences turmoil within their basic survival which prevents them from focusing on their natural individuation and self-discovery journeys.[34,35]

Caregivers

Caregiver stakeholders had a much broader image of their ideal transitions.

Overall, the majority wanted **clear communication from providers**. As mentioned above, many would learn that their youth had more or less time before they discharged, information that changed sporadically.

Caregivers want their **TAY discharged with a caring peer** or other staff members available. Some families had experienced fatal consequences to a lone discharge.



Families need support. **The majority wanted providers to help them learn how to support their TAY**. These parents do not always know what to do in these stressful situations and asked for both parent coaching and support for their own healing.

Respite was another important request from families. When they are supporting their 16- to 25-year-old at home they would like to have a safe and therapeutic place for the young person to go when they experience an incident that does not warrant an inpatient setting.

Families reported **significant benefits from wrap-around support, peer counseling, and family counseling**. They highlighted that peer counselors for both them and for their TAY were invaluable assets to the recovery of their dynamics.

Another, **and far less prevalent,** side of caregiver stakeholders were those who considered family support to be child removal from their homes, stricter laws, and increased incarceration policies regarding teen and young adult behavior and substance use. Reporting that incarceration would be prevent their TAY from experiencing homelessness.

Regarding housing, **caregivers most often wanted their youth to live back home or in group housing settings**. They were weary of independent apartment living. Many caregivers also suggested that TAY need to use willpower to overcome their obstacles. Some caregivers were of the mind that incarceration was the answer and wanted to their youth who had engaged in any criminal activity were institutionalized in those settings.

Providers

By and large providers dream of **ample, flexible, diverse, stable housing options** for youth and young adults. They want everyone to have stable housing. While many cited transitional housing and group home settings as preferable, because it would be **easier for them to incorporate their behavioral health supports**, they cosigned outreach and case management as indispensable.

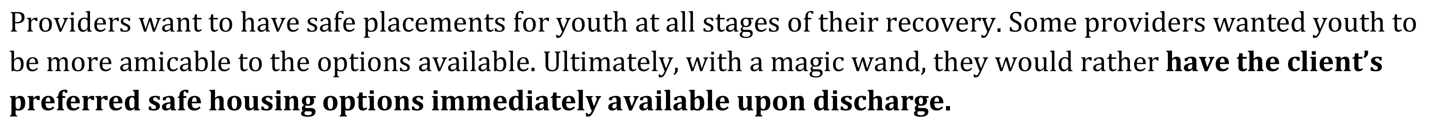
Providers believed that **increasing case management** services and **peer supports** would make substantial recovery ripples throughout the field.

They want **more resources** to link young people with including housing, money, food, employment, and education. They recognized the incorporation of caring relationships with both TAY's children and their service animals as vital to recovery.

Providers would also like to have **clear communication with each other**. They want to have the **time and resources** necessary to effectively coordinate care.

Providers need an **adequate salary and full staffing.** This would help reduce burnout and give them the time to more thoughtfully follow up and link TAY with any available resources.

Many providers want to use the expertise of **youth live-expert voice** in their program development.



Providers want to have safe placements for youth at all stages of their recovery. Some providers wanted youth to be more amicable to the options available. Ultimately, with a magic wand, they would rather **have the client's preferred safe housing options immediately available upon discharge.**

Section 3.0 understanding TAY

To better serve transition-age youth, we must first understand who TAY are as a population. TAY are leaders, gurus, teachers, families, neighbors, and support systems. They are often coming into a heavy realization as they transition out of childhood mastery. These new adults are in the process of actualized human potential, and it is our responsibility as adults and peers to welcome them.

These young people have incredible insight and wisdom. As experts in childhood, teenage years, and young adulthood, they provide unique perspectives to help illuminate solutions which those of us who are farther removed and entrenched in the points of view that come with advancing age, do not see.

Neurobiological factors

This 16-25 age range is the beginning of adulthood.[1] As a species, humans have one of the longest periods of formative development. We experience biological milestones that are spaced farther out, making interdependence a survival necessity. As we mature, we bond to each other in a way that few other species do.[40,41] This contributes to the messiness of an "out on your own at 18" idea.

Neurodevelopmentally, transition-age youth experience significant shifts that influence their reasoning and behavior. Common highlights of development during this stage include the increase in mass within the pre-frontal cortex, maturation of the limbic system, and synaptic pruning. Simplified, respectively, these phenomena can cause greater **impulsivity, emotionality, and long-term pattern formation** (in both healthy and deleterious ways).[42–44]

Section 3.1 Transitioning TAY into stable housing

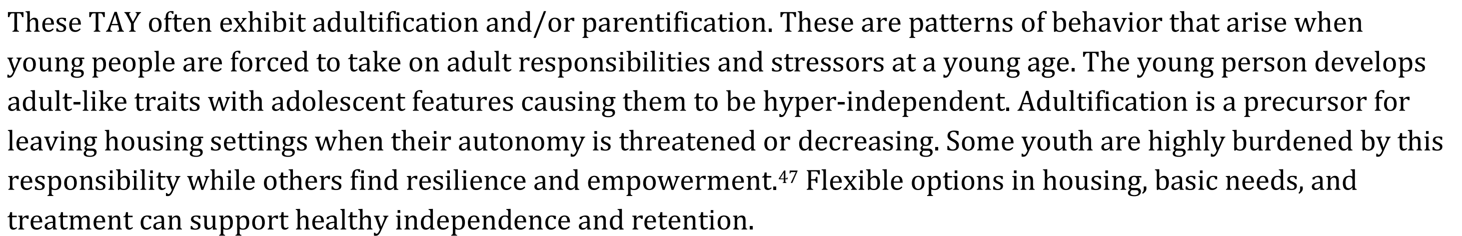
Access to behavioral health services for TAY experiencing homelessness

TAY that experience homelessness are in a unique position. As a group, their transition is grounded in resilience and survival. This means that behavioral health care is vital to heal trauma, which adds security and wellness to TAY foundations.

Accessing developmentally appropriate services can be a challenge. Generally, **behavioral health services are divided into four sections**: under 18 or over 18 and with substance use disorders or mental health disorders. This means that youth may have challenges accessing treatment for both a substance use disorder and mental illness and may be in services with people either much younger or older than them. That is why behavioral health integration and TAY-specific programming are so important.

Unique perspectives of TAY experiencing homelessness

Generally, most TAY are learning how to drive, dating, finishing high school, and going to college during this time. While this can be the case for TAY experiencing homelessness, these young people experience higher levels of responsibility.[45,46]



These TAY often exhibit adultification and/or parentification. These are patterns of behavior that arise when young people are forced to take on adult responsibilities and stressors at a young age. The young person develops adult-like traits with adolescent features causing them to be hyper-independent. Adultification is a precursor for leaving housing settings when their autonomy is threatened or decreasing. Some youth are highly burdened by this responsibility while others find resilience and empowerment.[47] Flexible options in housing, basic needs, and treatment can support healthy independence and retention.

How do TAY become homeless

Housing can be taken from TAY for many reasons. Predominantly, independent, safe, and stable housing are not options. Abuse and neglect from families and programs are a common reasons for those under 18 with affordability as a significant factor for those over 18.[3,48–50] Rather than a right for youth, housing is used as a privilege. Abuse and neglect from families and programs often manifest by using homelessness as "punishment." These TAY are often punished for using substances or expressing their LGBTQ+ identity.[2,3,49] LGBTQ+ youth make up between 20-40% of TAY experiencing homelessness with Queer and Trans Black, Indigenous, and People of Color (QT-BIPOC) TAY making up a disproportionate number of homeless youth.[31]

Access to money and a credit history are housing barriers are often experienced by those over 18 years old. Youth 18 and older may not have money for housing or the ability to maintain it.[46] Rooming with others is not always the solution. It is common for young people experiencing homelessness to have significant experience with shared housing: sleeping on couches, in group home settings, foster families, etc. Many times these environments are unsafe with high conflict and even sexual assault. [50–52] This is the primary reason why TAY argue for independent housing situations.

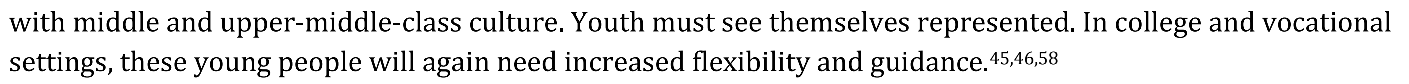
When attempting to obtain independent dwellings, TAY without homes needs access to the following:

- credit history,
- a stable income where rent is 30% of the total income earned,
- banking, co-signers,
- references,
- application fees,
- first, last and deposit, and occasionally pet deposit,
- and a clean criminal history.[2,53–55]

Developmentally appropriate independent living

From socio-cultural and neurodevelopmental lenses, in our Western society, it is appropriate for young people to want to learn how to live as individuals, creating and commanding their homes.[56] This is an important time to learn more complex boundary setting, how to keep an apartment and mitigate some of the natural stressors young people experience developmentally. To do this, TAY needs support that is available in the form of guidance and mentorship.[14,15,57]

While many TAY can struggle to conceptualize and integrate their impact potential, this is exacerbated in TAY experiencing homelessness by the way of class. Often these young people do not see college as an option or relate



with middle and upper-middle-class culture. Youth must see themselves represented. In college and vocational settings, these young people will again need increased flexibility and guidance.[45,46,58]

Section 4.0 maintaining stable housing

According to stakeholders and literature there are three major elements to maintain stable housing for TAY that were houseless all of which should be approached through a culturally responsive and developmentally appropriate lenses.

- **Basic Needs**
- **Community**
- **Recovery**

Basic needs are the things that youth need to survive and maintain their services. This includes (but is not limited to): culturally and developmentally appropriate: housing, food, clean water, toiletries, transportation, money, legal aid, education, and employment.[59]

Community integration is another vital focus for TAY to maintain housing, the major component of which is the development and maintenance of relationships. Based on stakeholder feedback and research, this includes but is not limited to: culturally responsive and developmentally appropriate connections with: oneself, parenting support, family, friendships, and community representation.[42,60]

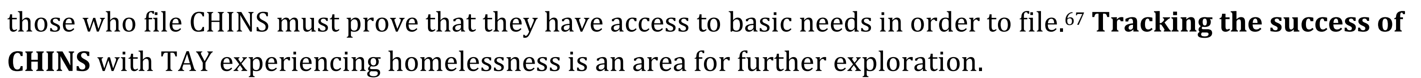
Recovery involves strong behavioral health supports to help empower, heal, and build skills to maintain their housing. This includes but is not limited to culturally responsive and developmentally appropriate: outreach, easy access, client-driven goal setting, case management, peer support, integrity within the system, and flexible policies.[19,61,62]

Section 4.1 basic needs

Under basic needs, housing first, harm reduction, employment, education, and linkage with money, and food were integral for the sustained recovery of young people. [14,29,54,59] **TAY experiencing homelessness experience compounding barriers to housing** including: credit history, stable income where rent is 30% of the total income earned, banking, co-signers, references, application fees, first-last and deposit, and occasionally pet deposit and a blank criminal history. [2,53–55]

The age of majority (18) prevents youth ages 16-18 from going into legally binding contracts unless they become emancipated.[63,64] **Unaccompanied TAY below the age of 18 must access the foster care system and/or legal system in order to acquire housing and full employment**. [63,65] In order to procure the resources from these options, the young person must meet the severity of abuse needed to be admitted into the foster care system and there must be foster placement options available. Even for those who enter this system, housing and basic need linkage are not guaranteed.[49,66]

For those who are not being cared for by government systems and their biological family, Child in Need of Services (CHINS), petitions are an option. However, stakeholder reports suggested that these were ineffective and further traumatizing to youth. They report that young people will often use CHINS to gain access to basic needs. However,



those who file CHINS must prove that they have access to basic needs in order to file.[67] **Tracking the success of CHINS** with TAY experiencing homelessness is an area for further exploration.

Similar to CHINS, emancipation is another option that 16- and 17-year-olds have through the legal system. Emancipation is another challenging legal order to complete as the young person must show that they have and can care for their own basic needs.[65] If they do obtain emancipation, they no longer qualify for child welfare assistance. **Anecdotal reports from service providers suggest that even when young people obtain emancipation, landlords and employers often treat them as minors**, thus perpetuating the access issue that led to emancipation.

These challenges do not end at the age of 18 when TAY access the adult system. TAY on both ends of the age of majority struggle to obtain basic needs the consequences of which are often grave. TAY experiencing homelessness are in unique danger of encountering life-threatening experiences such as sexual trafficking, drug overdose, and even murder. [50,68]

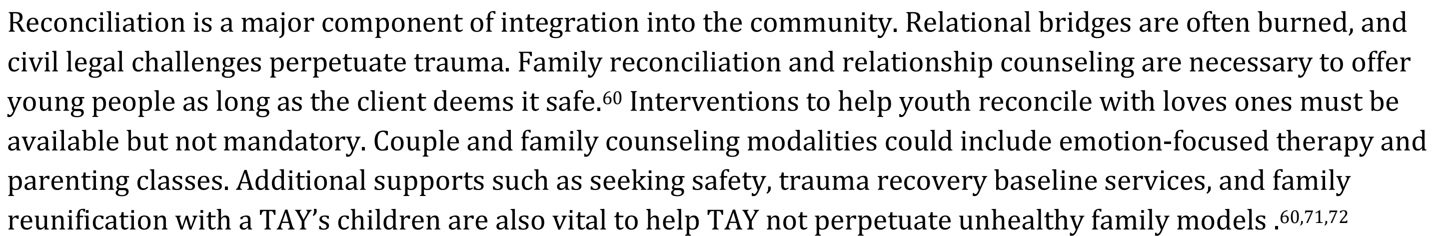
Section 4.2 community

As emerging adults, TAY peer connections and mentoring are vital. They are adapting to adulthood. Adapting to adulthood means building networks, learning social guidelines, along with becoming accustomed to stepping into confidence and authority. This is a time where young people are building an adult identity in relation to the world around them. Rather than seeking adult authorities, TAY look for guides who will help them navigate their individuation.[19,57]

Generally, biological family members are often expected to provide such unconditional love and mentorship services. For homeless youth, this is rare. **90% of homeless youth in Washington shelters report that they are fleeing abusive home environments**.[48,50,68–70] This was reflected in both literature and stakeholder feedback with several participants reporting that they “never” want to be housed with biological family owing to abusive relationships. It is vital to consider and support the safety and autonomy of these young people.

Comparatively, most caregiver stakeholders of these young people were eager to receive parent coaching to aid in their youth’s healing and prevent homelessness. At-risk families such as those who have children in the mental health system want to participate in their youth’s care, receive their own supports, and have family counseling available. [60]

TAY are resilient and those experiencing homelessness often build deep bonds with chosen street family who help them traverse danger and trauma. These people are often the most relatable and adept at supporting the youth. **Integrating all supports for a TAY** can help youth transition in supportive and holistic ways. By involving all people TAY consider to be close and family, treatment providers can decrease stigma in communities, teach valuable social skills, and help the young person transition into their recovery with a lessened risk of relapse. Without this involvement providers risk TAY feeling as though they must choose between themselves and their chosen family.



Reconciliation is a major component of integration into the community. Relational bridges are often burned, and civil legal challenges perpetuate trauma. Family reconciliation and relationship counseling are necessary to offer young people as long as the client deems it safe.[60] Interventions to help youth reconcile with loves ones must be available but not mandatory. Couple and family counseling modalities could include emotion-focused therapy and parenting classes. Additional supports such as seeking safety, trauma recovery baseline services, and family reunification with a TAY's children are also vital to help TAY not perpetuate unhealthy family models .[60,71,72]

Section 4.3 recovery

Lastly, we have recovery. When it comes to inpatient discharges for this population, communication and warm hand-offs are vital. [28] Young people need follow-up and linkage. **For example, when a TAY leaves inpatient treatment, they may be trying to find or maintain employment, transport themselves to appointments, and obtain/maintain healthy connections and leisure activities, this can often become unrealistic to maintain.** Agencies must have flexible options to reach these youth. TAY want to access behavioral health easily rather than chasing it down.

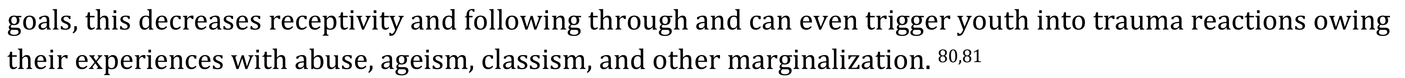
Harm reduction is another modality that is appropriate and important. **For young adults experiencing homelessness, abstinence may not be their goal.**[62,73] Focusing on a harm reduction model rather than an abstinence model (along with having diverse care providers on staff) will help homeless TAY come into their individual evolving experience of healthy living.

Homeless TAY have experienced immense trauma and oppression (often synonymously).[69,74] **Trauma-informed care, cultural responsiveness, and radical healing must be utilized in the treatment of these youth.**[74–76] Some provider stakeholders found themselves frustrated at their TAY clients for "not wanting to change" and vice versa. It is the provider's responsibility to better serve the youth. Three helpful approaches to diminish the tension include: trauma-informed care, cultural responsiveness, and radical healing.

Case management and care coordination are other vital supports for young people exiting treatment settings. [77] As mentioned before, **most young people do not have access to transportation options and scheduling skills that many adults who are well educated and stably housed do.** Case managers and care coordinators can support these elements of aftercare. TAY often do not know where their appointments are, how to get there, how to identify and work with their insurance companies, or how to take care of other aspects of their healthcare.

Peer support is another integral piece of developmentally appropriate care.[19,24] TAY are more receptive to seeing recovery in action. Working with a peer counselor can help them connect with someone who has been through similar struggles and can teach them how to implement recovery into their daily lives.

Client-driven goal setting is another important part of ongoing care. [78,79] Clients are motivated to change things that they want to change in their lives. Client-driven goal setting can help clients develop important adult skills such as identifying their goals, what is needed to complete the goals, learning assertive communication, advocating for their needs, and then completing the initial ambition. When clinicians, parents, or other authority figures assign



goals, this decreases receptivity and following through and can even trigger youth into trauma reactions owing their experiences with abuse, ageism, classism, and other marginalization. [80,81]

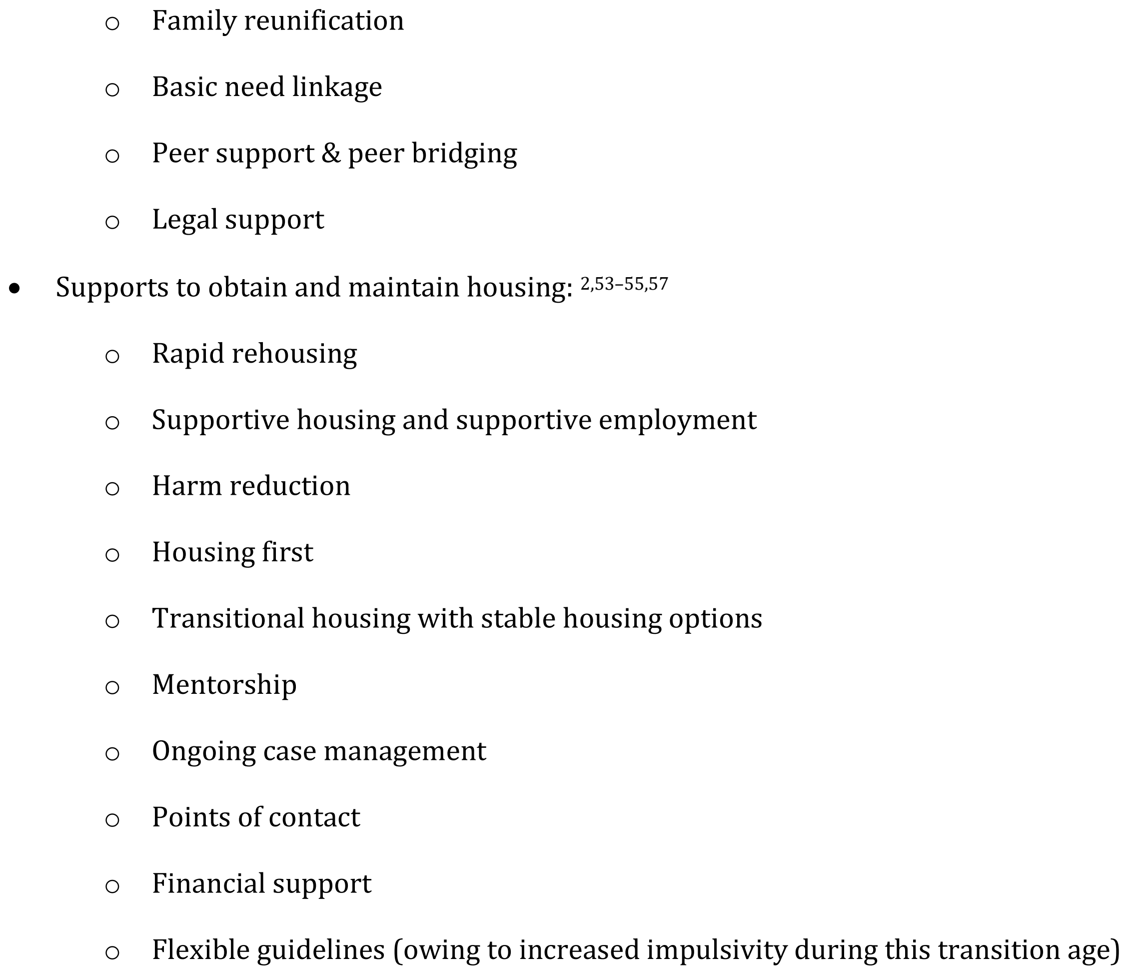
In line with goal setting, TAY want to develop mastery and engage in leisure activities.[3] **For example, hobby activities may have not been available to these youth.** This is important for recovery as boredom and isolation are the leading causes for symptom relapse among TAY. Supporting the exploration of passions and fun activities must be an integrated into the recovery process.[82]

Within the treatment setting, youth leadership can enhance successful transitions. When youth are given the mentorship and opportunities to lead in treatment settings, the innovation, and ideas they form are often more tailored and developmentally appropriate. TAY develop a sense of mastery and confidence, along with skills that they can add to resumes and take to advocacy if they desire. [2,3,83,84]

Section 4.4 overview

Best Practice Findings for TAY experiencing homelessness:

- Lived Expert Voice [2,3,83,84]
    - Youth leadership opportunities
    - Youth Peers
    - Skill building and Empowerment.
    - Client-driven goal setting
- Discharge: [2,3,8,19,24,28,53,59]
    - Warm hand-offs
    - Housing linkage
    - Transportation
    - Education/employment
    - Case management
    - Care coordination
    - Check-ins
    - Basic needs (including money)
    - Natural support linkage



- Family reunification
- Basic need linkage
- Peer support & peer bridging
- Legal support

- Supports to obtain and maintain housing: [2,53–55,57]
  - Rapid rehousing
  - Supportive housing and supportive employment
  - Harm reduction
  - Housing first
  - Transitional housing with stable housing options
  - Mentorship
  - Ongoing case management
  - Points of contact
  - Financial support
  - Flexible guidelines (owing to increased impulsivity during this transition age)

Section 5.0 recommendations for HCA

Current work on discharge into stable housing is ongoing. In an effort to break down silos HCA works collaboratively with the Department of Commerce and Division of Children Youth and Families who fund and provide housing supports in the community. Here are some of the ways HCA as an agency is working towards discharge into safe and stable housing.

