Youth and Young Adult Continuum of Care *September 29, 2020 – 3-5 pm*

No.	Agenda Item	Leads

1.	**Updates**
	SB 6560 – Youth exiting into homelessness
		Kim Justice (Office of Homeless Youth)
		• SB 6560 (2018) – directed OHY and DCYF to develop a plan to ensure youth exiting out of public systems exit into stable housing.
		• Legislation spurred by shocking data (2015) – Over the course of the year, data showed over 1800 young people exited state systems and experienced homeless; majority were exiting the behavioral health system.
		• Will share more recent data with this group when it is released.
		• Plan on OHY website:
		  ○ Ensure existing systems work
		  ○ Support local communities to support youth when they return
		  ○ Developing housing for youth exiting systems
		
		Sazi Wald (HCA, Division of Behavioral Health and Recovery [DBHR])
		• Look at transitions from inpatient to outpatient treatment, ages 15-25. Ensuring they get all the supports they need.
		• Using a co-design process to create VBP, education, and policy recommendations to HCA leadership.
		• In co-design phase – meeting with young people who are lived experts in IP and homelessness, parents and caregivers, and providers. To understand what things look like on the ground, and what we need to do to improve them.
		• Create recommendations and present to HCA leadership next Spring; finalize in summer.
		• Thank you all! Please reach out to me sazi.wald@hca.wa.gov 360-790-4560. I appreciate the invite, excitement, and opportunity to be here!
		
		Liz Trautman (Mockingbird Society)
		• This year's Youth Leadership Summit – raised issue: looking at the ways that state systems of care end up sourcing law enforcement for issues with homeless youth.
		• Examples: When young people are removed from their home to enter into foster care, when they're staying at a group home or a youth shelter and a behavioral health issue arises (potential arrests). Particularly profound implications for young people of color.
		• Ask: For all systems of care to step back and think about how their work happens and whether it's reinforcing or reducing the role of law enforcement in their clients' lives. Look at crisis response piece.
		• Looking at a few different places – contract language for OHY grantees, for example.
		
		Discussion
		• One area of potential alignment – BH crisis response teams for youth (Clark County, Catholic Community Services of Western WA).
		• Benton Co – police who only respond as MH responders.
		• Potential area: Young people can't consent to medical care without parent/ guardian. School option (McKinney-Vento); doesn't work in summers, times when kids are not

		in school, homeless/no parent or guardian. Young people have not been able to consent to their own COVID-19 tests. • What's unique about Clark County program – ongoing meetings for accountability; parent peer; seven day followup. • **Q:** Whose job is to carry the SB 6560 recommendations? **A:** *Kim: Work is being carried forward by a core team of agency representatives and stakeholders; that team continues to meet to map out implementation of the recommendations in the report. Broadly speaking, we need champions since agencies don't have dedicated capacity to solve these large, complex problems.* *Sazi: Once the recs to HCA leadership are finalized next summer, it will be clearer where these proposed solutions should go and how to move them forward. Moving other work, such as respite services, will be helpful.* • **Q:** Are all transitional housing concerns for independent youth, or do you also look to support the families who are bringing those youth back into the family residence who may also be unstable? **A:** *My hope is that this is for the span of circumstances. Thus the importance of co-designing with families as well so that transition linkage can be structured yet flexible to get each individual and family connected with each other what they need during the transition.* Thank you. Often a "home" looks much more stable then it is. • King County also has a crisis response team specifically focused on homeless youth ages 18-24. • **Q:** Do any of the existing crisis response teams serve youth under 18? *A: The one in Clark County does. Any youth under the age of 18.* *Pierce county does and I believe Catholic Community Services may also provide crisis response services in other counties as well.* *King County has Children's Crisis Response and Outreach System (CCORS) for those 3 – 18y/o. It is community based, and can provide services up to 8 weeks to stabilize the crisis.* • **Q:** How much of Section 8 or other HUD services used for these placement Sazi? **A:** *Options such as section 8 and other fabulous housing connections are definitely being explored!* • Rep. Davis, I am not aware of another group that is really taking this on and it sure seems to me that this would be a great group to do so…both in the short and long term! • Agreed. I see this as a form of a "step down" support system for some that are at a high level of therapeutic success. As in working with the homeless adults in our area, when you know where to find your clients you can also service them more fully. • **Action item: Kim will review the report's recommendations and determine if there is something that could move forward this year.**
2.	Family Initiated Treatment (FIT)	**Kimberly Wright** (HCA, DBHR) • FIT program manager – report coming out in September. • 2020 Survey of youth, parents, and providers. • 216 respondents – 63% providers, 5% youth (11 youth), 31% parents (68). • This year baseline – doing the survey for 2 more years. • Looking at how to get broader reach, more youth and parents. • Parents: More than 70% believed FIT helped youth get access to services they need; more than 70% felt like parents did not get enough support….?

