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

June 5, 2025

Glossary of Terms

CYBHWG: Children and Youth Behavioral Health Work Group
FYSPRT: Family Youth System Partner Round Table
HCA: WA Health Care Authority
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)
HPDF: Homeless Prevention Diversion Fund
CPSS: Certified Peer Support Specialist
CLIP: Children's Long-term Inpatient Program

Meeting Topics

Breakout Discussion on Peer Support
Breakout Discussion on Age of Consent
Next Steps

Discussion Summary

Breakout Discussion on Peer Support

Peer Support: Certified peer specialists work with individuals and parents of children receiving mental health or substance use disorder services. They use their own lived experiences to help their peers find hope and to support their recovery.

1. What is the need or the gap?
    a. Peer support is an under-utilized resource.
    b. BH workforce is overburdened.
    c. Certification Training is limited to Ages 18 and up.
2. Why does it matter?
    a. BH Workforce shortages can be softened with Certified Peer Specialists and other peer support.
    b. Youth are heavily influenced by peers.
    c. Youth can access care faster.
    d. Creates a sense of autonomy for youth.
        i. Job creation, wages for young people.
        ii. Youth choose who they lean on for support.
        iii. Peers can help navigate the BH system.
        iv. Peers are given a sense of purpose through helping peers.
3. What are we solving for?

   a. Filling in the gaps of the BH workforce.
   b. Peer Support Credential requirements can be expensive and time intensive for agencies and individuals (80 hours for Certified Peer Specialist and 40 hours for Certified Peer Counselor).
   c. Recruiting younger people with shared lived experiences who are closer in age to individuals who need Peer Support.
   d. Raise awareness of Peer Support and its availability.
   e. Increase funding of Peer Support programs.
4. What does success look like?
   a. An increased number of Certified Peer Specialists, Certified Peer Counselors and available roles.
   b. Reduced number of redundant requirements for CPS.
   c. CPS are utilized more often in continuum of care.
   d. School implementation of Peer Support training (i.e. Students Providing and Receiving Knowledge, SPARK program in Pasco, Washington. 80 hours of training).
   e. Peer support is part of Multi-Tiered Systems of Support (MTSS) and a Natural Helpers program in all schools as Tier 1.
      i. Tier 2: Referral into Wraparound, WISe, for example; peers with higher level of experience.
   f. Fair salaries for peers.
5. What do we need to achieve that success?
   a. Funding, including funding that is consistent.
   b. Coordination of healthcare.
   c. Parental involvement, Schools, teachers, and admin need to be on board with peers; allowing people in schools can be difficult; messaging should include data, evidence, and why it's important; elicit questions; media campaign.
   d. Ensure the program is fully understood and accepted by all.
   e. Make Peer Certification easier to make the role billable.
   f. Marketing and advertising to raise awareness.

Breakout Discussion on Age of Consent

1. What is the problem?
   a. The age of consent has been based on chronological age, rather than whether or not a youth has the ability to make long term decisions. Perhaps it could be based on the developmental capacity of consent or expanding the mature minor statute to include behavioral health risk.
   b. Substance use isn't in the law for consideration when making "gravely disabled" determinations RCW 71.05.260.
   c. Family initiated treatment isn't working for families where children are in crisis.
   d. Decision makers and decision-making process are not clear.
2. Why does it matter?
   a. Age of consent was originally created to prevent forced, non-evidence-based treatment, allowing youth to seek care of their own accord.
   b. At-risk youth are able to avoid treatment even when it may be medically necessary.
3. What does success look like?
   a. Youth who want treatment have access.

        i. Resources are not used by parental force or youth who do not want treatment.
    b. Autonomy for youth that doesn't put them at further risk.
    c. More access to available treatment statewide.
    d. More Department of Health beds accessible statewide (only 109 available through CLIP)
4. What do we need to achieve success?
    a. Clear decision-making practices with guidance.
    b. Eliminate programs that are not evidence-based. (i.e. "Conversion therapy").
    c. Strong determinants for when inpatient treatment is needed.
    d. More language in the determination of "grave disability" around substance-use
    e. Better long-term/treatment programs.
    f. More facilities with good quality of care.

Following the meeting, Peggy Dolane shared a summary she produced of problems related to ITA and consent, recommendations, and a review of the relevant RCWS. This will be considered by the group for inclusion in what it submits to Washington Thriving.

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@bhcatalyst.org and michelle.karnath@clark.wa.gov.
2. The subgroup will meet next on July 1, 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.*