Some of the current highlighted efforts from HCA:

HCA is currently working on several behavioral health pieces of the discharge puzzle to ensure that providers are supported.

- HCA contracting requires that evidence-based discharge practices be used.
    - This includes attempting connections with:
        - legal supports,
        - life skills,
        - safe and stable housing,
        - culturally responsive and appropriate services,
        - basic needs, behavioral health supports,
        - among other health and wellness related options.
- Technical assistance within HCA contracting supports the practice of beginning discharge planning when a person enters the facility.
- Within the Division of Behavioral Health and Recovery, the Children's Long-term Inpatient team created a workgroup focused on improving discharge and admission. The workgroup created a discharge guidance document for CLIP services across the state. The document includes linkage with safe and stable housing and support linkages for parents.
- Regarding community linkages, HCA keeps educational service districts (ESD) updated on programming options and availability, along with being a resource for ESDs and OSPI.
- HCA's Behavioral Health Data System (BHDS) provides ongoing data collection.
- HCA is currently exploring the creation of a clearer definition of care coordination services for future contracts and funding. This process includes the consideration for TAY experiencing homelessness.
- In Governor Jay Inslee's signed budget on May 18th in, conjunction with the American Rescue Plan Act passed in March 2021 by Congress, HCA will be increasing behavioral health provider reimbursement rates as of October 2021 including reimbursement for specific low-level codes.

Areas for growth:

- A permanent full-time employee (FTE) within HCA could explore how to pay for and implement a "care enhancement professional" for each TAY that leave inpatient treatment across MCO types to ensure case management, care coordination, and ongoing care linkage are provided 12-month post-discharge from inpatient treatment. Creating such a position may be something HCA wants to explore.

- An additional permanent FTE within HCA could explore how to pay for and implement the youth live-expert voice of TAY that experience homelessness and their families at agency, community, and state levels within behavioral health. Creating such a position may be something HCA wants to explore.
- Improve the ability for collection and analysis of data for follow-up care, including case management and care coordination through a data dashboard that tracks housing status upon discharge up to 12 months.
- Consider contracting with and training our MCOs to ensure that MCOs are linking up with their TAY clients with appropriate services and clearly explaining health care options that come with their plan to their TAY members.
- Perform an internal exploration of homelessness as a level rising to incident report tracking.
- Integrate TAY developmentally appropriate service considerations throughout adult and children program development and services offered by HCA and the State Plan.
- Explore the addition of homelessness services into claims data.
- Collaborate with value-based purchasing work that is ongoing within HCA.
    - This could include convening an outcome-based workgroup for value-based purchasing in behavioral health that included linking TAY with stable housing.
- Perform a comprehensive review and public report of current Medicaid discharge data on transition age youth experiencing homelessness to be update bi-annually for tracking outcomes.
- Explore the addition of contract language for follow up at 3 and 7 days, then one week, then 2 weeks, then one month, 3 months, 6 months, 12 months to ensure TAY are linked with stable housing, other basic needs, natural supports, and behavioral health services.

MCO contracts recommendations:

Regarding our MCO contracting, as HCA shifts into value-based purchasing structures exploration into purchasing packages for homeless TAY should include:

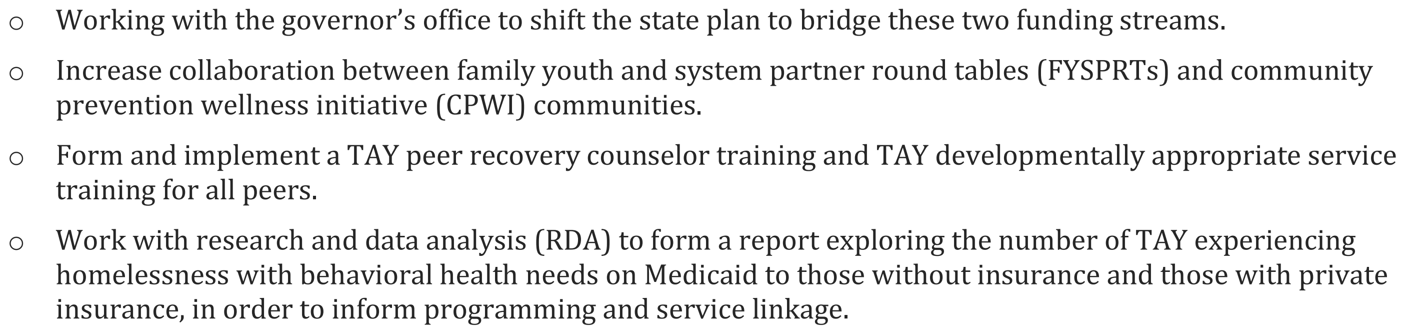
- Linkage with physical health, medication, dental, and medication monitoring when appropriate.
- Warm handoff to outpatient behavioral health supports.
- Peer Bridgers to support 90-days post-discharge with handoff options to ongoing peer supports to 12 months post-discharge.
- A comprehensive introduction to the MCO care coordinator.
- Linkage with ongoing case management.
- Supportive housing and supportive employment.
- Gender affirmative care.
- Family healing and reunification support.
- Couple and Family counseling support as needed.
- Supporting with the linkage of community supports and maintenance of healthy relationships.
- Follow up with inpatient care that client is linked with the supports.
- Notification when client refuses discharge referral or the referral is inactive.

- Culturally responsive care including healing interventions that are native to the client's respective heritage.
- Linkage with ongoing family and reunification support.
- Linkages with community supports:
  - Cultural supports
  - Education
  - Employment
  - Entertainment
  - Identification cards and other paperwork needed to access basic services
  - Legal support
  - Life skills—including financial literacy
  - Mentorship
  - Parenting support as needed
  - Spiritual supports
  - Stable housing

- These linkages should be documented and barriers to successful hand-off should be tracked and published on a public dashboard so that workgroups and advocates can support the improvement of filling in the gaps of care.
- Inpatient peer bridgers, case managers, care coordinators, discharge planners or other appropriate care staff should follow up with clients or the client's ongoing supports three days, two weeks, 1 month, and 3 months after discharge to ensure they were linked successfully with their supports.

Innovation:

- To increase lived-expert voice, the addition of paid youth lived expert boards in leadership at inpatient and outpatient centers would be an excellent way to build mastery, skills, and increase appropriate care. This will help us support evidence-based practice development lead by youth lived experts.
- We must explore and then implement the voices and practices of and for neurodivergent TAY.
- We must explore and then implement the voices and practices of and for TAY with traumatic brain injury (TBIs) and chronic illness.
- Form and disseminate training to work with TAY.
- Changes in the SERI to provide support to youth with Z codes and/or who do not meet criteria for an ICD10 diagnosis so that youth do not have to meet such a high level of care need before gaining access to services.
- Exploration of a way to provide services that are preventative for those who do not meet criteria for a diagnosis but would benefit from services.
- Anti-racist curriculum and intervention implementation into behavioral health treatment centers.
- Further integration of mental health and substance use disorder treatment services.



- Working with the governor's office to shift the state plan to bridge these two funding streams.
- Increase collaboration between family youth and system partner round tables (FYSPRTs) and community prevention wellness initiative (CPWI) communities.
- Form and implement a TAY peer recovery counselor training and TAY developmentally appropriate service training for all peers.
- Work with research and data analysis (RDA) to form a report exploring the number of TAY experiencing homelessness with behavioral health needs on Medicaid to those without insurance and those with private insurance, in order to inform programming and service linkage.

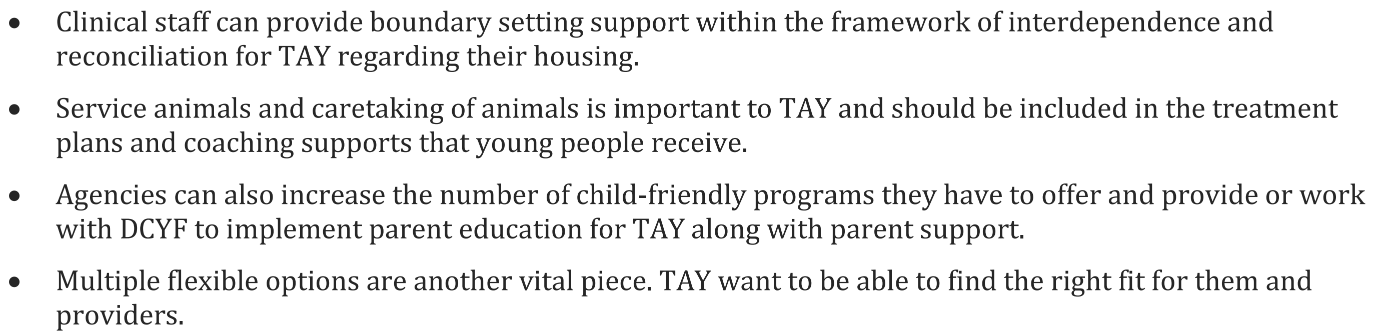
Utilize training and technical assistance funding to increase provider competency in:

- Radical healing.
- Culturally responsive care.
- Trauma informed care.
- TAY certification requirements for providers through DOH as most providers will serve TAY throughout their career.
- Domestic violence in homeless TAY.
- Working with young parents.
- Harm reduction.
- Housing first.
- Neurodevelopment.
- Client-driven care and client-centered care.

Section 5.1 system and provider recommendations

Providers have many options to support TAY experiencing homelessness. Throughout this report we have recommended several ways to deliver services in a developmentally appropriate ways for this population. Some of the highlights are listed below.

- First, youth must be linked with safe and stable housing and behavioral health supports. For housing options, providers can connect with: DCYF, Commerce, the recovery registry, and local entities. Agencies can also apply for housing grants and provide supportive housing options themselves.
- Providers can also utilize the discharge planner guide through HCA and report suggested improvements to help with this process. This includes linkage with basic needs in addition to housing, relationship supports, and recovery maintenance services.
- Innovative agencies can pilot a case management hub, where clients can call and receive case management wherever they go across the state. This could be used to advocate for increased funding in case management services.
- Care coordination and case management services are important to help the client maintain their recovery supports. Care coordinators should follow up with youth at 3 days, 1 week, 3 weeks, 1 month, 2 months, 3 months, 6 months, and 1 year. These follow ups should have flexible options for young people to opt in and out of follow ups with ample explanation for benefits and risks.
- Increasing the peer workforce will help these youth find support. Agencies and providers can expand peer support programming to better meet the needs of these clients through their healing journey. Inpatient treatment centers should have peer bridger programming widely available.
- Providers should deliver harm reduction and developmentally appropriate care to this age group. Housing and care should never be used as a punishment or a reward for behavior as they are human rights.
- Training in developmental and culturally affirming care that includes anti-racist and LGBTQ+ competence should be standardized practices.
- Providers can increase youth voice at the top by encouraging the inclusion of youth voice in their leadership and program design. Grants can be used to pay for their expertise along with mentorship to help young people understand their value.
- During community provider meetings TAY clients should have the opportunity to voice feedback and support decision making.
- Additionally, lived experts report that they want programs to follow through with their discharge planning. Not only to have them drive those discharge plans but also get ample support to link up with those services.
- Programs offered to youth must be flexible and account for their increased emotionality and variability throughout their recovery.
- Since this population is shifting into adulthood, relationship linkage is vital. Providers can offer modalities such as Emotion Focused Therapy [68,69], Ecologically Based Family Therapy, Functional Family Therapy, and other forms of evidence-based family counseling with biological and chosen family members using both child and adult attachment frameworks.[39,70]

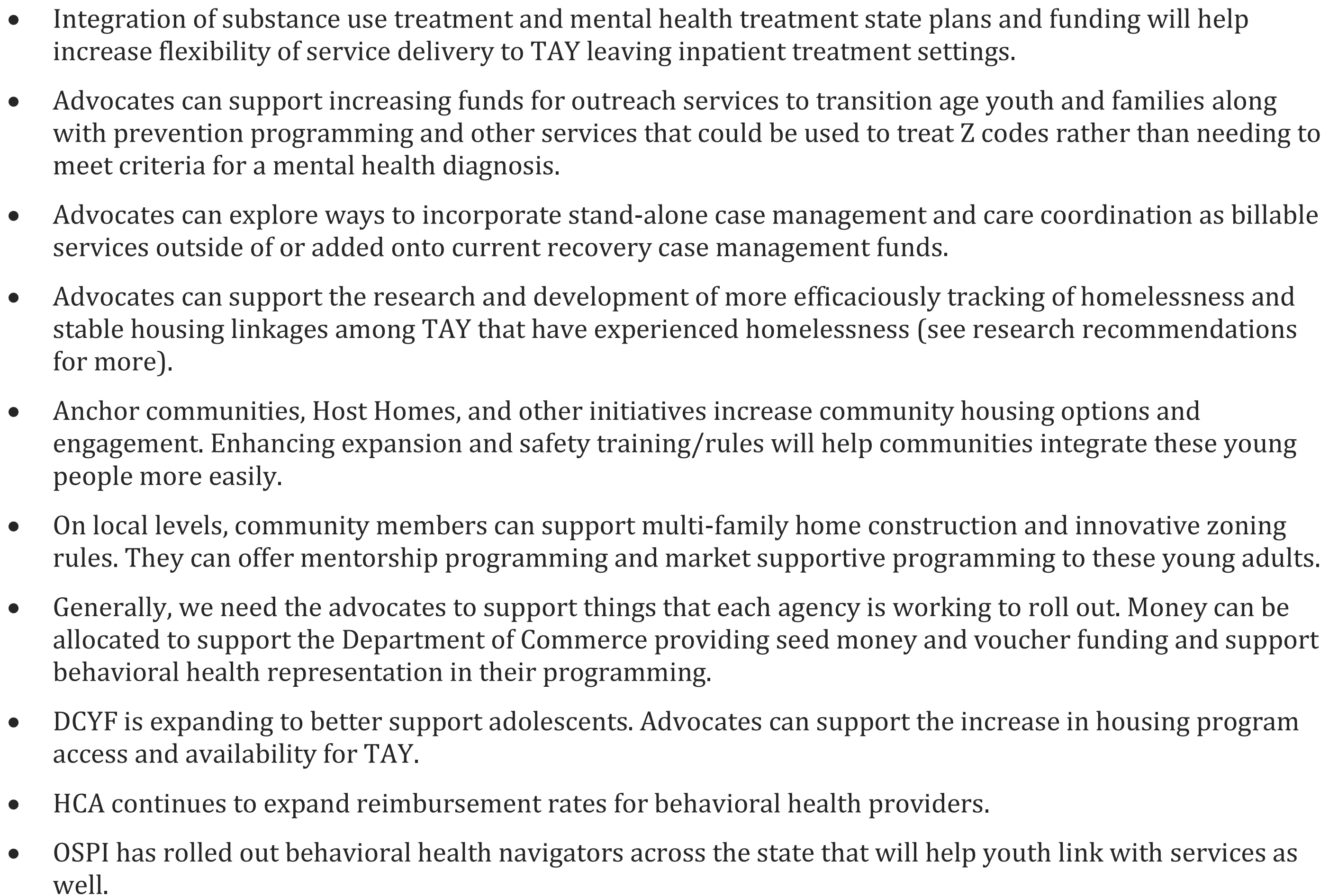


- Clinical staff can provide boundary setting support within the framework of interdependence and reconciliation for TAY regarding their housing.
- Service animals and caretaking of animals is important to TAY and should be included in the treatment plans and coaching supports that young people receive.
- Agencies can also increase the number of child-friendly programs they have to offer and provide or work with DCYF to implement parent education for TAY along with parent support.
- Multiple flexible options are another vital piece. TAY want to be able to find the right fit for them and providers.

Section 5.2 advocate recommendations

Advocates have a lot of power in this work as they can help direct law change and money to support these youth. When it comes to behavioral health there are several ways that they can help TAY experiencing homelessness coming out of inpatient treatment.

- Advocates can support the integration of a broad provider network so that providers can be better linked with one another.
- Advocates can increase money for behavioral health and housing first services in rural communities.
  - Within this, advocates should ensure transportation (among other things) is also included so that clients can access the care they need.
- Funding for case management is another important avenue for advocacy. Piloting a case management hub and/or central line for people to be able to link with a consistent case manager to support their transition into long-term would be highly advantageous for continuity of care.
- Another area is the compensation of TAY lived expert stakeholders and increasing their voice in our system. A behavioral health homeless TAY lived expert stakeholder group that mentors and pays its stakeholders would be able to support agencies across the state.
- HCA should remain at the table working with the opportunities available for TAY experiencing homelessness. Ensuring the continuation of this population's representation within HCA will help decrease silos between state agencies when supporting these TAY.
- Advocates should support an audit of state rules that hinder stable housing linkages. For example, adding housing linkage to the following WACs:
  - WAC:
    - 246-341-0610 Assessment
    - 246-341-0620 Individual Service Plan
    - 246-341-0710 Outpatient Services
    - 246-341-1108 Discharge Residential SUD treatment general
    - 246-341-1116 Residential substance Use Disorder treatment for Youth
    - 246-341-1128 mental health inpatient services minors
    - 246-341-1150 Inpatient services triage discharge, warm hand off and housing
- Along with exploring other laws such as age of majority and consent that hinder TAY from accessing safe and stable housing.
- Two other areas of tracking and evaluation to be supported by advocates include:
  - The tracking and evaluation of Washington State CHINS petitions.
  - The tracking and evaluation of child neglect cases through DCYF among TAY compared with children and adolescents.



- Integration of substance use treatment and mental health treatment state plans and funding will help increase flexibility of service delivery to TAY leaving inpatient treatment settings.
- Advocates can support increasing funds for outreach services to transition age youth and families along with prevention programming and other services that could be used to treat Z codes rather than needing to meet criteria for a mental health diagnosis.
- Advocates can explore ways to incorporate stand-alone case management and care coordination as billable services outside of or added onto current recovery case management funds.
- Advocates can support the research and development of more efficaciously tracking of homelessness and stable housing linkages among TAY that have experienced homelessness (see research recommendations for more).
- Anchor communities, Host Homes, and other initiatives increase community housing options and engagement. Enhancing expansion and safety training/rules will help communities integrate these young people more easily.
- On local levels, community members can support multi-family home construction and innovative zoning rules. They can offer mentorship programming and market supportive programming to these young adults.
- Generally, we need the advocates to support things that each agency is working to roll out. Money can be allocated to support the Department of Commerce providing seed money and voucher funding and support behavioral health representation in their programming.
- DCYF is expanding to better support adolescents. Advocates can support the increase in housing program access and availability for TAY.
- HCA continues to expand reimbursement rates for behavioral health providers.
- OSPI has rolled out behavioral health navigators across the state that will help youth link with services as well.

Section 5.3 researcher recommendations

There are many research opportunities to develop best practices for TAY.

Throughout the literature reviews studies on best practices for discharge from behavioral health for TAY experiencing homelessness were null. Studies that were similar to this challenge, showed very small sample sizes. Much of the literature used in this report explored TAY services in community behavioral health or medical settings, often either with adults age 18+ or adolescents aged 18-. Below is a list of research opportunities to support best practice discharge for TAY experiencing homelessness:

- Explore the efficacy of housing first and harm reduction with homeless TAY.
- Explore the efficacy of transitional group housing settings versus individual housing settings with supports for homeless TAY.
- Explore the positive aspects that this population needs to cultivate (such as meaning and relationships).
- Explore the efficacy of peer bridging and peer counseling with homeless TAY.
- An in-depth analysis on the cost benefits of behavioral health and housing first interventions.
- An analysis on how many and how often TAY experiencing homelessness use our emergency department systems as entry to behavioral health services.
- Explore the point at which this population begins to lose engagement with behavioral health and social services and what those services have done to increase engagement.
- Create a best practice to help behavioral health discharge planners link youth with meaningful positive social supports.
- Evaluate inpatient behavioral health programming co-created and overseen by TAY lived experts.
- While there is literature on the topic of value-based purchasing (VBP) for integrated care with behavioral health components, there are not specific studies about VBP for behavioral health specifically. This is vital to understand better as Medicaid begins to roll out VBP across the integrated health field. Additionally, new payment structures outside of fee-for-service should be explored to help with payment to providers.
- Explore payment structures that work best for TAY experiencing homelessness versus the general population and identify the outcomes that we should be looking for regarding the payment structures.
- Evaluate the rates and payment structure for behavioral health care that have the best outcomes in the realm of basic needs, relationships, and recovery for this population (as defined in this report).
- Identify payment and policy methods for enrolling and paying for services for TAY who do not meet the qualifications for prevention (too high of a need) or treatment (not yet meeting medical necessity) but could eventually need treatment services.
- Explore transition age youth attachment versus child and adult attachment.
- Research the most effective follow up times for centers to check on TAY experiencing homelessness to ensure that they are receiving quality services, highlighting the common points of challenge and their respective solutions.

- Form an empirically backed tool that evaluates the practices of centers and programs in order to ensure that TAY are equitably linked with housing services.
- Develop a tool to track TAY homelessness and stable housing linkages more efficaciously.

Appendix I stakeholder process

Stakeholder feedback is an important part of gathering information from the community to better serve that them. Speaking with Washington residents who have direct expertise in these matters can help us better create, inform, and roll out best practices for the future. For example, stakeholders in rural areas of the state may have different transportation access than in an urban area.

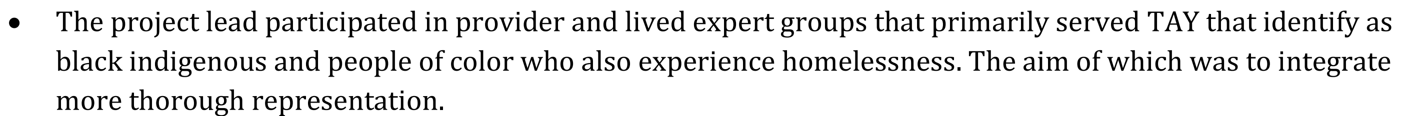
Our objective was to learn more about the current state of treatment transitions for TAY experiencing homelessness when they leave inpatient behavioral health treatment.

It was important for us to obtain a representative sample of Washington residents that are affected by these policies. So, we created four main stakeholder groups:

- **18-25-year-old TAY lived experts** that experienced homelessness and inpatient treatment between the ages of 16-25.
- **26-35-year-old TAY lived experts** that experienced homelessness and inpatient treatment between the ages of 16-25.
- **Families of young lived experts** that experienced homelessness and inpatient treatment between the ages of 16-25.
- **Service Providers and administrators** who serve youth and families with the above experience.