		• Parents: access to services, wait times, access to services, lack of discharge safety plans, others • Providers; Most substantial barrier – lack of understanding of how to use FIT, lack of agency policies, lack of bed • Identified opps from survey for improvements • Online training in development, engagement training for providers • Ongoing TA by phone **Discussion** • **Q:** Timeline for modules? **A:** *Have 3 training modules – (1) overview, (2) policy and process (for parents and providers), (3) engagement (for providers). Ensuring that they have appropriate guidance – complex statute. Roadblocks – COVID, contracting.* • To whom are you doing the outreach? • Could you do outreach to parents through schools? • **Q:** Is there an opportunity to do in-person training? **A:** *Original plan was in-person training. Then COVID-19. One-on-one TA?* • **Q:** Any communications to all providers? **A:** *Did listserv announcements to all providers and all hospitals.* • Ricky's Law – WSHA did a couple of webinars – but doesn't reach all providers. Repetition is key, hooks, carrots, etc. • If you hear about providers who need TA, let us know through the inbox. • **Q:** Outreach to school counselors, primary care providers, OSPI BH navigators? Communities that serve POC? Non-English speaking communities? Partnerships? **A:** *Have done outreach to SBHCs early on. Agree. Appreciate partnerships.* • Reach out to Assn of WA Principals, OSPI. • Navigators and community educators at MCOs – how to reach out to young people? If there is a desire for partners, they are doing this work, too. • **Q:** What's the threshold where a family's child would not get treatment? **A:** *Threshold for medical necessity is the same for FIT as other treatment.* • Ann Gray offered to get info out to BH navigators. • It still sounds like the biggest issue around HB1874 is education. • They're often the "front line" for hearing MH concerns and the need for outpatient tx. • The awareness training probably needs to extend to providers as well as families. • I am concerned about participation for the modules when places like Seattle Children's offered more than one training for providers and it was not attended well. *That's a really important note. There are training materials that can be shared, but there will need to be direct connections with providers to build that network.* • We have found a lack to conform or wish to participate as it is a choice. • This is part question/part "please consider" – would be great to educate those who will hear about youth MH concerns at the beginning (school counselors, primary care providers, and staff, OSPI, behavioral health navigators, etc.) and not only focus on behavioral health providers. Have those groups been considered for outreach? *Our CYF team works very closely with OSPI, and will continue to work with them moving forward. Specifically we will be working with OSPI to ensure the navigators have access to the FIT information. There could be presentations at regional FYSPRTs as well.* • I just off a call with Community Educators/Navigators re: educating youth in Juvenile Rehab (primarily youth of color) on Medicaid/MCOs/Services. Could this be an education partner also?

		• There is a lack of understanding of it being a law. • I can help get this information out through OSPI and the Behavioral Health Navigators that are housed in all the ESD's. Thank you! • Notably "medical necessity" is a lower standard required for ITA (likelihood of serious harm or gravely disabled). • I am excited to connect with anyone interested in furthering this work please feel free to reach out to me at either HCAFamilyInitiatedTreatment@hca.wa.gov or Kimberly.wright@hca.wa.gov we also have more information on FIT available at www.hca.wa.gov/FIT and www.hca.wa.gov/FITproviders
3.	**Recommendation development** Timeline/Framing	• Budget shortfall – roughly half of what was previously forecast (originally $8.8B). • Opportunities for revenue generation for behavioral health. • If we don't expand BH, loss of life and loss of quality of life would be substantial. • Focus on issues that this group could make a unique contribution that is not being handled elsewhere.

