Children and Youth Behavioral Health Work Group – Youth and Young Adult Continuum of Care (YYACC) Subgroup

July 1, 2025

Glossary of Terms

AOT: Assisted Outpatient Treatment
CYBHWG: Children and Youth Behavioral Health Work Group
FYSPRT: Family Youth System Partner Round Table
HCA: WA Health Care Authority
LRA/LRO: Less Restrictive Alternative Treatment/Order
TAY: Transition-Aged Youth
Washington Thriving: Washington State Prenatal through Age 25 (P-25) Behavioral Health Strategic Plan
YYA: Youth and Young Adult (ages 13 through 25)
SMI: Serious Mental Illness

Meeting Topics

Breakout Discussion on Life Skills
Treatment Advocacy Center Presentation on Serious Mental Illness
Breakout Discussion on Serious Mental Illness
Next Steps

Discussion Summary

Breakout Discussion on Life Skills

The group talked about how to empower youth by increasing life skill learning for ages 16-25, emphasizing the need for access for the following populations:

1. Foster care and system-involved youth
2. Homeless youth
3. BIPOC youth
4. LGBTQ+ and gender-diverse youth
5. Neurodivergent youth (e.g., autism, intellectual disabilities)

Youth from low-income families or underserved rural communities

1. What is the problem?
    a. Transitional-age youth (16–25) face challenges acquiring life skills needed for adulthood.

   b. Existing systems (especially for youth exiting foster care, homelessness, or with disabilities) are fragmented, underfunded, and not fully responsive to individual or cultural needs.
   c. Life skills programs can feel irrelevant (e.g., teaching cooking when youth lack housing).
   d. Youth are expected to navigate adulthood and complex systems without adequate preparation or consistent supports.
   e. There's a lack of accessible, culturally responsive, developmentally appropriate, and individualized services across communities.
2. Why does it matter?
   a. Youth without life skills struggle with independence, employment, housing stability, and mental health.
   b. Inadequate preparation can lead to homelessness, system reentry (e.g., juvenile justice, hospitals), or reliance on survival strategies.
   c. Missed opportunities to support youth can perpetuate systemic inequities, especially for BIPOC, LGBTQ+, neurodiverse, and system-involved youth.
3. What are we solving for?
   a. A comprehensive, flexible, and culturally responsive "menu" or "smorgasbord" of life skills training that youth can choose from based on their needs and goals.
   b. Equitable access to supports that foster autonomy, decision-making, and resilience.
      i. Integrated services that are available regardless of system involvement or geography (urban/rural).
4. What does success look like?
   a. Youth feel heard, respected, and genuinely supported in developing life skills that matter to them.
   b. Programs are co-designed with youth input and adapt to their evolving needs.
   c. Youth successfully transition into adulthood with stable housing, employment, health, and community connections.
   d. Support systems proactively provide access, warm handoffs, and incentives (e.g., stipends, gift cards) for participation.
   e. Life skills education is embedded in natural community settings (e.g., family resource centers, schools, youth-led spaces).
5. What do we need to achieve that success?
   a. Direct youth involvement in designing, implementing, and evaluating programs.
   b. Creative use of existing community resources (e.g., family resource centers, big sibling/mentor models).
   c. Securing sustained funding through public investment, philanthropy, or pilot programs with proven outcomes.
   d. Building partnerships (e.g., with housing authorities for vouchers, schools for curriculum).

e. Embedding life skills education into public education, community-based programs, and natural family settings.
f. Offering both virtual and in-person options to increase accessibility.
g. Providing incentives and recognition for skill development.

Presentation on Serious Mental Illness

Jerri Clark of Treatment Advocacy Center shared a presentation on their work to eliminate the barriers to timely and effective treatment of serious mental illness (SMI). See supporting slides for more info.

Breakout Discussion on Serious Mental Illness

1. What is the problem?
    a. People with severe mental illness (SMI)—especially those with psychosis—often experience anosognosia, meaning they lack awareness of their illness and don't believe they need help.
    b. Systems in place (e.g., outpatient care, hospitalizations) are ineffective for this group because they rely on individuals recognizing their need for treatment.
    c. Current involuntary treatment options (e.g., LRA/LRO) often lack the supportive infrastructure needed for success.
    d. Assisted Outpatient Treatment (AOT) programs are underdeveloped in Washington State, and misconceptions about cost and coercion limit their use.
    e. Families and peers are often sidelined in care decisions, despite being critical sources of knowledge and support.
    f. There is insufficient combined care addressing both SMI and co-occurring substance use disorders.
2. Why does it matter?
    a. People with anosognosia are at high risk of repeated hospitalizations, homelessness, incarceration, and suicide.
    b. Without assertive interventions, the most vulnerable individuals fall through the cracks, creating enormous human and financial costs.
    c. Compassionate involuntary treatment can restore autonomy that is already lost to the illness.
3. What are we solving for?
    a. A system that recognizes and addresses anosognosia as a barrier to care.
    b. Expansion of AOT and other supportive involuntary treatment programs that combine compassion, accountability, and services.
    c. Better use of peer support, with training on anosognosia and the limits of autonomy in severe illness.
    d. Integration of family voices and experience in treatment planning.
    e. More effective diversion programs that connect people with SMI to treatment rather than jail.
4. What would success look like?

   a. Robust, statewide AOT programs with strong outreach teams, court monitors, and meaningful support services (e.g., housing help, employment resources).
   b. Families and peers are actively involved in care decisions, with respect for their input.
   c. Reduction in avoidable hospitalizations, incarcerations, and homelessness among individuals with SMI.
   d. Public and provider understanding that involuntary treatment can be compassionate and recovery-oriented.
5. What would it take to achieve success?
   a. Broader stakeholder buy-in to AOT and similar programs.
   b. Public education about anosognosia, SMI, and the role of involuntary treatment.
   c. Policy and funding support for scaling up AOT and related services statewide.
   d. Integration of substance use disorder treatment with mental health care.
   e. Structural incentives and support for providers participating in AOT.

Next Steps

1. The subgroup will need volunteers to help draft recommendations for the Washington Thriving Strategic Plan. If you are interested in assisting with this task outside of regular meeting hours, please email info@bhcataylst.org and michelle.karnath@clark.wa.gov.
2. The subgroup will meet next on July 17, 3:30-5:30PM. *If you are not already on the YYACC mailing list and would like to be added, you can email cybhwg@hca.wa.gov indicating your preference.*