To get a more representative stakeholder sample across regions, race, and ethnicity snowball sampling was utilized. The project lead reached out to the community in the following ways:

- Attending meetings with the FYSPRT statewide, along with one regional FYSPRT meeting on the Westside of the state and one on the Eastside of the state.
- Information about the stakeholder engagement was sent out via gov delivery and project lead network channels.
- The project lead called and emailed providers directly using the Department of Health provider list.
- The project lead delivered additional presentations to various state-wide stakeholder groups.
- During stakeholder interviews the project lead encouraged participants to reach out to their friends and colleagues, sending follow-up emails when requested.
- The project lead called and emailed several shelters across the state from the OHY list.



- The project lead participated in provider and lived expert groups that primarily served TAY that identify as black indigenous and people of color who also experience homelessness. The aim of which was to integrate more thorough representation.

Survey and Interview process:

Question creation process:

- Survey/interview questions were crafted utilizing principles of trauma-informed care to ensure that participants would feel respected.[34,35]
- Surveys were peer-reviewed by colleagues at the state along with TAY lived experts.

Survey and interview administration process:

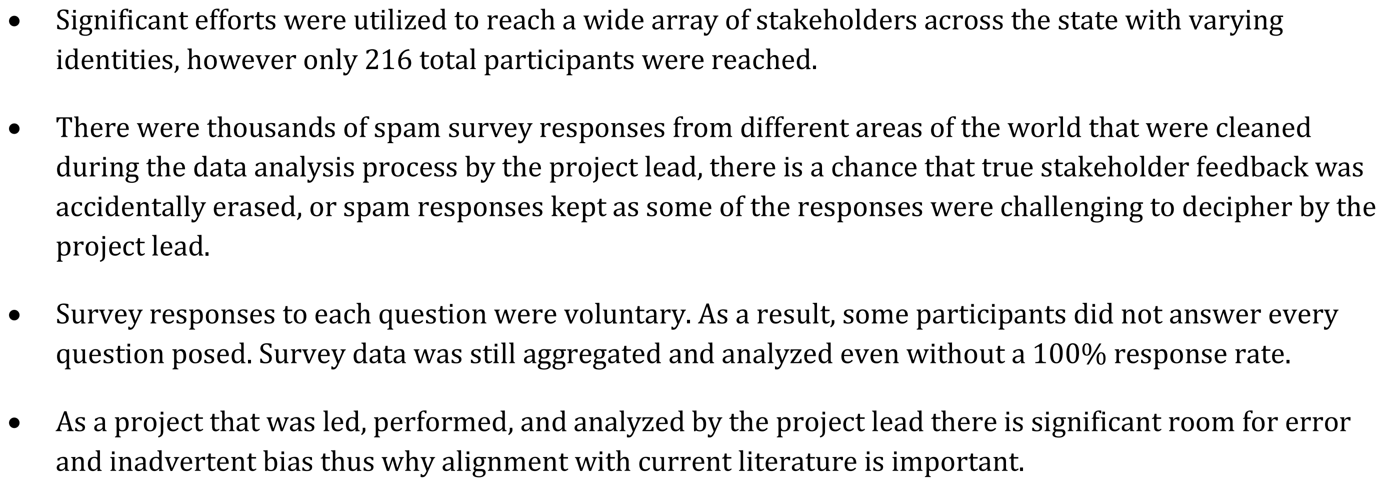
- Interested participants reached out directly to the project lead to schedule an interview or clicked a link provided in the survey email to provide feedback.
- Surveys were anonymous and administered both online through Survey Monkey and in-person by homeless shelter staff.
- Interviews were completed by reaching out to the project lead directly who performed phone calls and Zoom meetings with stakeholders.
    - Notes were taken by the project lead during the interview. Interviews were not recorded.
- Participant information was anonymized and aggregated after which time correspondence was deleted.
- Regarding compensation, lived experts ages 18-25 were offered a one-time $10 gift card to participate in surveys or a one-time $20 gift card to participate in interviews.

Data analysis process:

It is important to note that the stakeholder feedback gathered was not set up as official research. Principals of human-centered design specifically co-design and mixed methods analysis were used to inform the process of gathering stakeholder data. During analysis, summative content analysis was used to categorize interview notes and survey results.[36–39]

- Notes were taken using secure software during sessions by the project lead.
- The project lead categorized the survey data first and used those categorized themes to then code the data from the interviews.
- Over three months the themes were shifted by the project lead until they aligned.
- Themes were then put into Excel with the rest of the survey data to analyze.

Stakeholder process considerations:

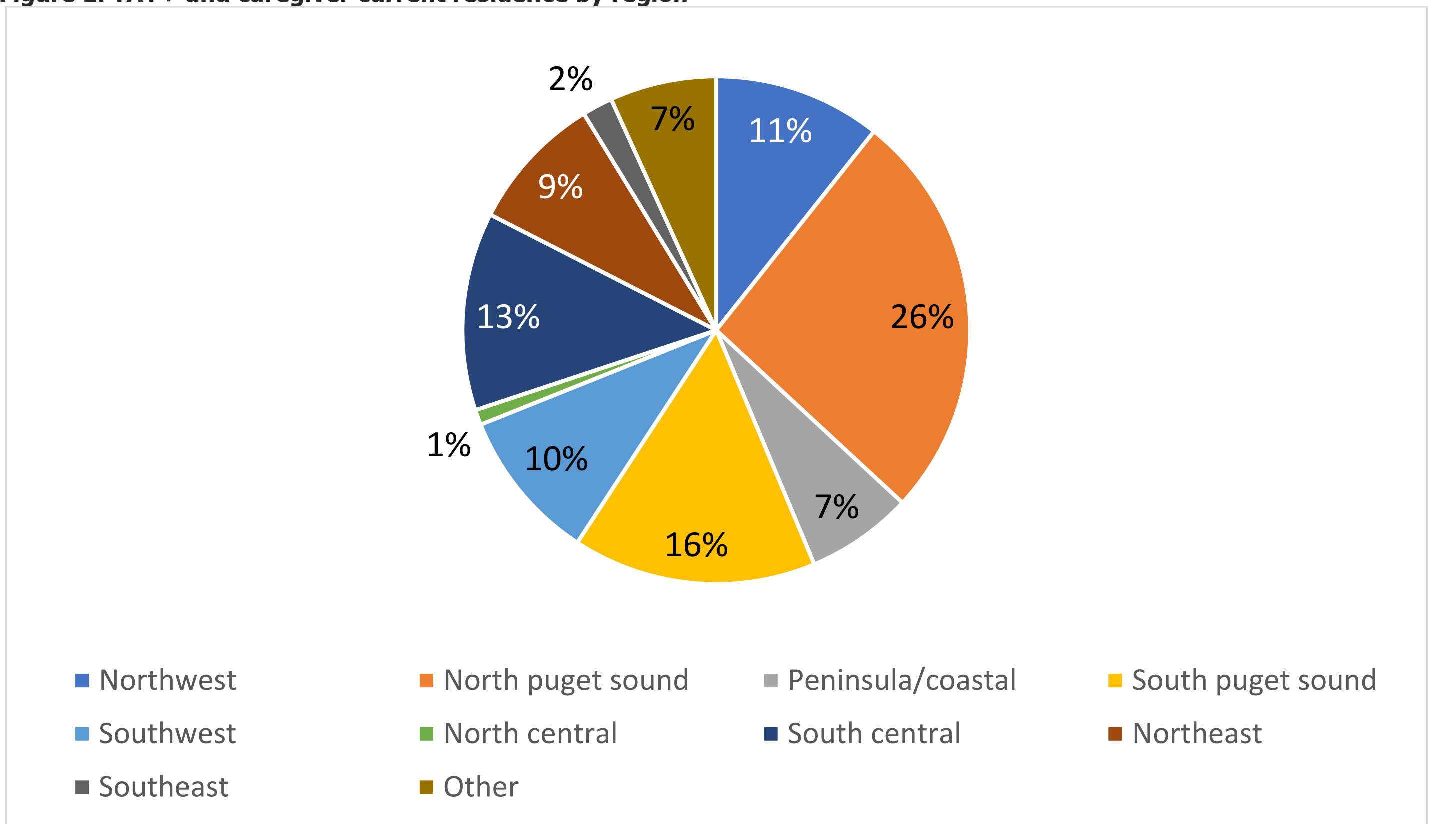


- Significant efforts were utilized to reach a wide array of stakeholders across the state with varying identities, however only 216 total participants were reached.
- There were thousands of spam survey responses from different areas of the world that were cleaned during the data analysis process by the project lead, there is a chance that true stakeholder feedback was accidentally erased, or spam responses kept as some of the responses were challenging to decipher by the project lead.
- Survey responses to each question were voluntary. As a result, some participants did not answer every question posed. Survey data was still aggregated and analyzed even without a 100% response rate.
- As a project that was led, performed, and analyzed by the project lead there is significant room for error and inadvertent bias thus why alignment with current literature is important.

Appendix II stakeholder data visuals

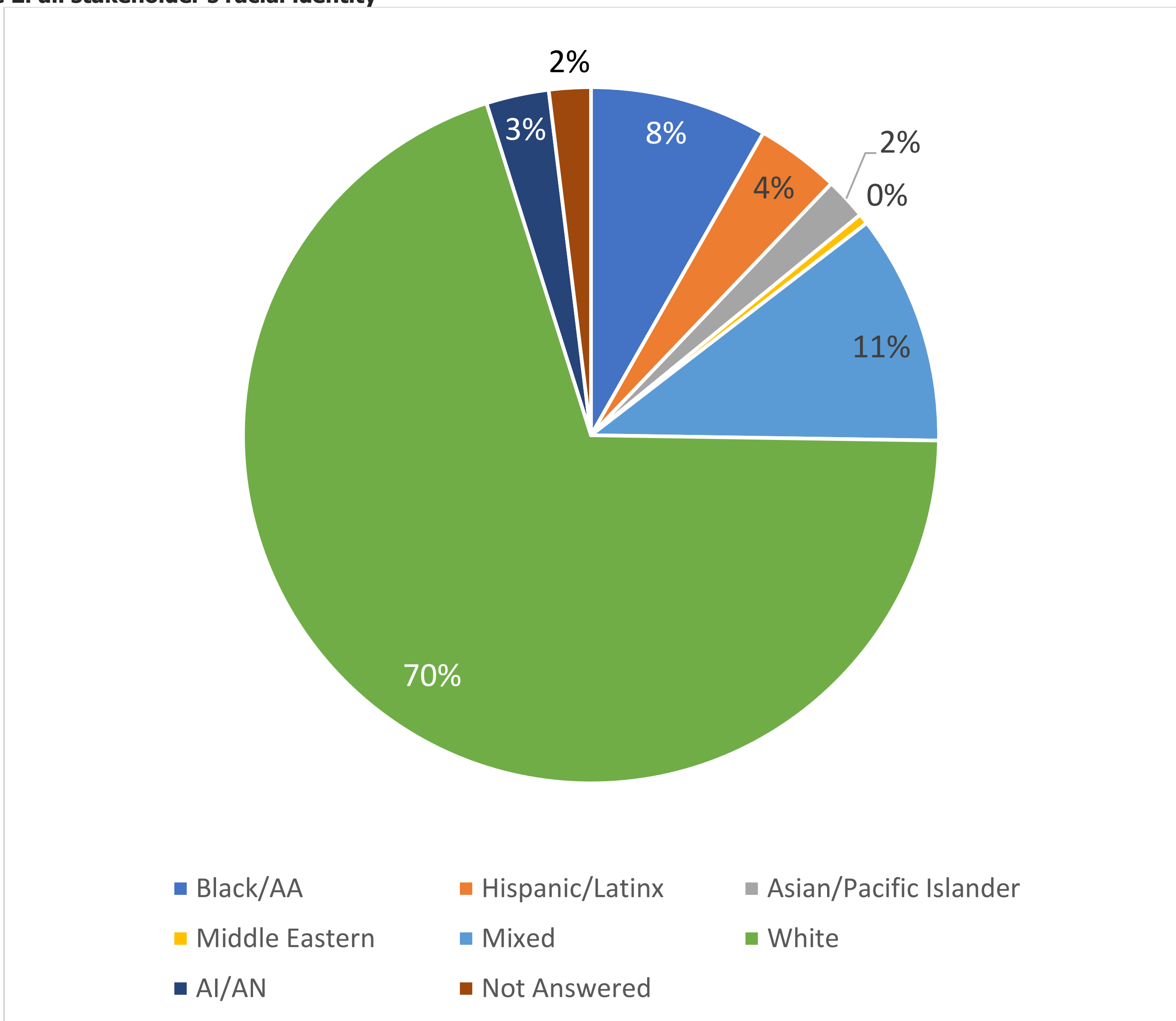
This section includes some of the relevant stakeholder demographics and answers to quantitative questions given to the TAY lived experts. TAY+ refers to TAY lived expert stakeholders ages 18-35.

Figure 1. TAY+ and caregiver current residence by region



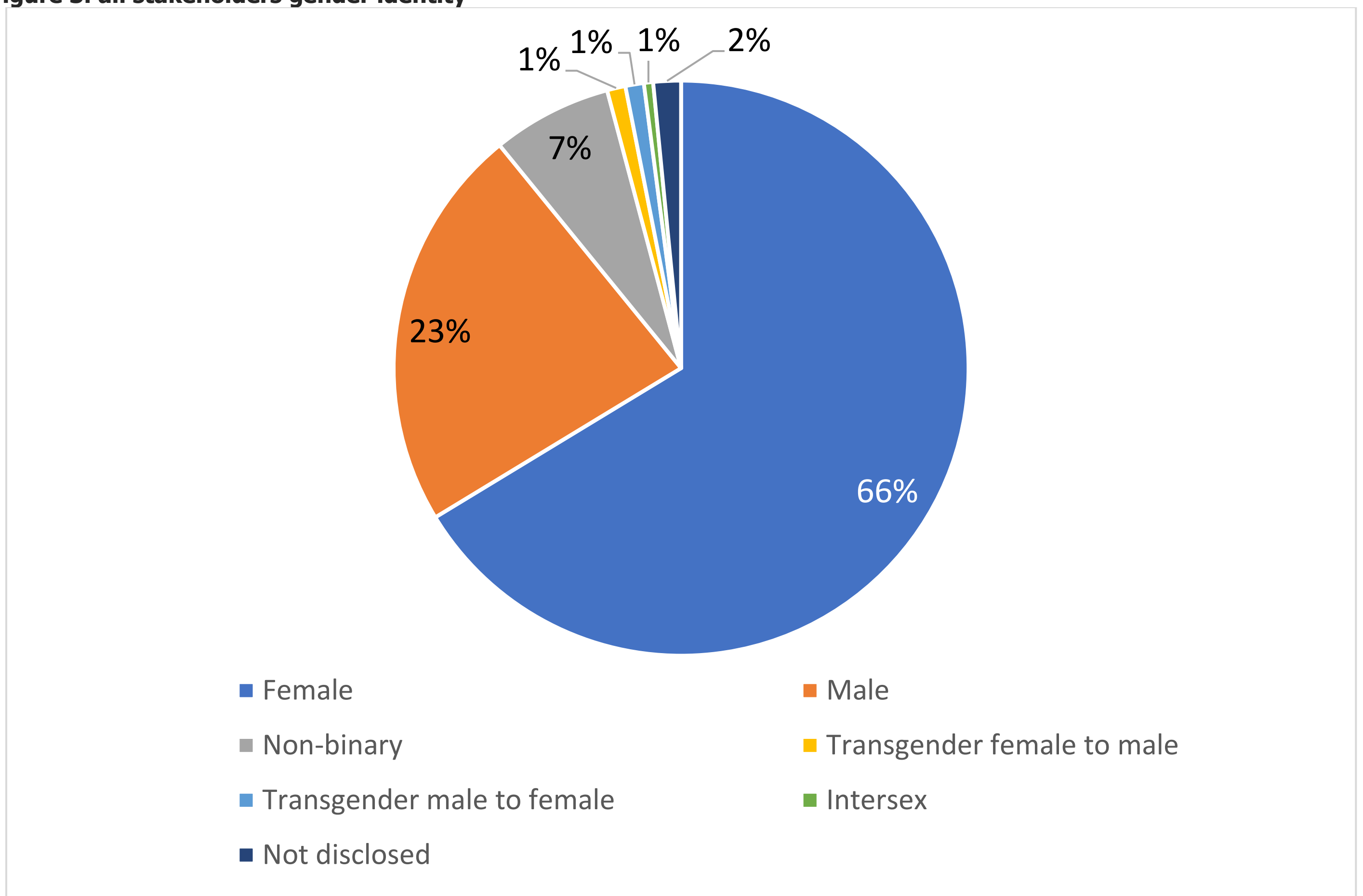
Of the stakeholders that responded, 69% were located in the five western regions, 14% were located in the two central regions, 11% were located in the two eastern regions, and 7% were residents either unsure of their region or currently living in other states.

Figure 2. all stakeholder's racial identity



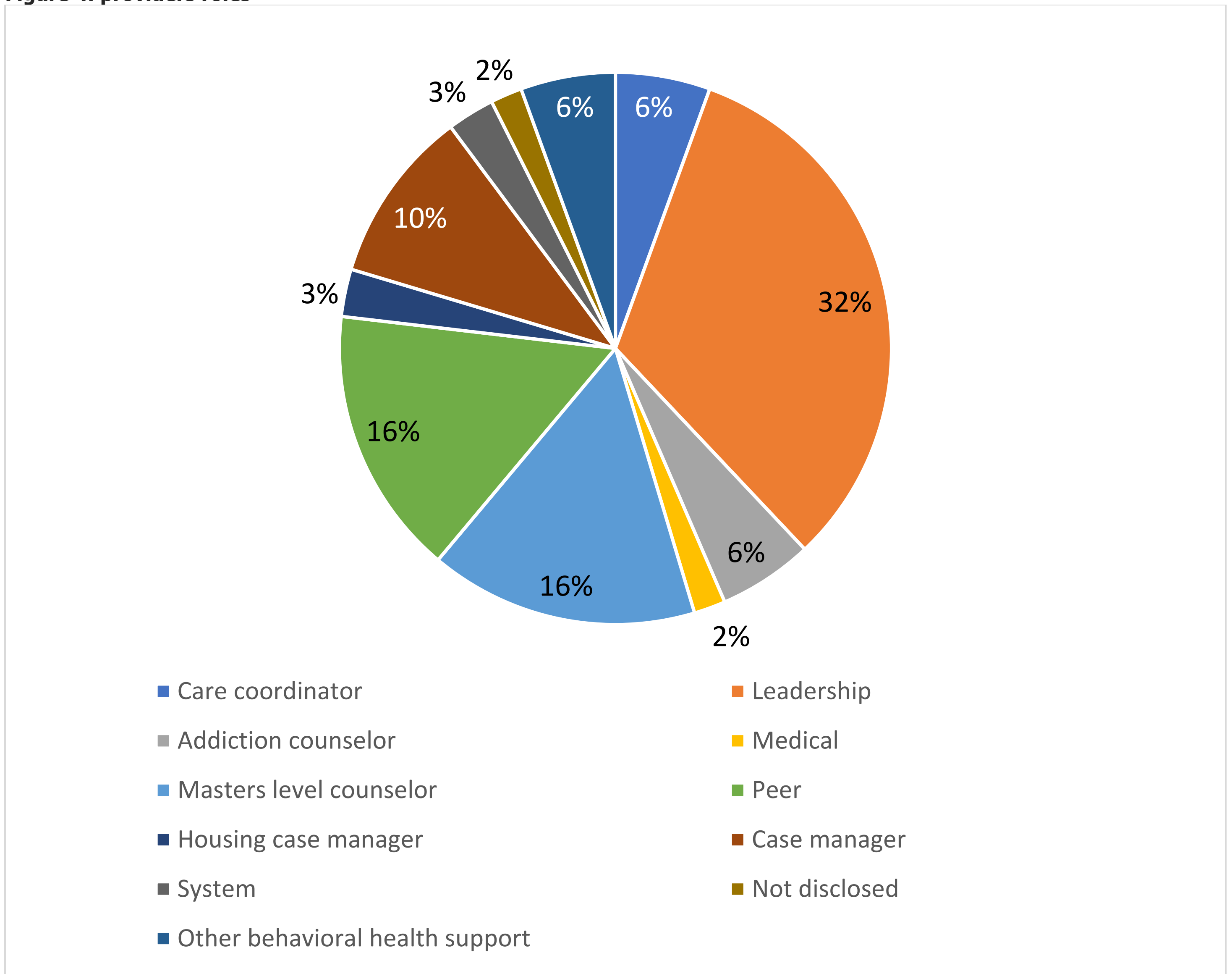
Of the stakeholders that responded, 70% identified themselves as white, 11% identified as Mixed, 8% identified as Black/African American, 4% identified as Hispanic/Latinx, 3% identified as American Indian and/or Alaska Native, 2% identified as Asian and/or Pacific Islander, 2% did not answer, and a very small number identified themselves as middle eastern.

Figure 3. all stakeholders gender identity



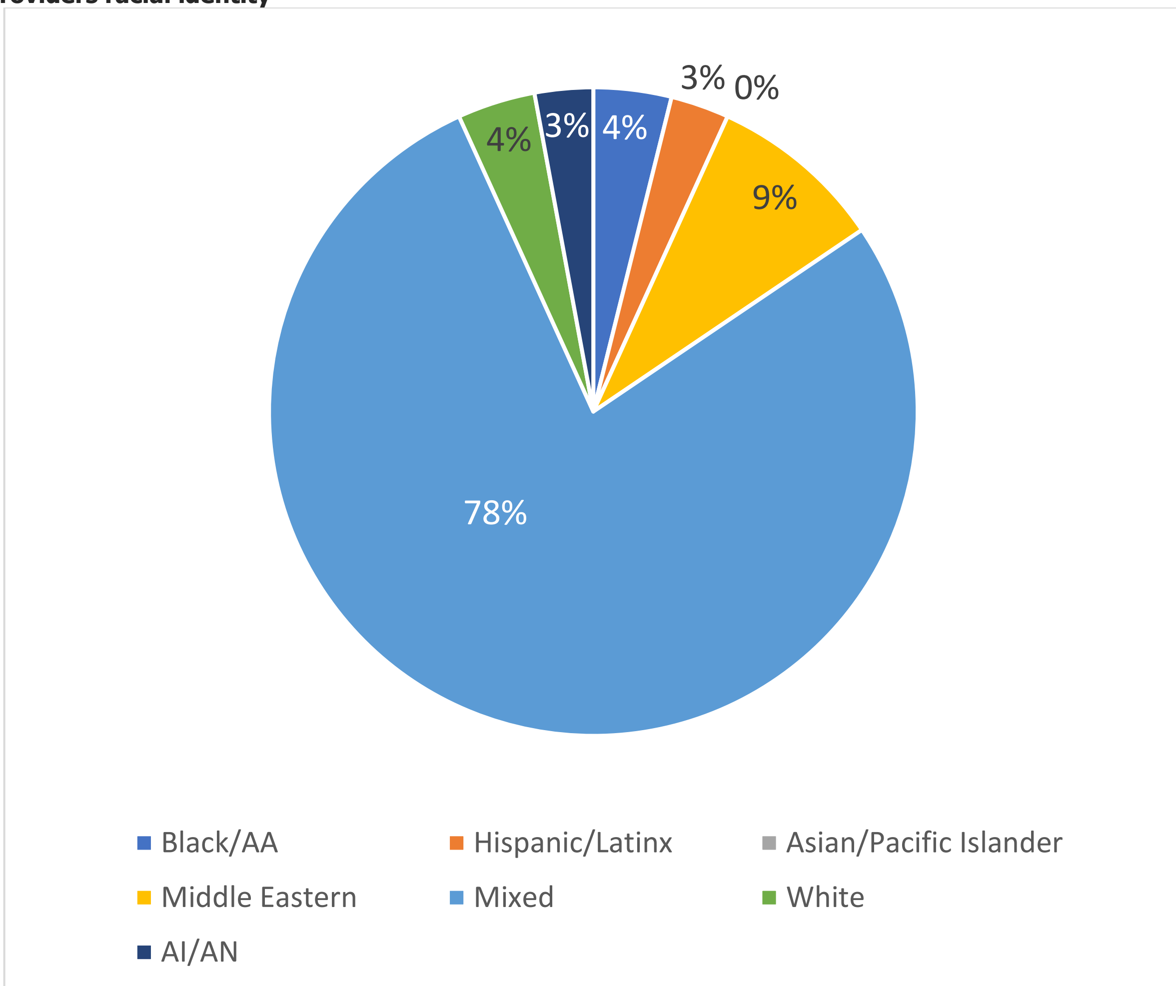
Of the stakeholders that responded, 66% identified themselves as female, 23% identified as male, 7% identified as Non-binary, 1% identified as transmen, 1% identified as transwomen, 1% identified as intersexed.