4.	**Recommendation development**
	Goal: Winnow down list to 2-4 recommendations we want to pursue for this session.
		Potential recommendations (raised at several meetings)
		• Expand youth/family peer support
		  ○ Peers in lower levels of care (outpatient) and higher levels of care (inpatient)
		  ○ Targeted recruitment/retention of peers of color
		  ○ Emotional support for peers in the workforce
		• Transition care for discharge from inpatient behavioral health and juvenile justice
		  ○ Use of technology (e.g., apps)
		  ○ Peer bridger model
		• Expand youth mobile crisis services
		
		Breakout Group 1 – Discussion summary
		Most of our conversation was around Peers
		1. Expand workforce
		2. Increase pay/livable wage
		3. Provide support for agencies employing peers
		4. Move to a community based model and not embedded in a behavioral health agency/system
		5. Provide appropriate support and education for peers
		
		We also discussed Youth Mobile Crisis Services and having the ability to provide a response to a youth/family that would avoid contact with law enforcement and divert from hospitalization.
		1. Utilize peers in this model
		2. Improve crisis line so better access to the mobile team
		
		Breakout Group 2 – Discussion summary
		Big picture:
		• Fundamental problems:
		  ○ Lack of resources/equitable access in some parts of the state.
		  ○ Lack of Step Down and Step up services.
		Peers:
		• Need for legal support and training for peers (and families) as well.
		• Barriers to peers within some higher levels of care.
		• Need a deep dive into what some of the barriers are – such as what Medicaid will and will not pay for, how to bridge services from JJ (no Medicaid) to after release.

		• Need research to cite, to back up the work that peers are doing. Transition from JJ: • Do we support work others are doing, or is this work for this group to lead? Crisis mobilization: • Did not get to as a separate item, but talked about it in terms of getting these types of services to parts of the state that don't currently have them. (regional equity). **Discussion/Chat** • Parent Partners and Peers in WISe need better training! • AMEN. The level of crisis is far higher than the level of experience and ability. • A comment on retention of Peers/staff/people of color from another conversation I was just in. There is an incorrect assumption that DNI increases innovation. If diverse staff are going into an environment that breeds or requires assimilation into the existing agency/work/environment culture it will only lead to poor retention. I would agree and assert an essential issue is doing the work to insure and support retention, not just getting people 'in the door'. • Additionally, when it comes to apps. One that might be interesting to explore for case management, transition and community connection for both client and provider might be Aunt Bertha.
5.	**Closing/Next steps**	Next meeting: Thursday, Oct. 8 **Action item: Arrange experts/presenters to provide info/input re recommendation issues**

Attendees

Kashi Arora (Seattle Children's)
Kevin Black (Staff, Senate Human Services)
Rachel Burke (HCA)
Becky Daughtry (HCA)
Rep. Lauren Davis
Rep. Carolyn Eslich
LaRessa Fourre (HCA)
Ann Gray (OSPI)
Kimberly Harris (HCA)
Theresa Hoke
Avreayl Jacobson (King Co Behavioral Health and Recovery)
Charlotte Janovyak (Asst to Rep. Davis)
Kim Justice (Office of Homeless Youth, Dept of Commerce)
Michelle Karnath (Clark County Juvenile Court, FYSPRT Parent Tri-lead)
Annette Klinefelter (A+K Ingenuity)
Laurie Lippold (Partners for Our Children)
Enos Mbajah (HCA)
Penny Quist (Parent advocate)
Ted Ryle (Juvenile Rehab, DCYF)
Janice Schutz (Washington State Community Connectors)
Rep. My-Linh Thai
Jim Theofelis (A Way Home Washington)
Liz Trautman (Mockingbird Society)
Bobby Trevino (Consultant)
Sazi Wald (HCA)
Rep. Emily Wicks
Kimberly Wright (HCA)