Figure 4. providers roles



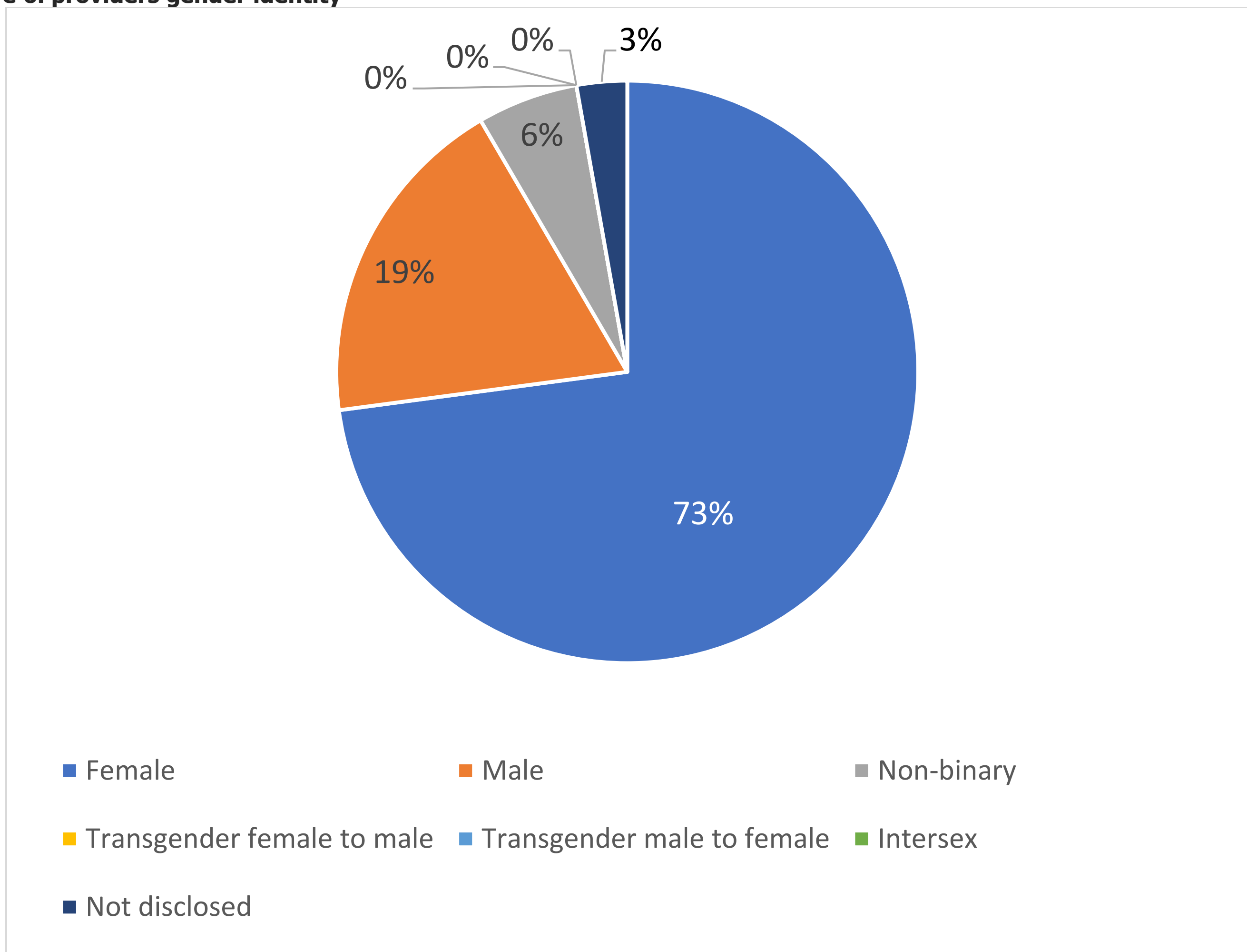
Of the service provider stakeholders that responded, 32% identified themselves as in some level of leadership, 16% identified as a master's level behavioral health counselor, 16% identified as peer counselors, 10% identified as general case managers, 6% identified as addiction counselors, 6% identified as care coordinators, 6% identified as other behavioral health support, 3% identified as system stakeholders, 2% identified as medical professionals, and 2% chose to not disclose.

Figure 5. providers racial identity



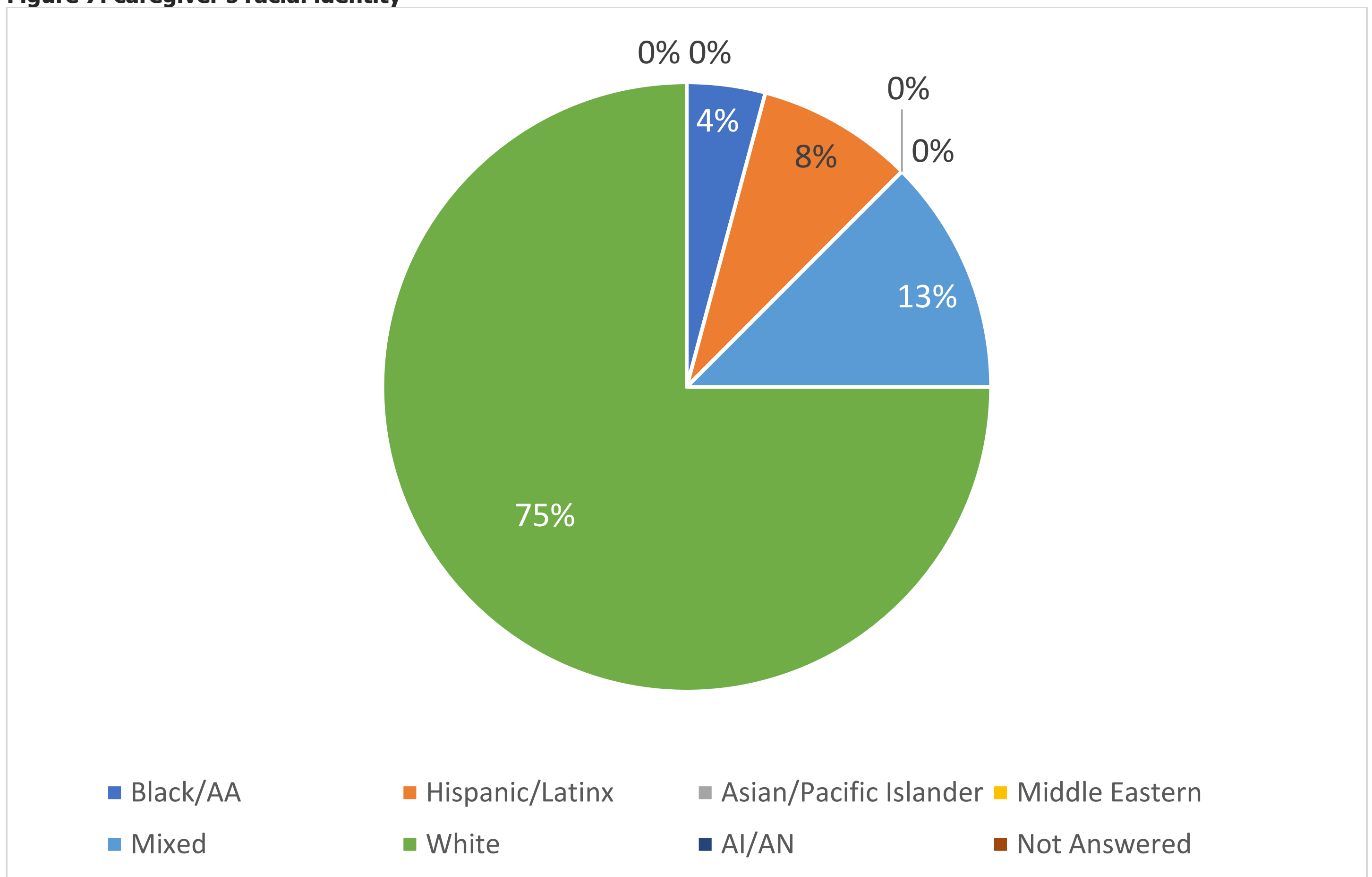
Of the service provider stakeholders that responded, 78% identified themselves Mixed race, 9% identified as Middle Eastern, 4% identified as Black and/or African American, 4% identified as White, 3% identified as American Indian and/or Alaska Native, 3% identified as Hispanic and/or Latinx, 0% identified as Asian and/or Pacific Islander.

Figure 6. providers gender identity



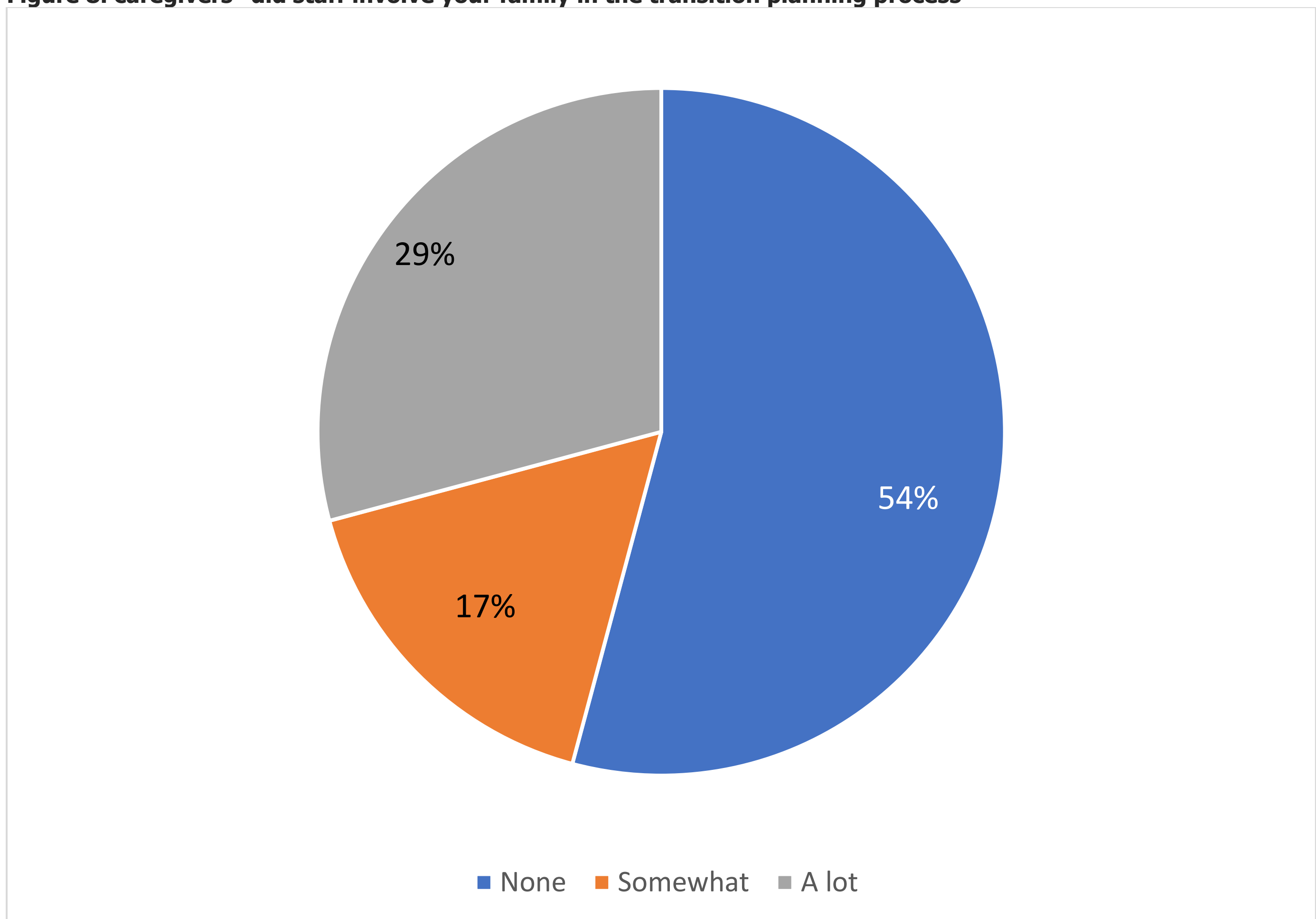
Of the service provider stakeholders that responded, 73% identified themselves Female, 19% identified as Male, 6% identified as Non-Binary, 3% chose not to disclose.

Figure 7. caregiver's racial identity



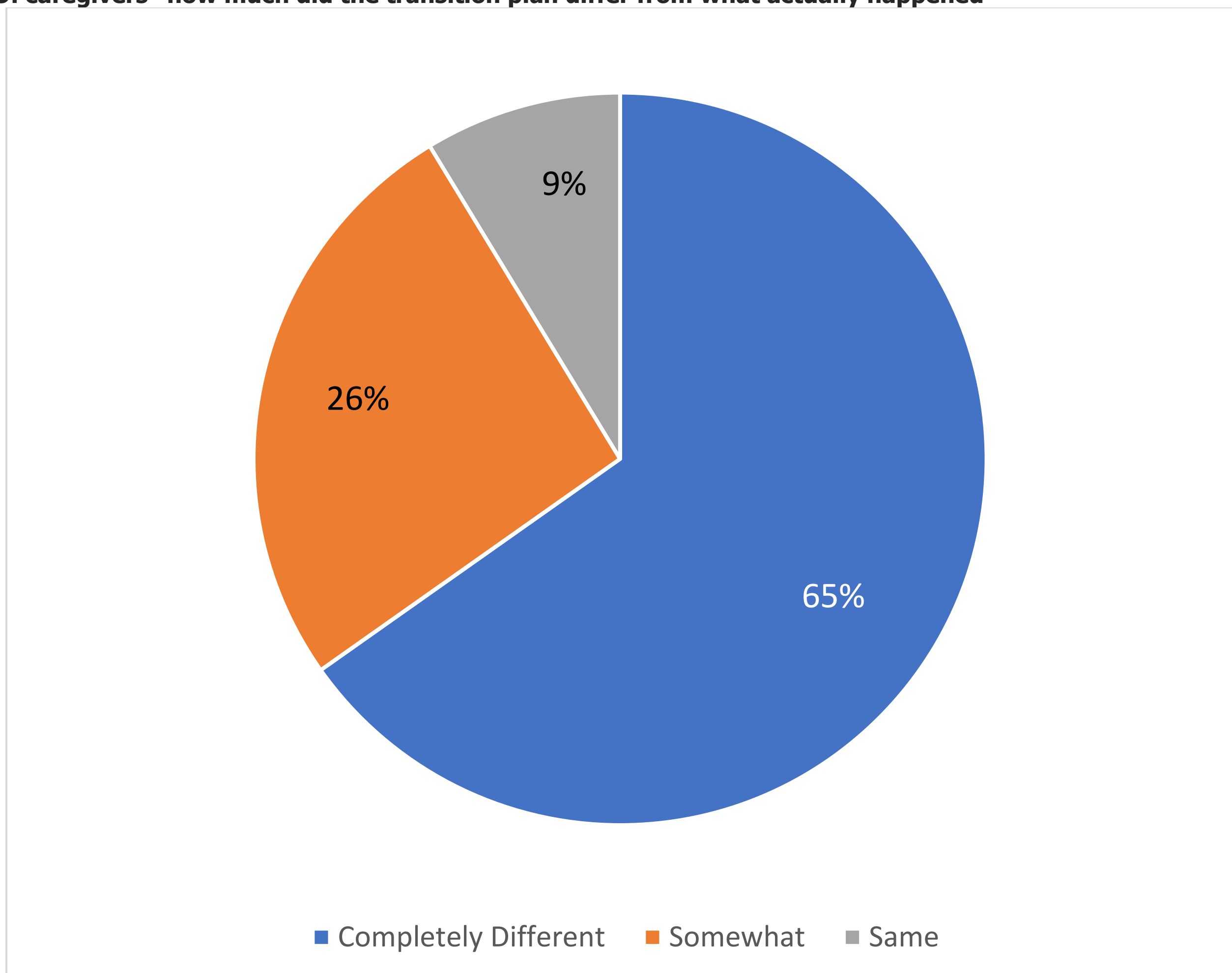
Of the caregiver stakeholders that responded, 75% identified themselves White, 13% identified as White, 8% identified as Hispanic and/or Latinx, 4% identified as White, 3% identified as American Indian and/or Alaska Native, 4% identified as Black and/or African American.

Figure 8. caregivers "did staff involve your family in the transition planning process"



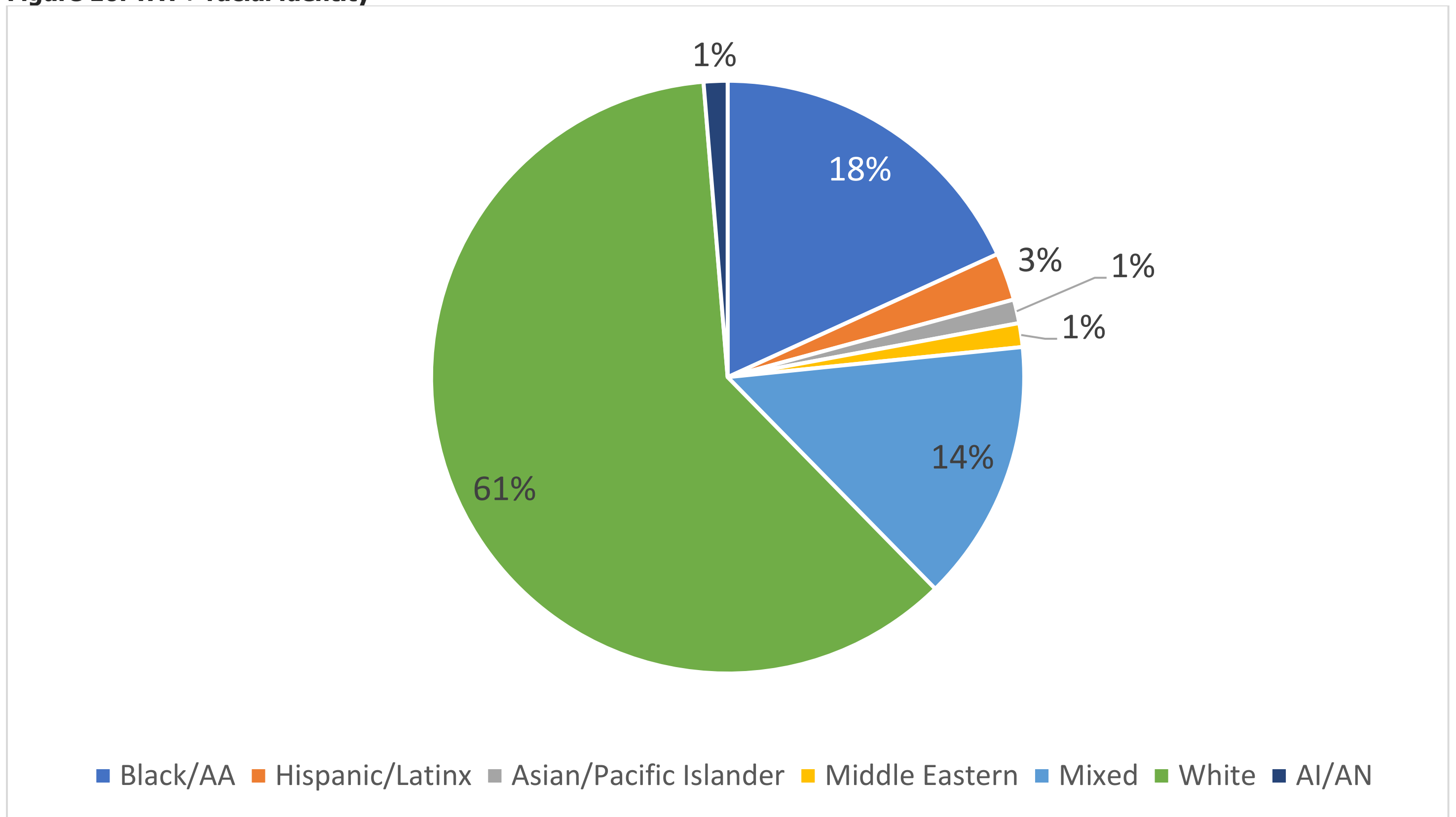
Of the caregiver stakeholders that responded, 54% reported that they had no involvement in their TAY's transition planning, 17% report that they were somewhat involved, and 29% report that they were involved a substantial amount.

Figure 9. caregivers "how much did the transition plan differ from what actually happened"



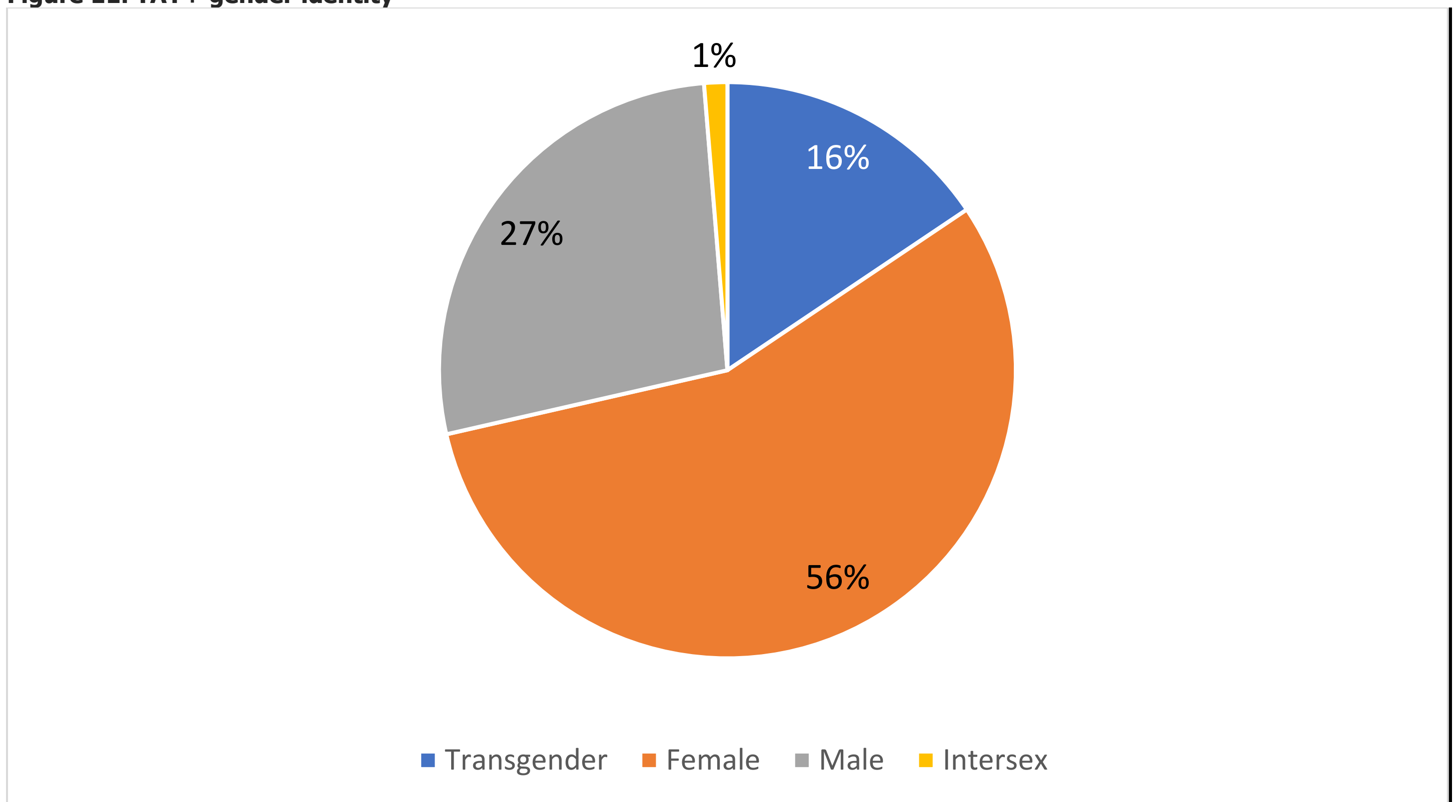
Of the caregiver stakeholders that responded, 65% reported that the transition plan was completely different from what they had agreed upon initially, 26% report that it was somewhat different, and 9% report that the everything went according to plan.

Figure 10. TAY+ racial identity



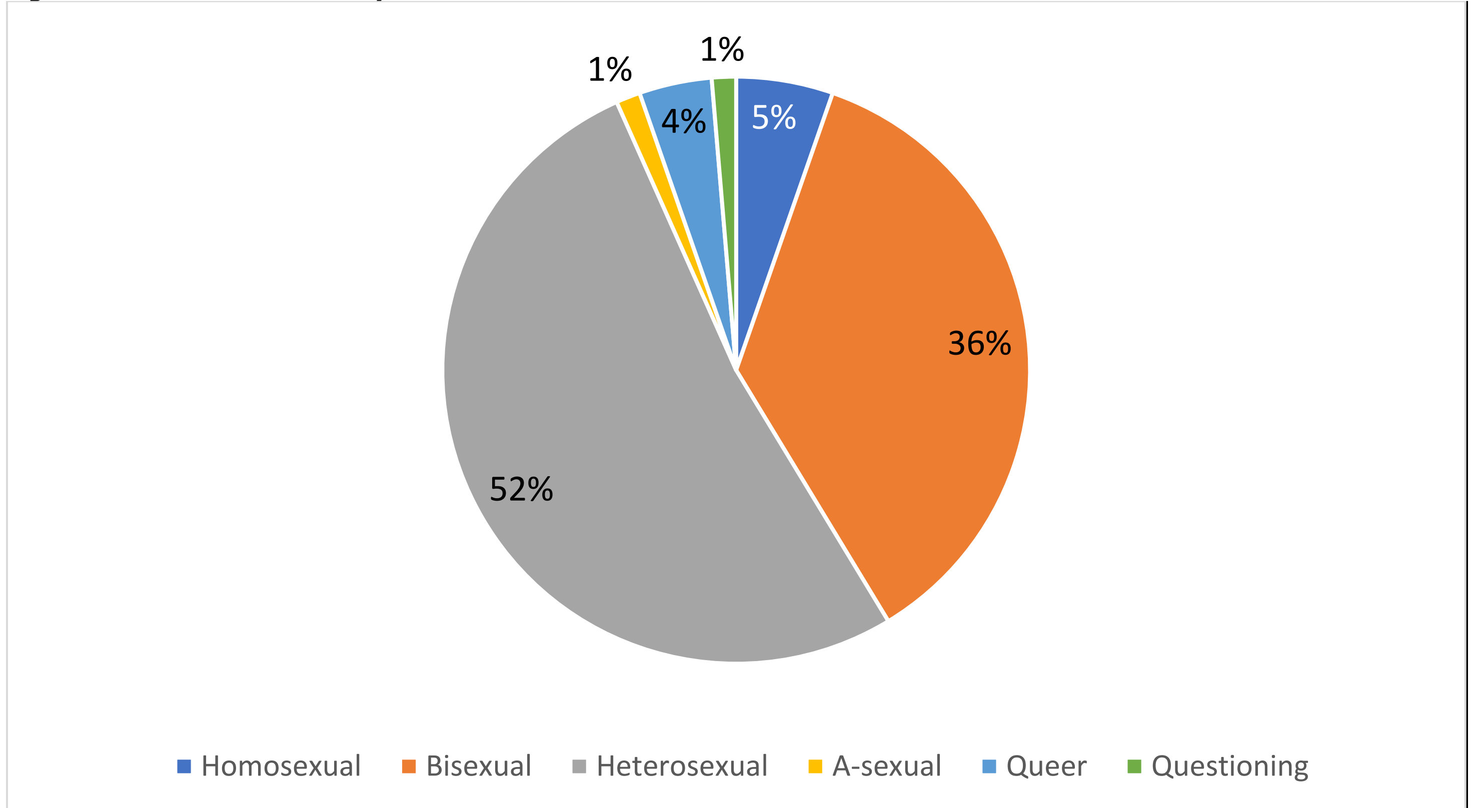
Of the TAY lived expert stakeholders that responded, 61% identified themselves as white, 14% identified as mixed, 18% identified as Black/African American, 3% identified as Hispanic/Latinx, 1% identified as American Indian and/or Alaska Native, 1% identified as Asian and/or Pacific Islander, and 1% identified as Middle Eastern.

Figure 11. TAY+ gender identity



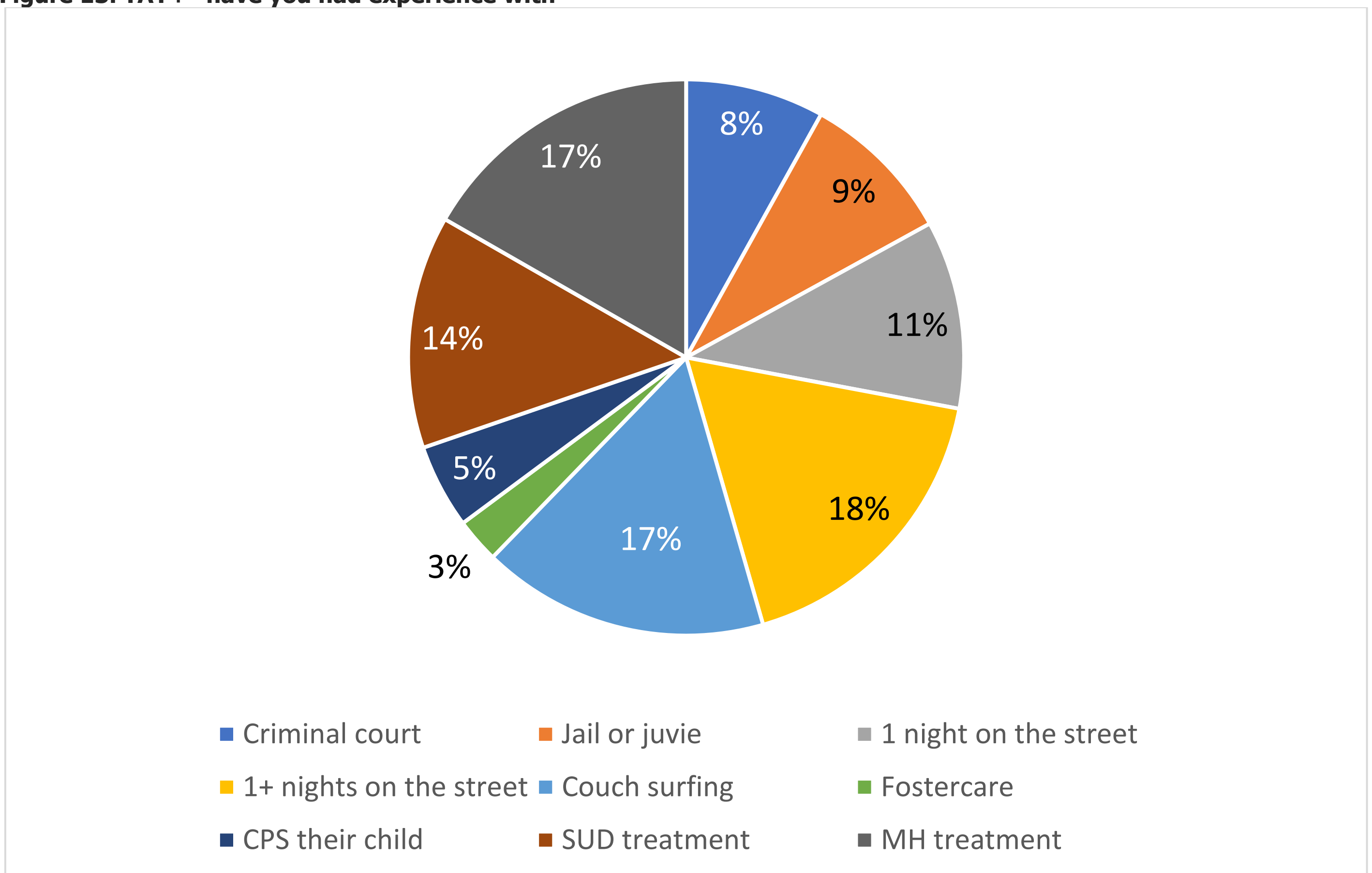
Of the TAY lived expert stakeholders that responded, 56% identified themselves Female, 27% identified as Male, 16% identified as transgender (including non-binary), and 1% identified as intersex.

Figure 12. TAY+ sexual identity



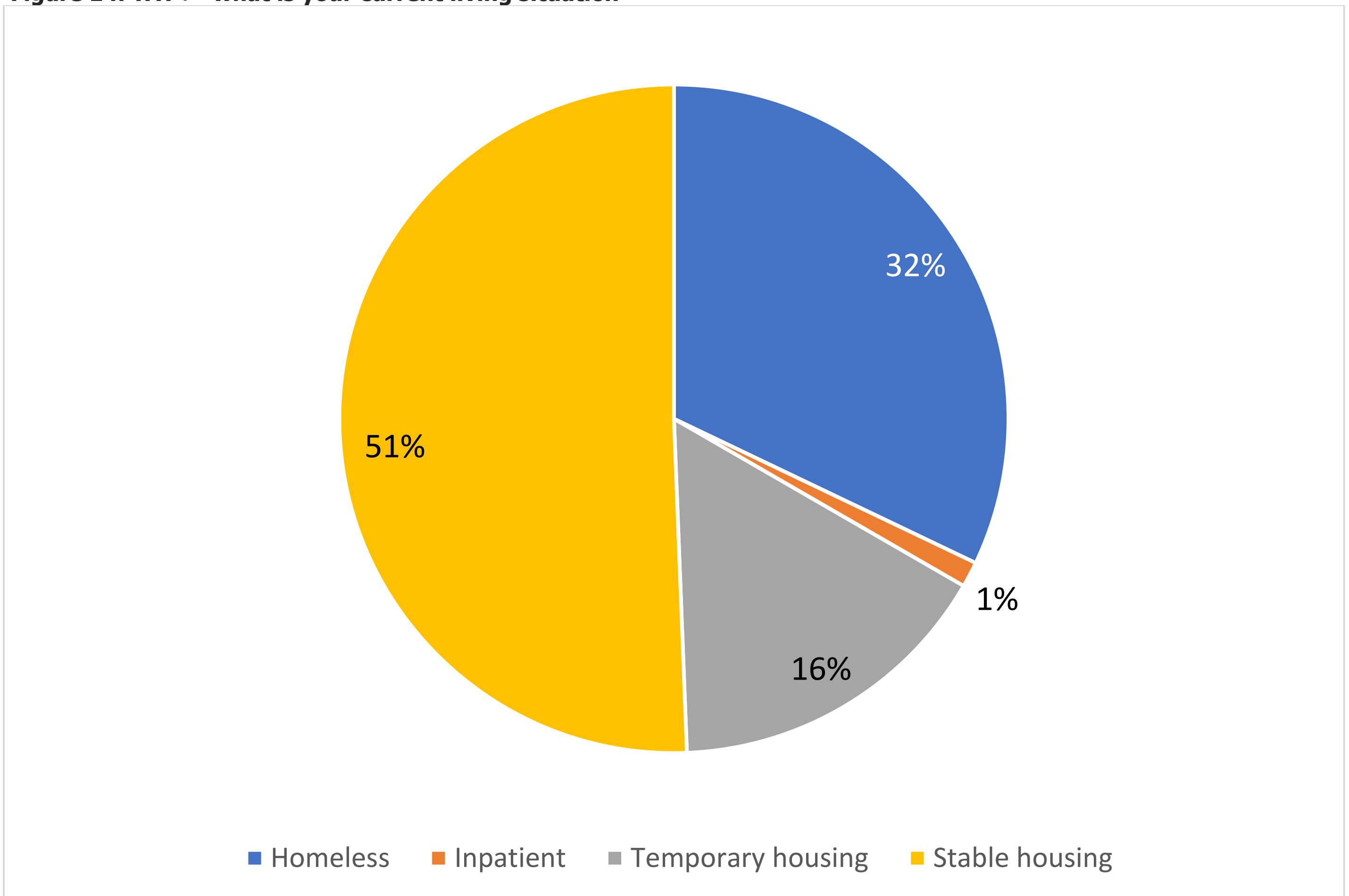
Sexuality status was included as many youth people experiencing homelessness also have identities within the lesbian, gay, bisexual, queer, and questioning (LGBTQ+) sphere. Of the TAY lived expert stakeholders that responded, 52% identified themselves heterosexual, 36% identified as bisexual, 5% identified as homosexual, 4% identified as queer, 1% identified as a-sexual, 1% identified as questioning.

Figure 13. TAY+ "have you had experience with"



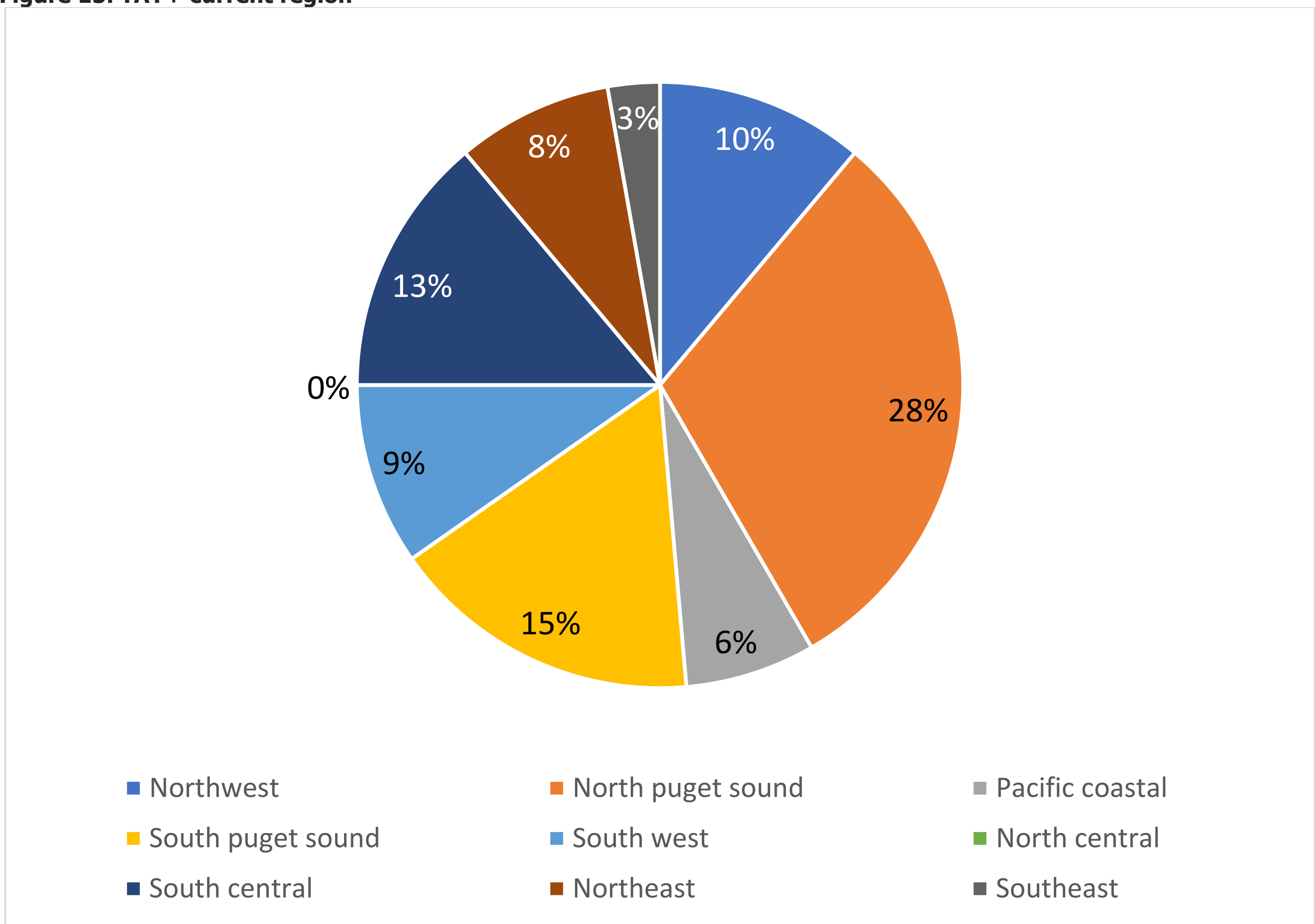
TAY lived experts were asked about their life experiences. Of the TAY lived expert stakeholders that responded, 8% identified that they have been court involved, 9% that they have been incarcerated, 11% identified that they had spent 1 night outside on the street, 18% identified that they had spent 1 or more nights on the street, 17% identified as having couch surfed at one point, 3% identified as having involvement in foster care, 5% identified that they had experienced CPS involvement with their child, 14% reported that they had gone through substance use disorder treatment, 17% reported that they had been in mental health treatment.

Figure 14. TAY+ "what is your current living situation"



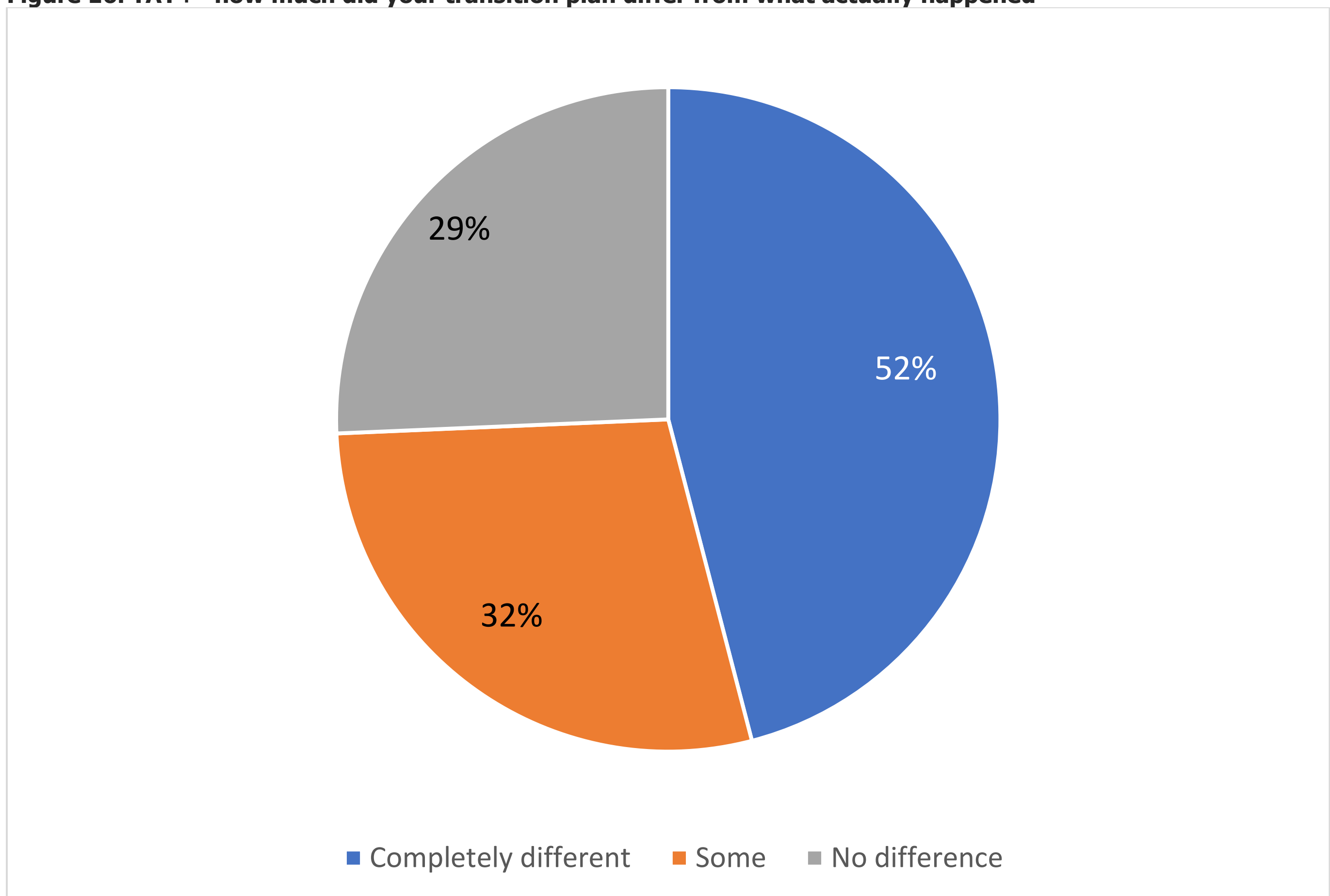
Of the TAY lived expert stakeholders that responded at the time they participated in this project, 51% currently lived in stable housing, 31% identified that they were experiencing homelessness, 16% identified that were living in temporary housing, 1% identified as currently in inpatient care unsure of their housing.

Figure 15. TAY+ current region



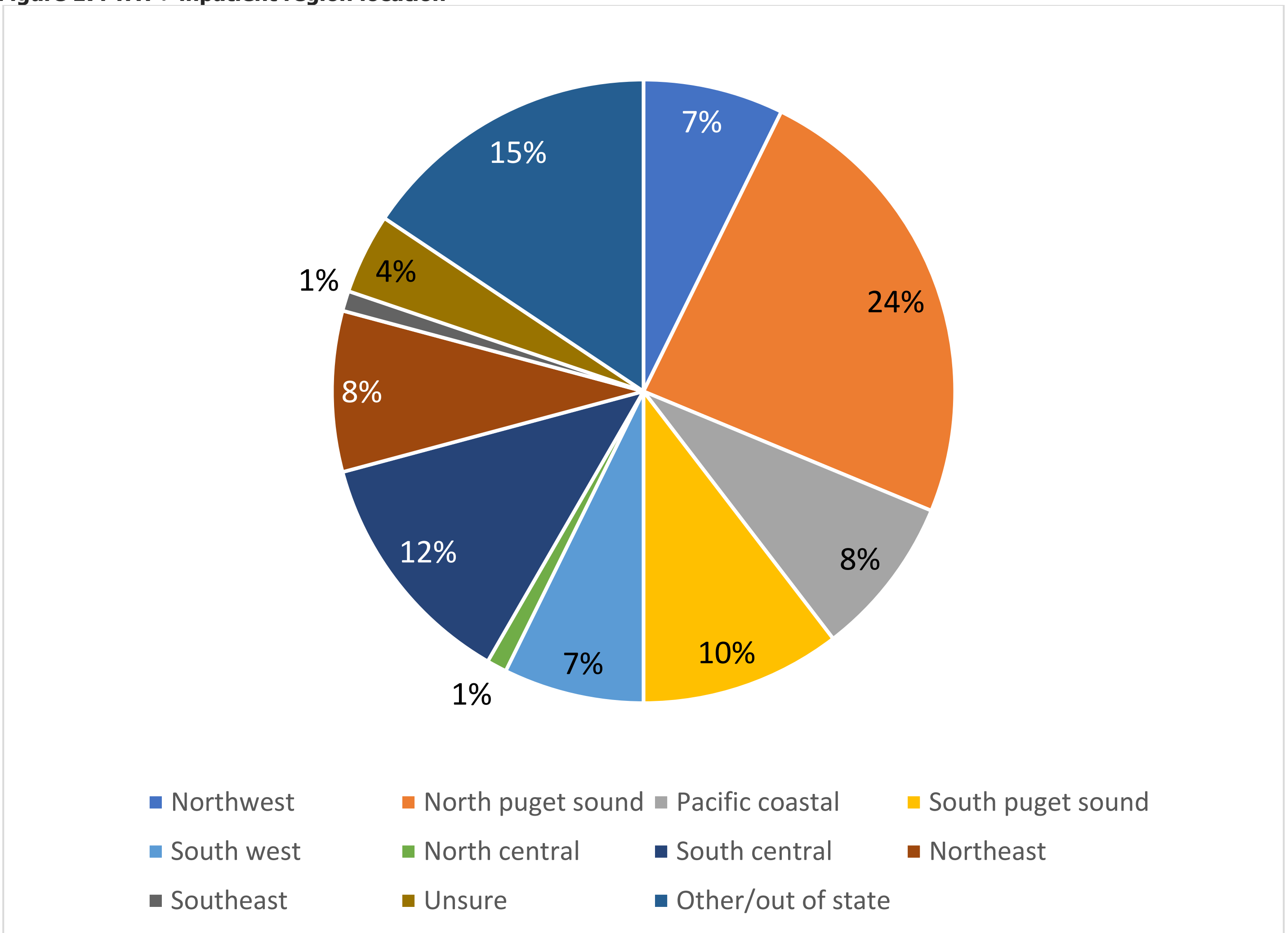
Of the TAY lived expert stakeholders that responded, 68% were located in the five western regions, 13% were located in the two central regions, 10% were located in the two eastern regions, 9% were residents either unsure of their region or currently living in a neighboring state, and no one was located in the north central region.

Figure 16. TAY+ "how much did your transition plan differ from what actually happened"



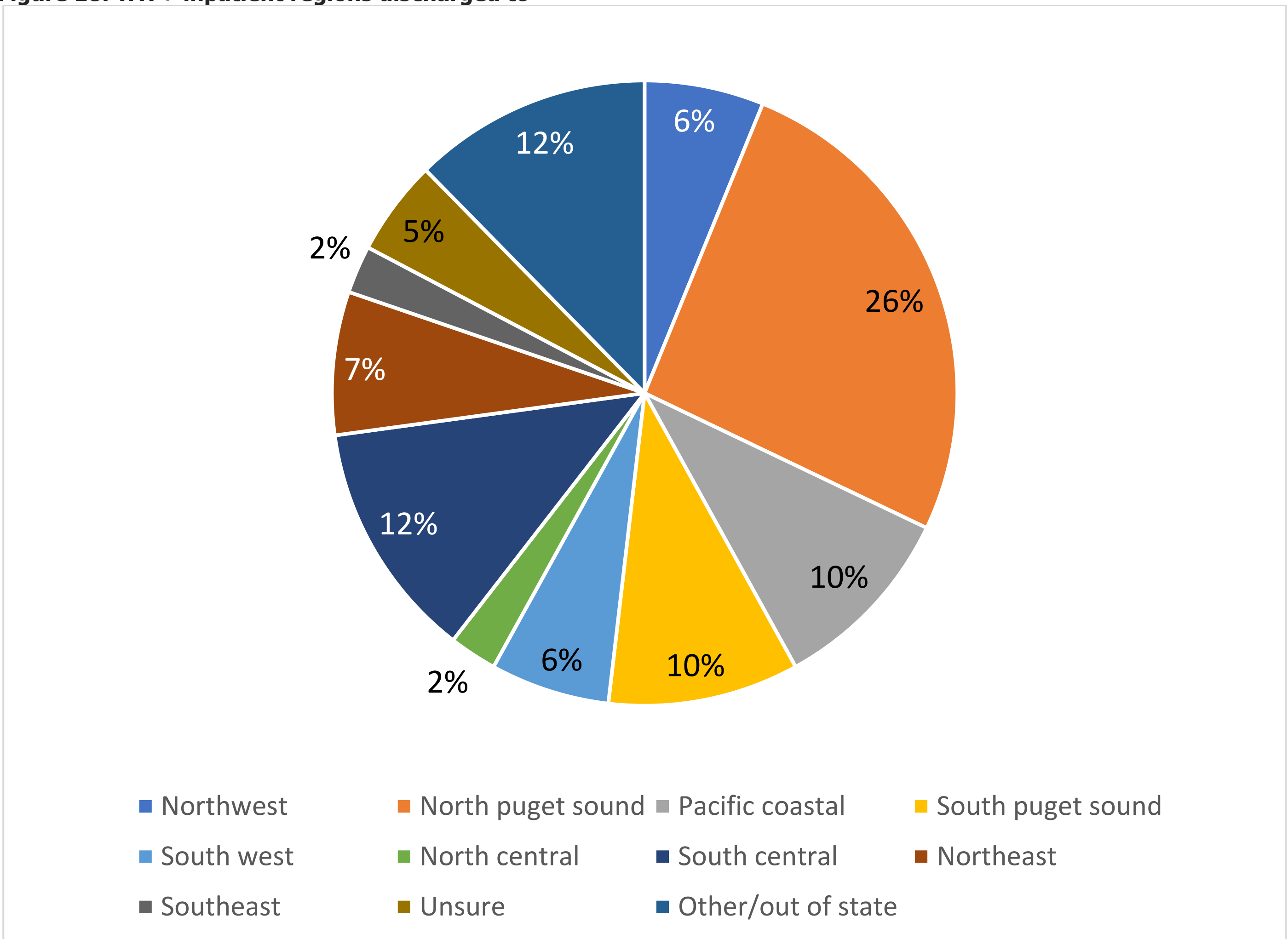
Of the TAY lived expert stakeholders that responded, 52% reported that the transition plan was completely different from what they had agreed upon initially, 32% report that it was somewhat different, and 29% report that the everything went according to plan.

Figure 17. TAY+ inpatient region location



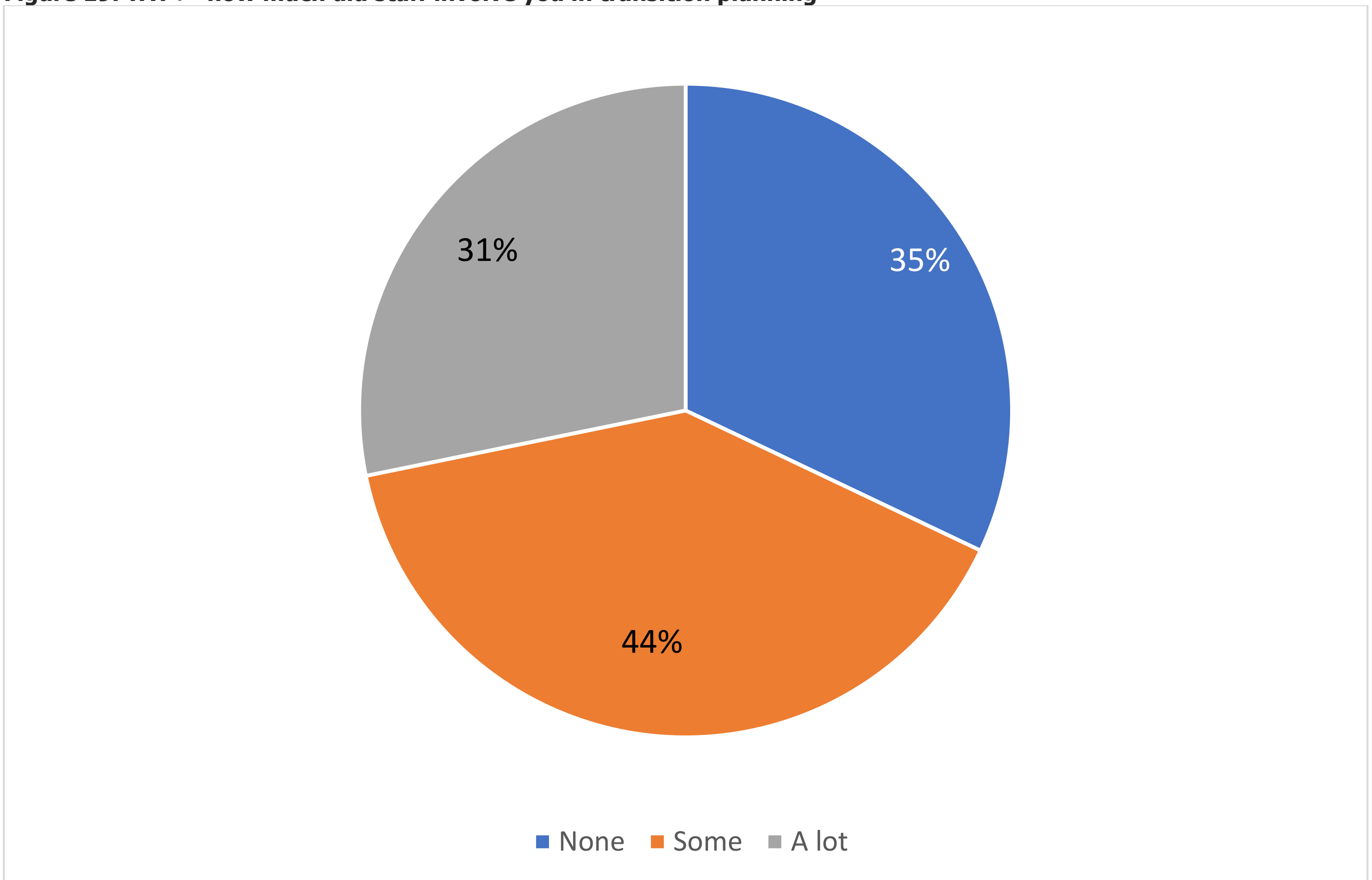
Of the TAY lived expert stakeholders that responded, 57% were located in the five western regions, 13% were located in the two central regions, 9% were located in the two eastern regions, and 15% went to inpatient out of state, and 4% were unsure where their inpatient treatment center was located.

Figure 18. TAY+ inpatient regions discharged to



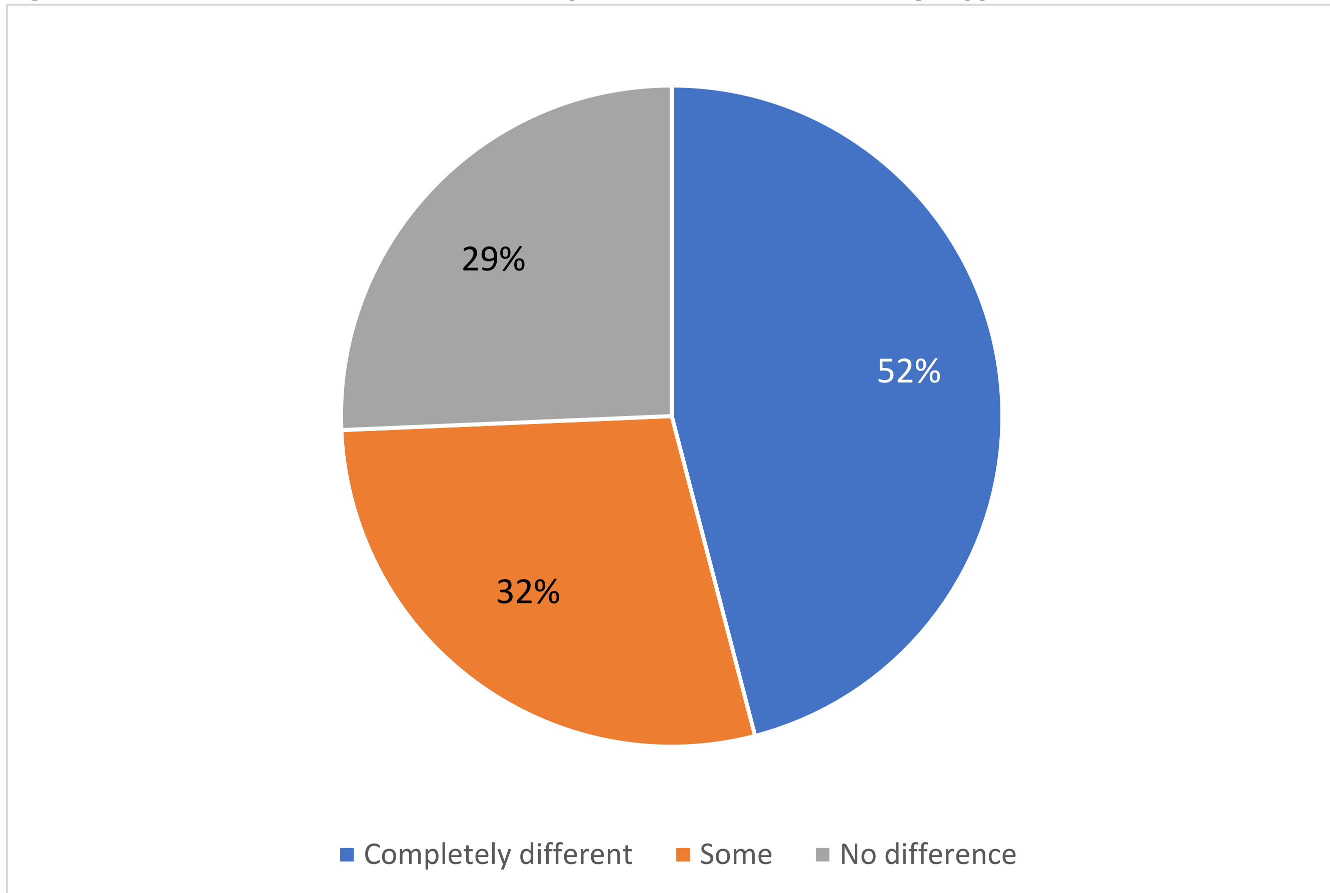
Of the TAY lived expert stakeholders that responded, 58% were discharged to the five western regions, 15% were discharged to the two central regions, 10% were discharged to the two eastern regions, and 12% were discharged out of state, and 5% were unsure where they were discharged to.

Figure 19. TAY+ "how much did staff involve you in transition planning"



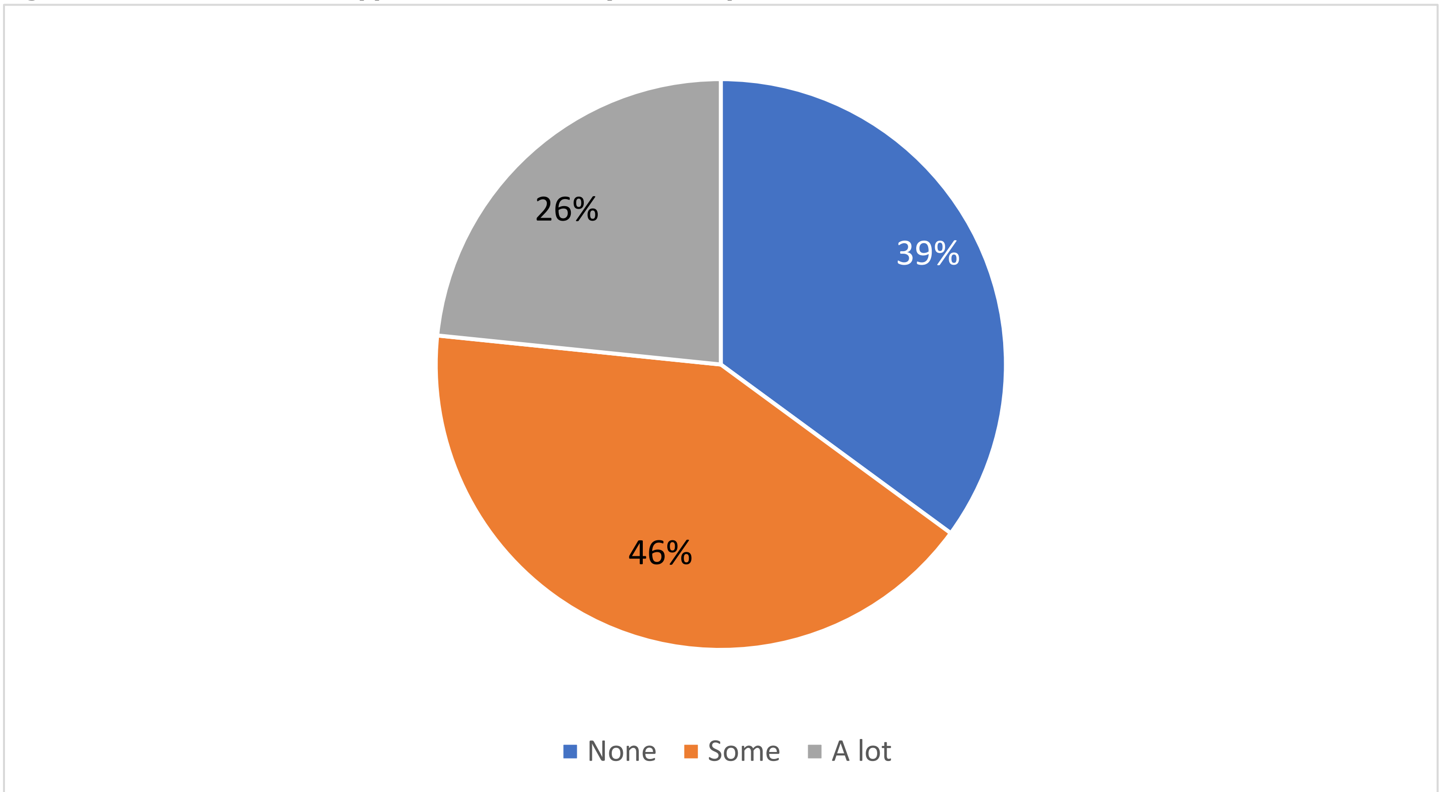
Of the TAY lived expert stakeholders that responded, 35% reported no involvement in the transition planning process, 44% report some involvement in the transition planning process, and 31% report substantial involvement in the transition planning process.

Figure 20. TAY+ "how much did the transition plan differ from what actually happened"



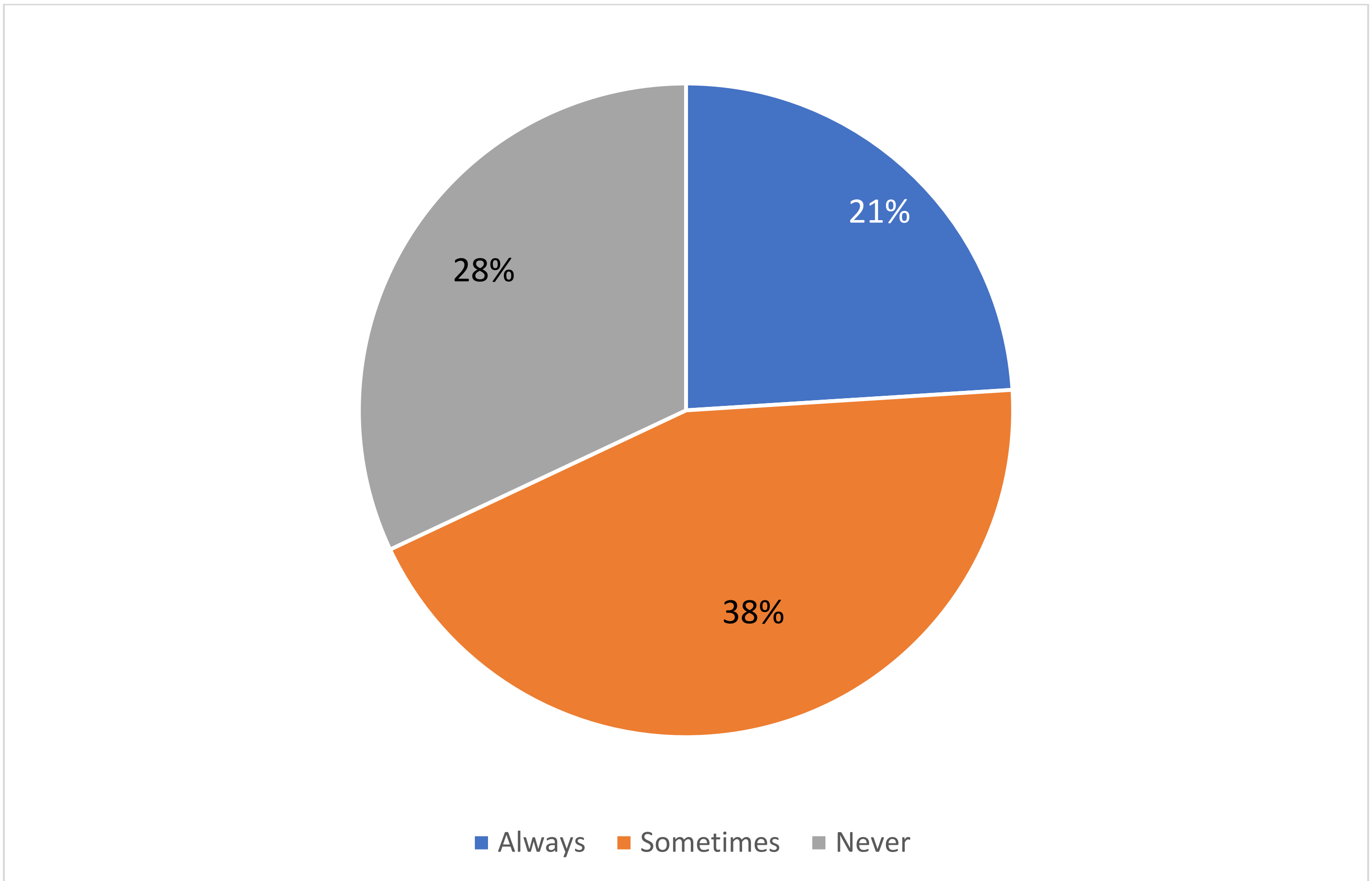
Of the TAY lived expert stakeholders that responded, 52% reported the plan and outcome were completely different, 32% report some difference in the transition plan and outcome, and 29% report the transition plan was the same as the outcome.

Figure 21. TAY+ "what did support look like after you left inpatient treatment"



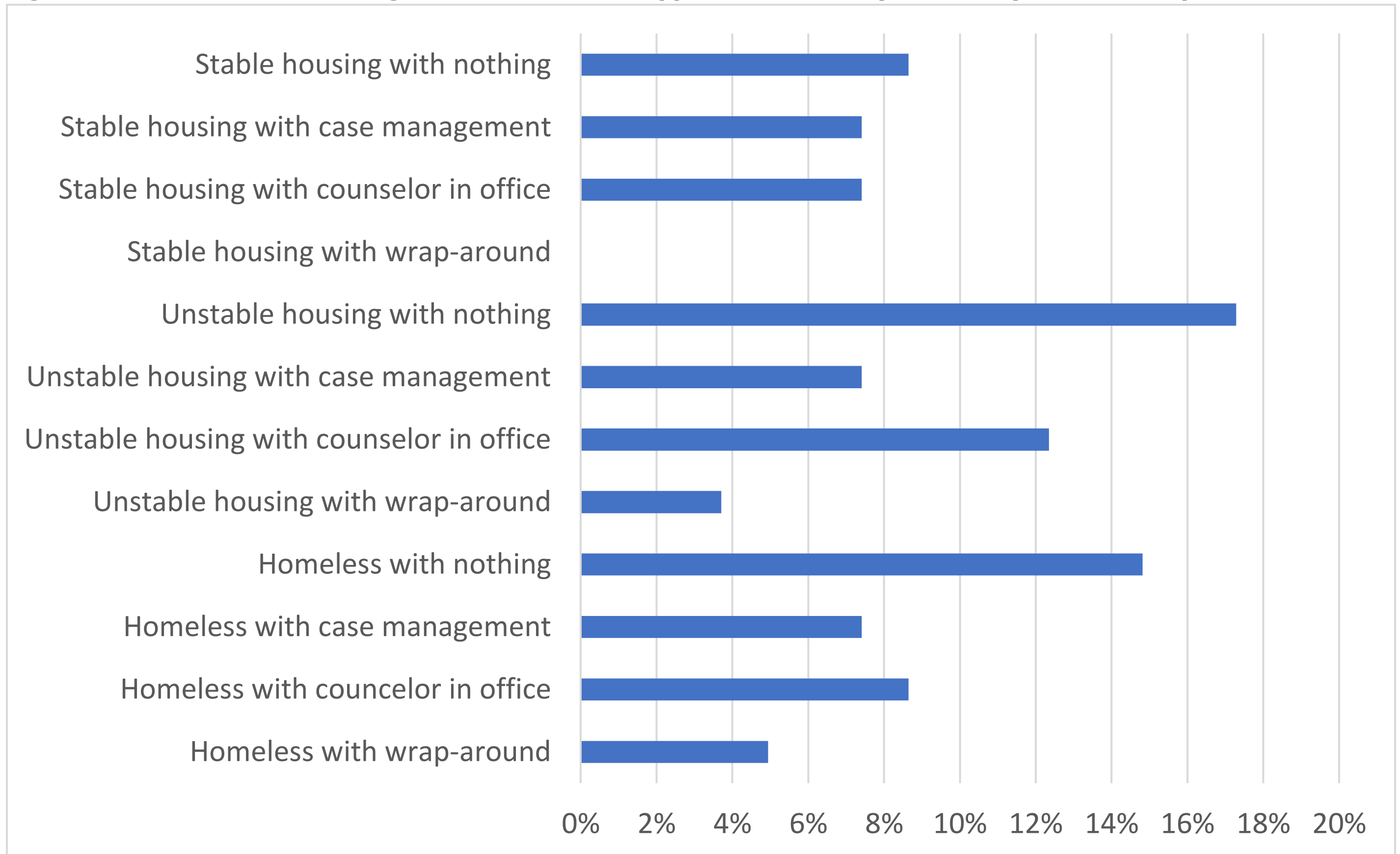
Of the TAY lived expert stakeholders that responded, 38% reported no support after discharge, 45% reported some support after discharge, and 26% reported a lot of support after discharge.

Figure 22. TAY+ "how often did you want your biological family involved in your treatment"



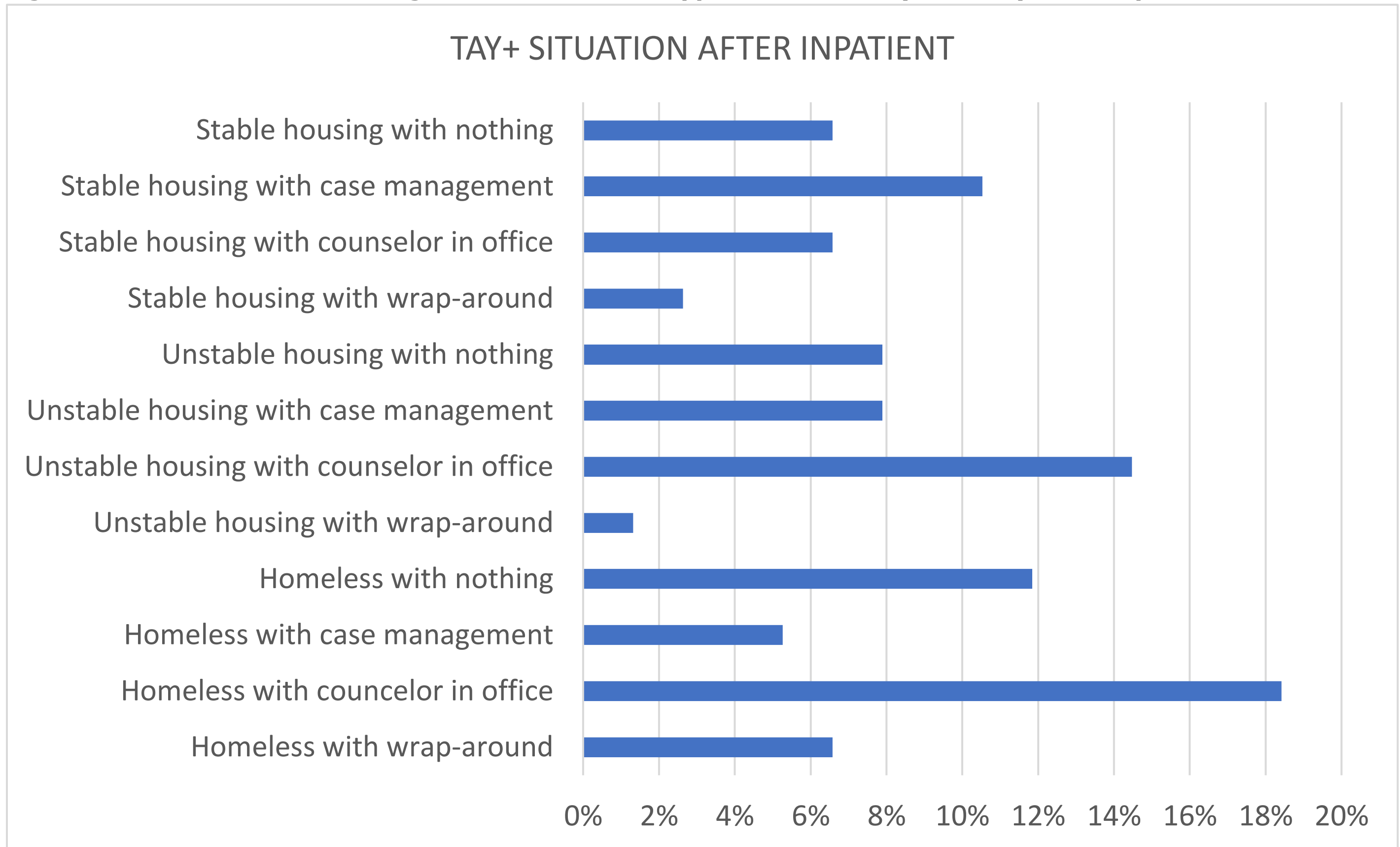
Of the TAY lived expert stakeholders that responded, 28% reported never wanting biological family involved in their treatment, 38% sometimes wanting biological family involved in their treatment, and 21% reported always wanting biological family involved in their treatment.

Figure 23. TAY "what did housing and mental health support look like for you before you went to inpatient treatment"



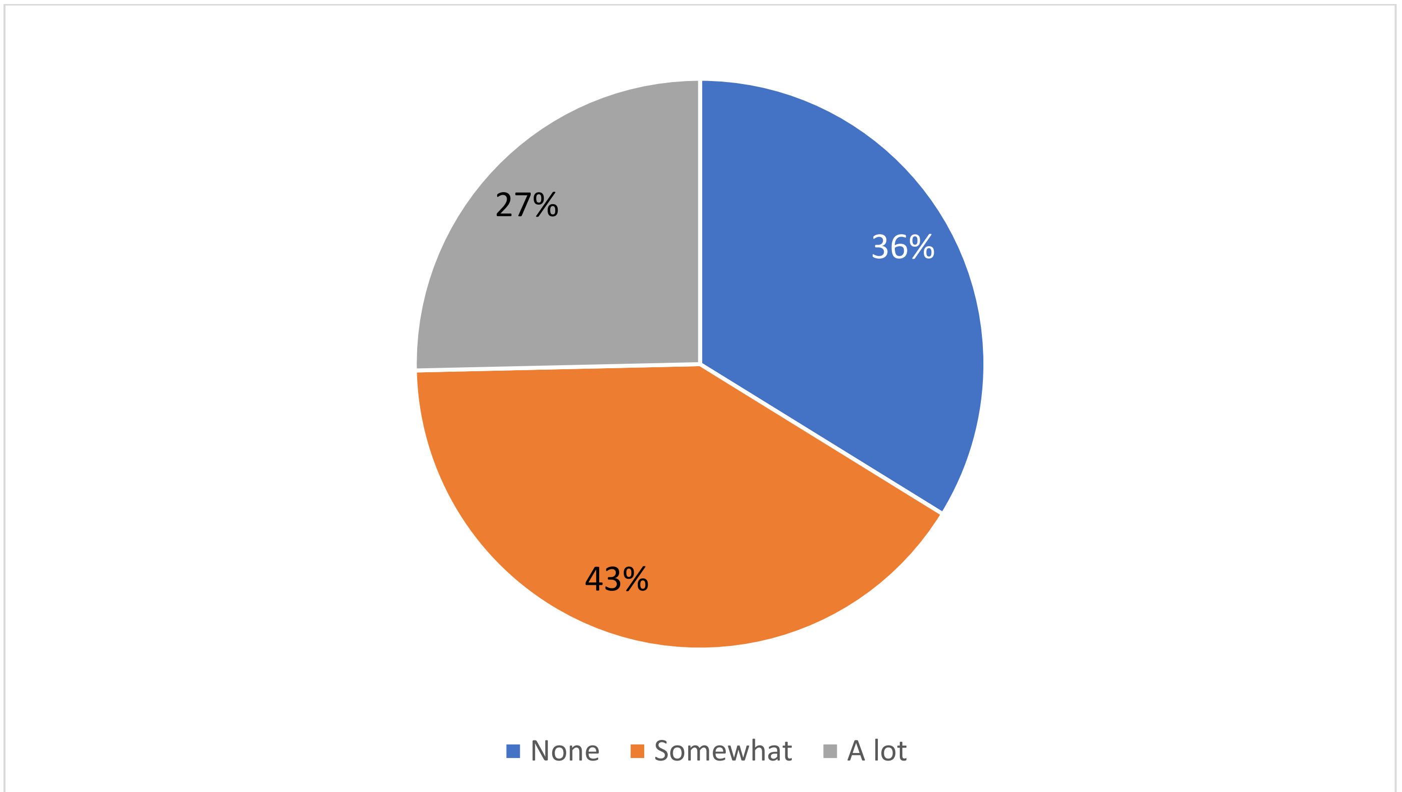
TAY lived experts were asked about their housing status and behavioral health access before inpatient behavioral health treatment. Stakeholders could report multiple experiences. Of the TAY lived expert stakeholders that responded, 9% reported stable housing and no behavioral health support before inpatient treatment, 7% reported stable housing and case management support before inpatient treatment, 7% reported stable housing and seeing a counselor in office before inpatient treatment, 0% reported stable housing and wrap-around services support before inpatient treatment, 17% reported unstable stable housing and no behavioral health support before inpatient treatment, 7% reported unstable housing and case management support before inpatient treatment, 12% reported unstable stable housing and seeing a counselor in office before inpatient treatment, 4% reported unstable housing and wrap-around services support before inpatient treatment, 15% reported no housing and no behavioral health support before inpatient treatment, 7% reported no housing and case management support before inpatient treatment, 9% reported no housing and seeing a counselor in office before inpatient treatment, and 5% reported no housing and wrap-around services support before inpatient treatment.

Figure 24. TAY+ "what did housing and mental health support look like for you after you left inpatient treatment"



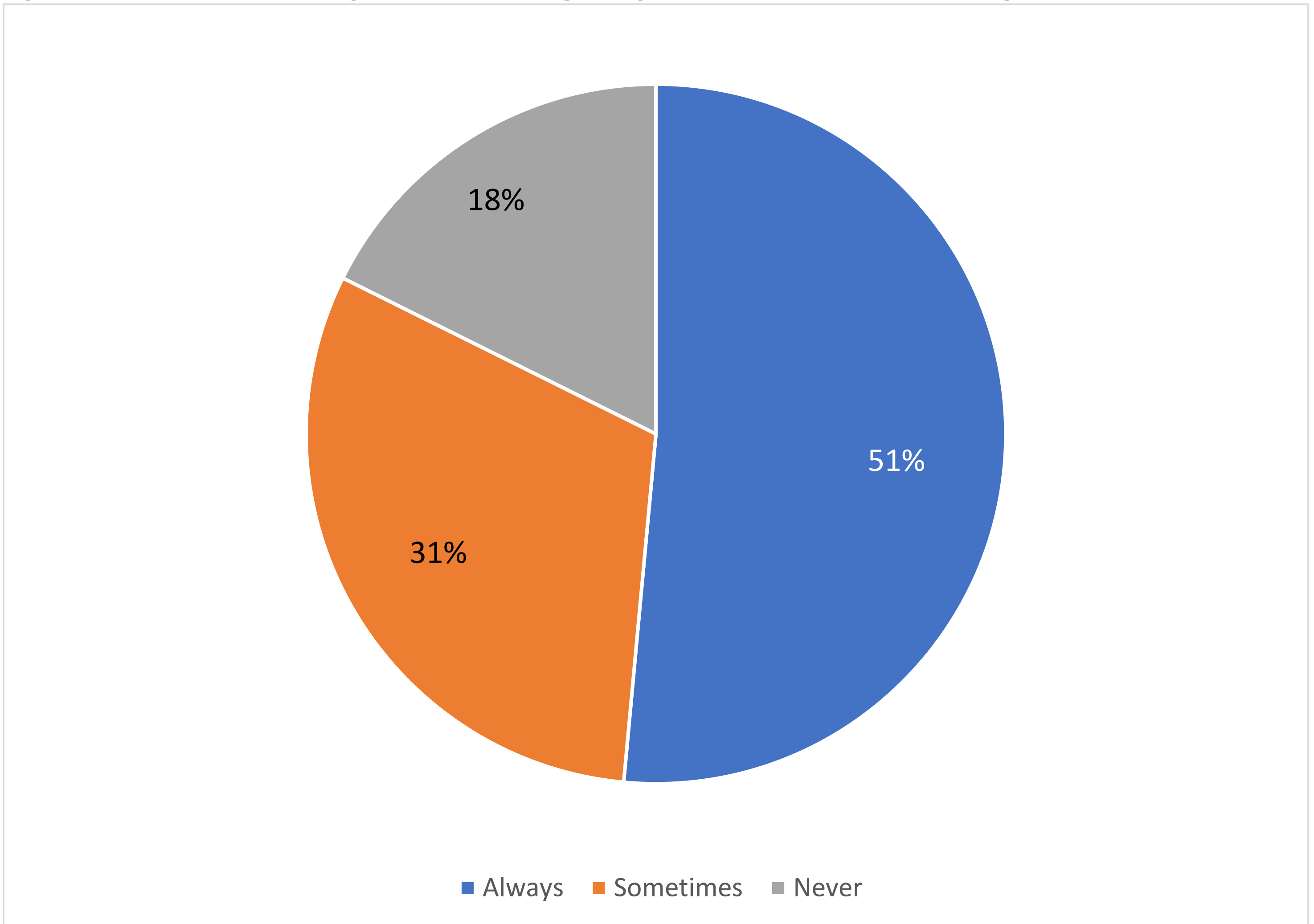
TAY lived experts were asked about their housing status and behavioral health access after inpatient behavioral health treatment. Stakeholders could report multiple experiences. Of the TAY lived expert stakeholders that responded, 7% reported stable housing and no behavioral health support after inpatient treatment, 11% reported stable housing and case management support after inpatient treatment, 7% reported stable housing and seeing a counselor in office after inpatient treatment, 3% reported stable housing and wrap-around services support before after treatment, 8% reported unstable stable housing and no behavioral health support after inpatient treatment, 8% reported unstable housing and case management support after inpatient treatment, 14% reported unstable stable housing and seeing a counselor in office after inpatient treatment, 1% reported unstable housing and wrap-around services support after inpatient treatment, 12% reported no housing and no behavioral health support after inpatient treatment, 5% reported no housing and case management support after inpatient treatment, 18% reported no housing and seeing a counselor in office after inpatient treatment, and 7% reported no housing and wrap-around services support after inpatient treatment.

Figure 25. TAY+ "how did the experience meet and not meet your cultural and healing needs"



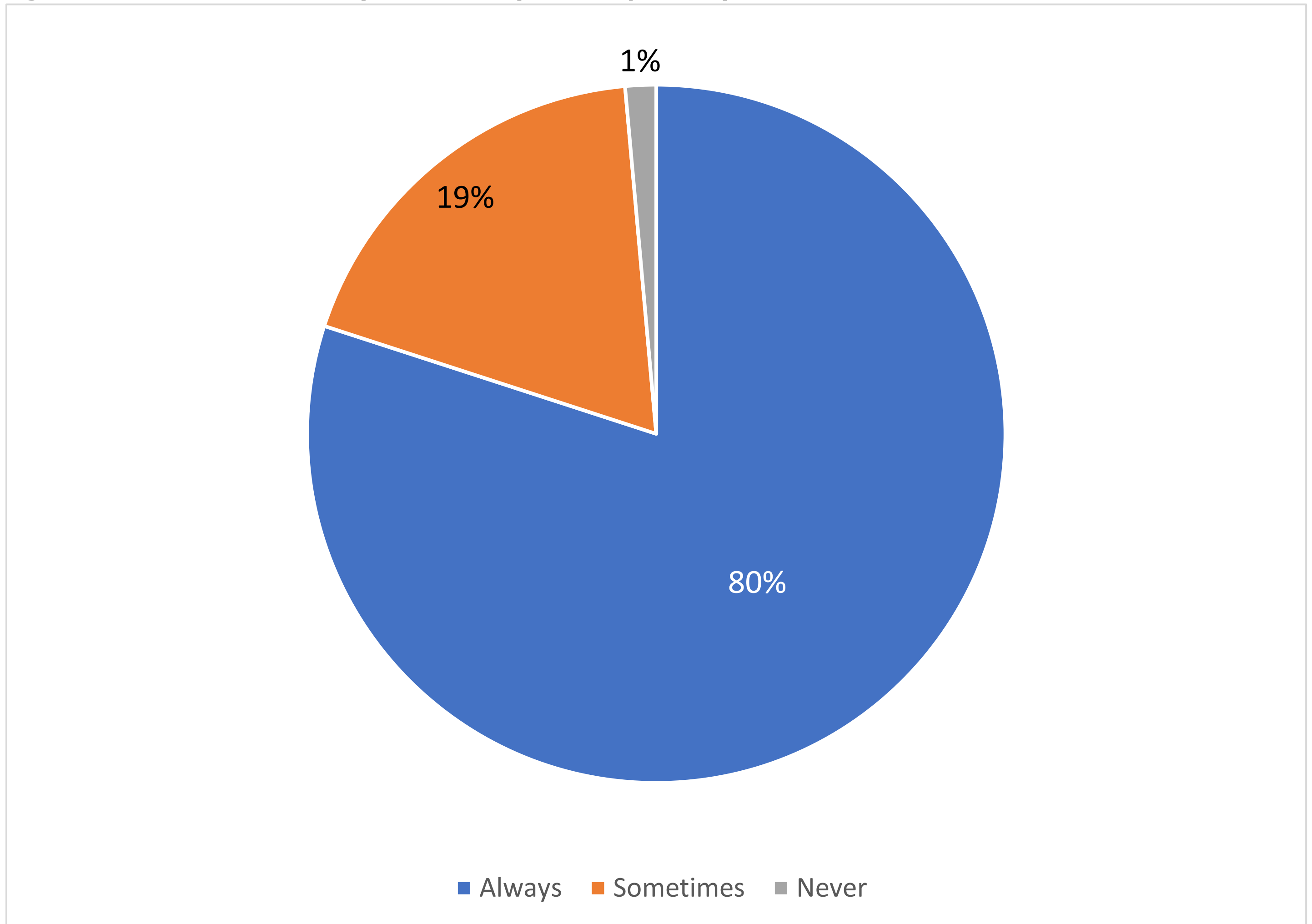
Of the TAY lived expert stakeholders that responded, 36% reported that their cultural and healing needs were not met, 43% report they were met somewhat, and 27% report that their cultural needs were significantly met.

Figure 26. TAY+ "how often did you want to be living with your blood relatives or other family"



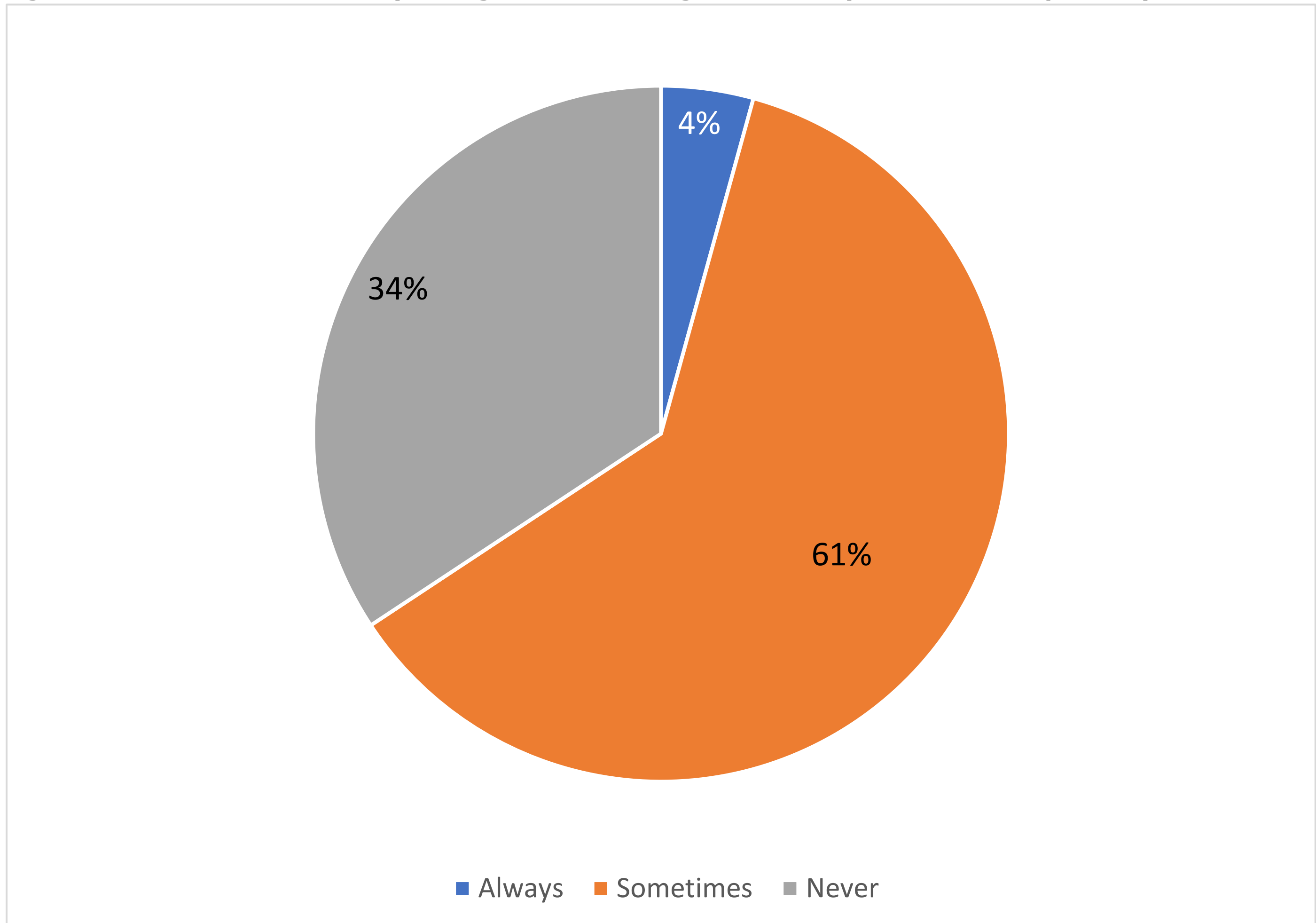
Of the TAY lived expert stakeholders that responded, 51% reported that they always wanted to live with family, 31% reported that they sometimes wanted to live with family, and 18% reported that they never wanted to live with family.

Figure 27. TAY+ "how often did you wish that you had a place of your own"



Of the TAY lived expert stakeholders that responded, 80% reported that they always wanted to live on their own, 19% reported that they sometimes wanted to live on their own, and 1% reported that they never wanted to live on their own.

Figure 28. TAY+ "how often were you alright with how things were when you didn't have a place of your own"



Of the TAY lived expert stakeholders that responded, 4% reported that they were always okay with how things were when they did not have their own place to live, 61% reported that they were sometimes okay with how things were when they did not have their own place to live, and 34% reported that they were never okay with how things were when they did not have their own place to live.

Appendix III literature review process

Literature review and expert consultation were used to better understand transition best practices for TAY.

We had three objectives:

- To identify best practices for discharging TAY that have experienced homelessness from behavioral health inpatient settings to ensure they experience safe and stable housing.
- Identify practice models fitting the above that are inclusive of people with marginalized identities for culturally responsive services.
- Explore options for ongoing data collection and reporting, to ensure these youth are connected with housing and behavioral health supports.

Literature review Process:

- Several online article databases were used. Including but not limited to: Google, Google Scholar, PubMed, UW Libraries (temporarily utilize by our intern), and Health WA the On-Call Library for Washington State Practitioners.
- More than 20 keywords were identified to guide the literature review the main keywords included but were not limited to a combination of the following terms: homeless, youth, Transition Age Youth, discharge, behavioral health, best practice, transition plan, stable housing, LGBTQ, BIPOC, and people of color.
- Resources including articles, reports, and conference recordings were discovered and reviewed by five DBHR staff members. Two staff members explored literature relevance.
- Several entities that provided best practice models and programs native to Washington and nationally were contacted. Representatives from Los Angeles county's various TAY programming, along with peer leaders and researchers from other areas across the nation were interviewed to learn more about their best practice findings and programming.
- The ADDRESSING model was used to identify identity and identity intersections that were included and excluded in literature.[81,86]
- Literature was compiled and noted in Excel spreadsheets, notes, and throughout the drafting of recommendations.
- A more formal literature review was briefly compiled through the lab at UW's EBPI but no literature on discharge and transition planning for TAY leaving inpatient behavioral health settings was found.

Literature review considerations:

It is important to note that the program lead was the primary investigator. While other staff helped with the literature at the beginning of the project, the project lead continued and completed the bulk of the review and interviews.

There may be literature that was not found and not reviewed as formal criteria were not created and held during the literature search. Such as formal tracking of keyword searches and the challenges with different databases showing various numbers of articles. Often research was expanded by exploring the relevant articles embedded within the references of initial article results.

Significant gaps were discovered in research that were discussed in the research recommendation section. Often research looked at young people that were not experiencing homelessness, some people that were in foster care systems and not behavioral health systems, or adults including 18 and older. No best practice inpatient behavioral health discharge and transition planning for TAY experiencing homelessness were found in the literature review search. As a result, similar and adjacent programming was used to piece together best practices.

Appendix IV References

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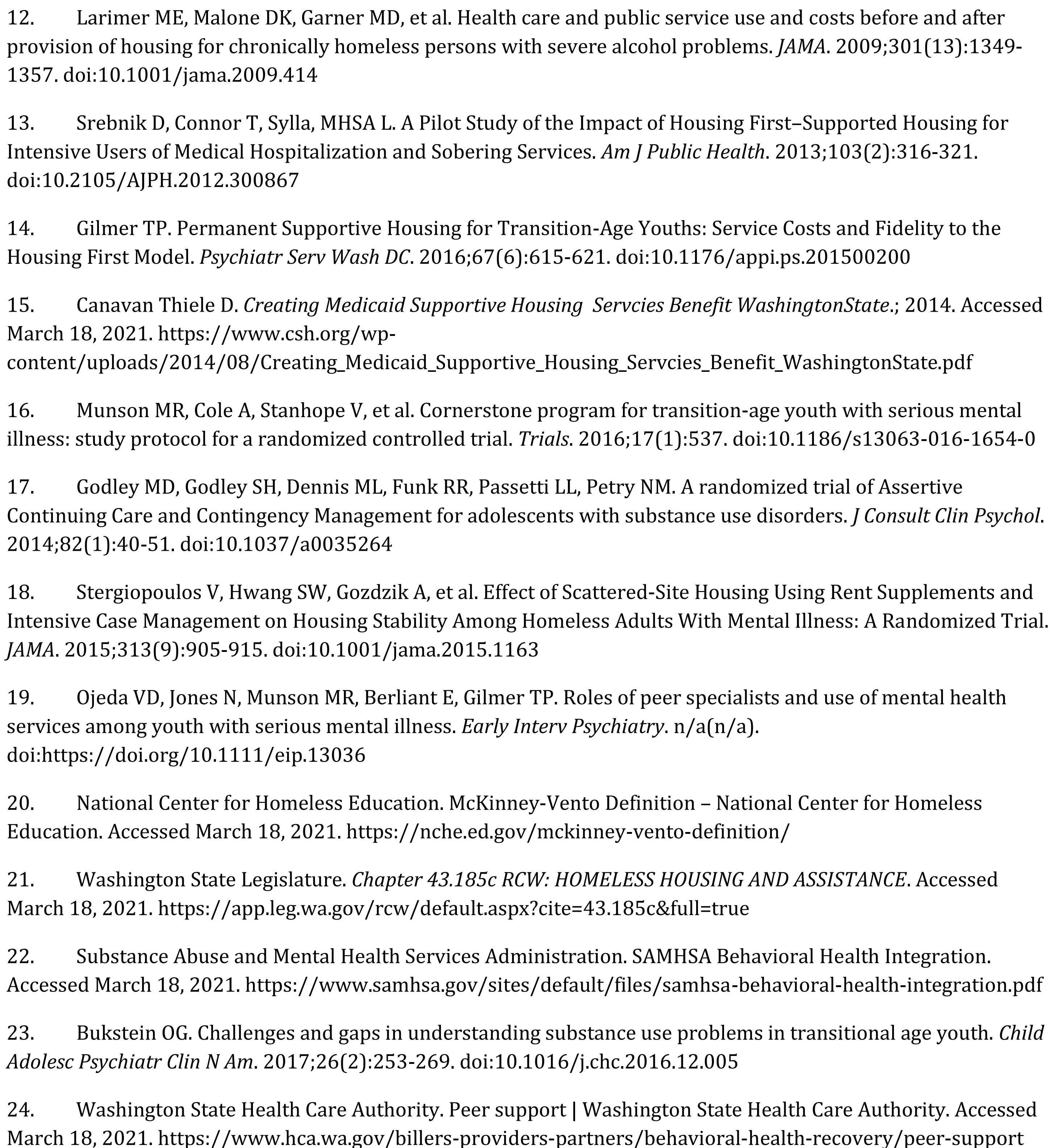

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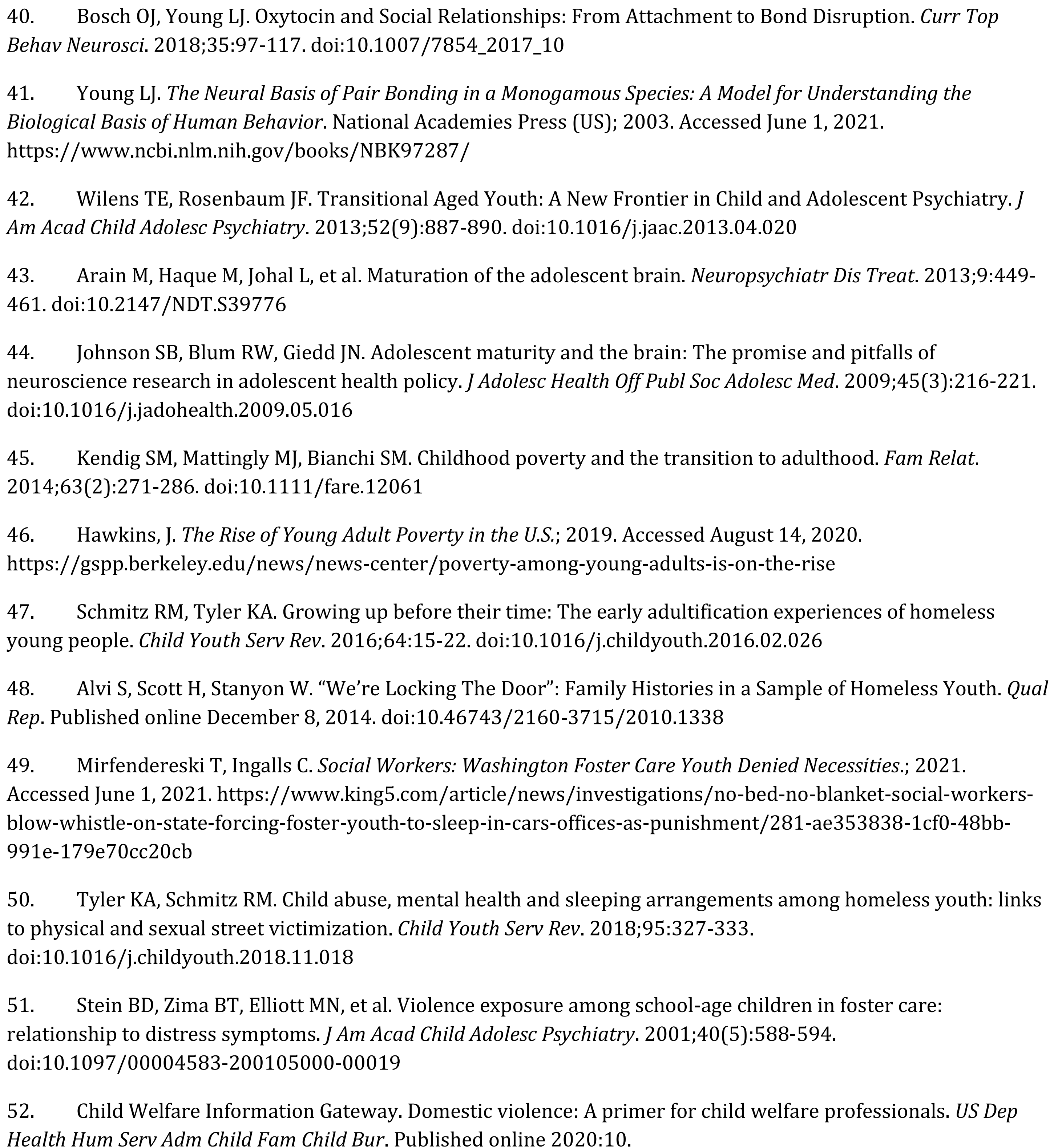

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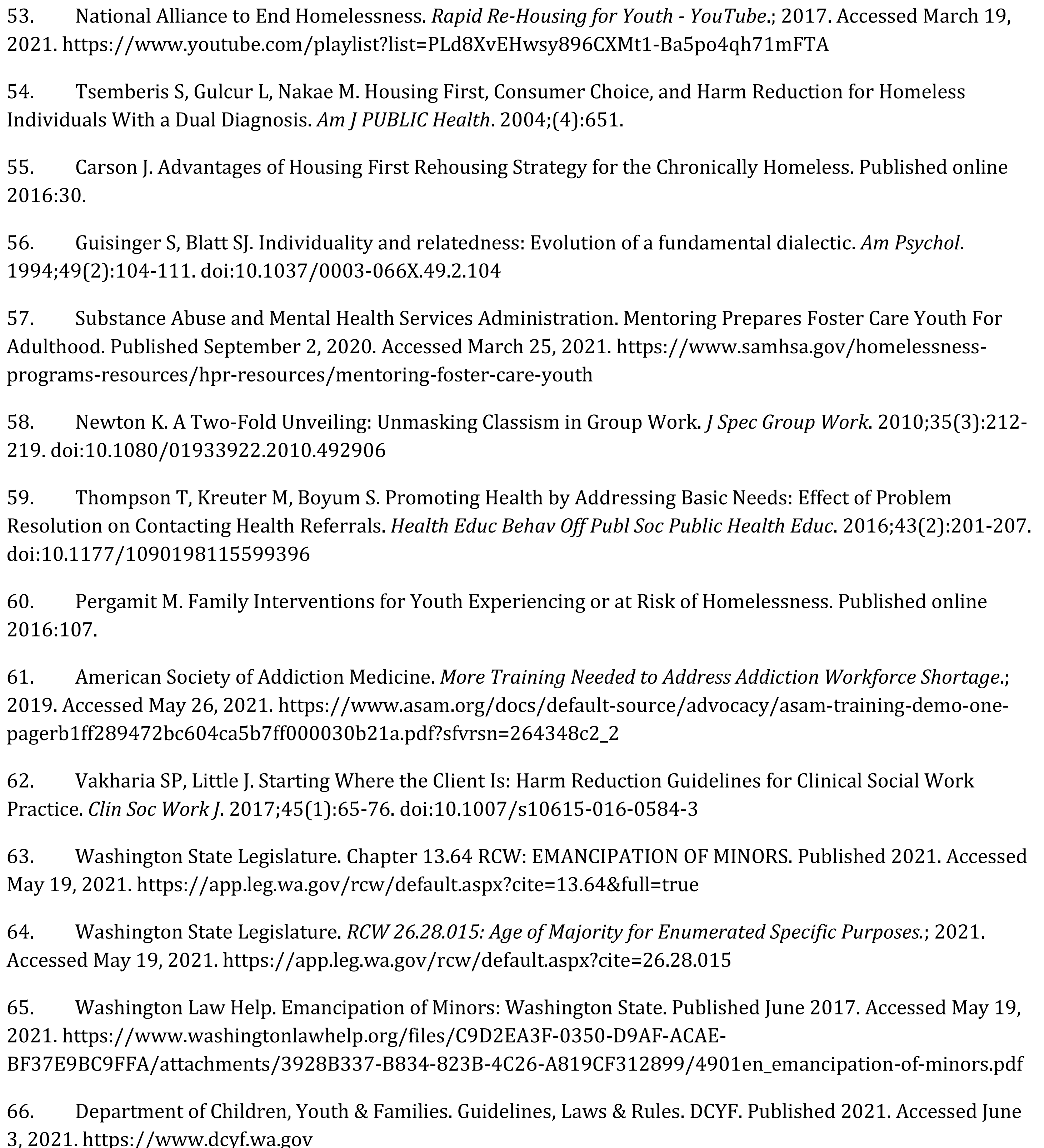

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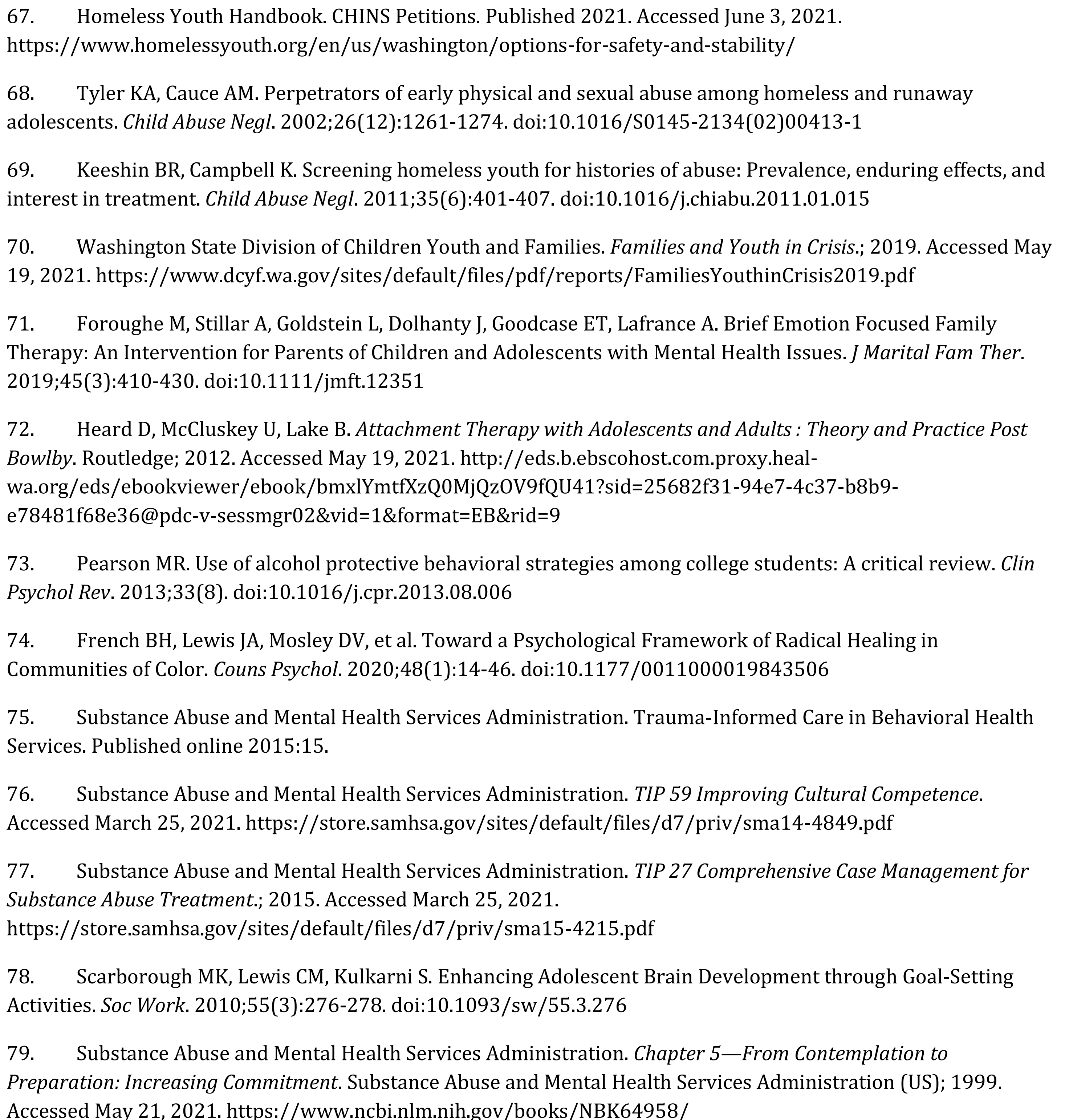

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