Notes

Children and Youth Behavioral Health Work Group (CYBHWG)

August 8, 2024

Current impact of opioids and fentanyl

Tao Kwan-Gett*, Department of Health (DOH)*
See TVW recording (10:04), see page 5 for slides

Highlights

- An overview of the latest data was given on Opioid and overdose deaths for children and youth.
- An update from Department of Health (DOH) Centers of Excellence for Prenatal substance use.
- Developments were shared on overdose education and naloxone distribution.
- Shared ideas were presented on the ways to decrease overdose deaths among children and youth in WA.

Youth treatment

Kris Shera, Jessica Blouse, Lauren Kula, and Amanda Lewis, *Health Care Authority (HCA)*
See TVW recording (35:50), see page 21 for slides

Highlights

- Language matters to reduce stigma around substance use; use Medication for Opioid Use Disorder (MOUD) instead of Medication Assisted Treatment (MAT).
- Recovery can mean different things to different people.
- There are three approved MOUD medication, this includes Methadone, Buprenorphine products (Suboxone, Sublocade, and Brixadi) and Naltrexone products.
- Goal is to stabilize and nonmaize a person's brain chemistry; similar to medicating for depression or anxiety.
- The current state of youth treatment was shared with attendees.

Medication for opioid use disorder

Dr. Kym Ahrens
See TVW recording (1:01:40), see page 41 for slides

Highlights

- An overview of clinical guidance around medication management was shared with attendees.
- Presentation slides shared the following:
    - US youth overdose trends.
    - Criteria for opioid use disorder (OUD).
    - The benefits of MOUD treatment.
    - An overview of access barriers.

Notes

School information for youth substance use

Rebecca Purser, Annie Hetzel, Brisa Sanchez, and Tammy Bolen, *Office of Superintendent of Public Instruction (OSPI)*
See TVW recording (1:26:30), see page 62 for slides

Highlights

- The presentation gave overview of fentanyl education
- OSPI presentation topics include:
  - Tribal schools Opioid Education Pilot project (HB 1956)
  - Opioid overdose response in schools (SB 5804)
  - Training and update to health standards
  - Project AWARE: advancing wellness and resilience in education

Recovery High School

Jennifer Wyatt, *King County*
See TVW recording (2:00:11), see page 91 for slides

Highlights

- An overview of the Seattle Public schools Interagency Academy was presented
- The Interagency Recovery Campus educates students up thorough age 21 who are working recovery programs in a sober setting.

Resource

- Interagency Recovery Campus Brochure and Briefs - 2023

Breakout Group Session

Highlights

Question
From what you have learned, where do you see the gaps and barriers that this group will need to be aware of related to opioid and substance use?

Comments

- What about youth with Intellectual and Developmental Disabilities (IDD) and Autistic Spectrum Disorder (ASD)? Cannot find a treatment provider to provide this treatment.
- Discussed opportunity for University of Washington (UW) counseling, Referrals, and PALS.
- Do private insurance companies have the same access?
- Teachers and counselors don't know what to do…what do we do about that?
- Discussed the stigma…how that plays into the issues. How do we help youth understand their options and choices.
- Blindness of exposure. Being in education, PK-12 system, we're thinking of little ones. When we think of Early Childhood Education and Assistance Program (ECAP) and Head start kids, we don't want to expose them to things they are not exposed to.

- When we think of all of the Social Emotional Learning (SEL) work that needs to be done, those skills and teachings are crucial for those kids to be able to process when big things are happening around them.
- Developmentally appreciate education is needed. A lot of times youth with IDD are not considered when thinking about opioids but often are quite vulnerable to circumstances.
- I'm big on social connections, while we need better pharmacological approaches, how are we building in social connections.
- We didn't have discussion during the presentations about how we generally don't have the workforce we need to be able to implement these key treatments. Rural communities may not even have a pediatrician, much care may be provided by Advanced Registered Nurse Practitioner (ARNP)'s and Physician Assistants (PAs) not physicians.

Question

Are we acting on everything we need to be across the continuum of care in relation to opioid and substance use?

Comments

- Propose the proviso that brings peer support into the hospitals immediately. And peer support will follow. Would there be an opportunity to do this in the schools?
- How do we truly move towards integrated care models where this is offered in any environment, not with the expectations of other treatment.
- Trauma treatment for youth is hard to find. We have "trauma informed care" but that's not the same thing. We need actual screens for trauma and treatment. Mobile response and the MRSS models, need trauma informed care but also, do they carry Naloxone? Can they do that? If someone goes out to a crisis call, can they appropriately respond?
- You never know where the trusted relationship will happen, whenever we have practitioners working with a family, if you go in and there are teenagers, and the family is concerned about Substance Use Disorder (SUD). How to do help people who are in the home/community to know how to help?

Crisis Response Improvement Strategy (CRIS)

Matt Scanlin, *Department of Health (DOH)*
See TVW recording (2:16:20), see page 97 for slides

Highlights

- An overview of the connection between 988 and 911 was shared with attendees.
- The 988 lifeline is a free, confidential service that offers support for individuals with thoughts of suicide, mental health crisis, substance use concerns, and any other kind of emotional distress.

Public Comment

See TVW recording (2:25:00)

- North King County has been doing some really excellent work at building a crisis continuum of care, and we're very happy to now, have built a complete crisis continuum of care with 988.
- The racer program and the crisis stabilization opening up in Kirkland. The follow up from those providers is astounding for our community members. We're very grateful to have it, and I'm really.

- Using this opportunity to speak to the need for building a mental health treatment system so that our crisis can actually refer people to treatment settings that can help people get into recovery.
- We need to lower the barriers to get into mental health treatment, so that fewer of our kids have to be sent out of state.
- There is a significant amount of learning loss; so, it is important that school districts are involved in these conversations in so many ways.
- How do we make it easier for kids in a residential treatment to stay in school and continue having opportunities to learn?

Closing

Watch on TVW

OPIOID UPDATE

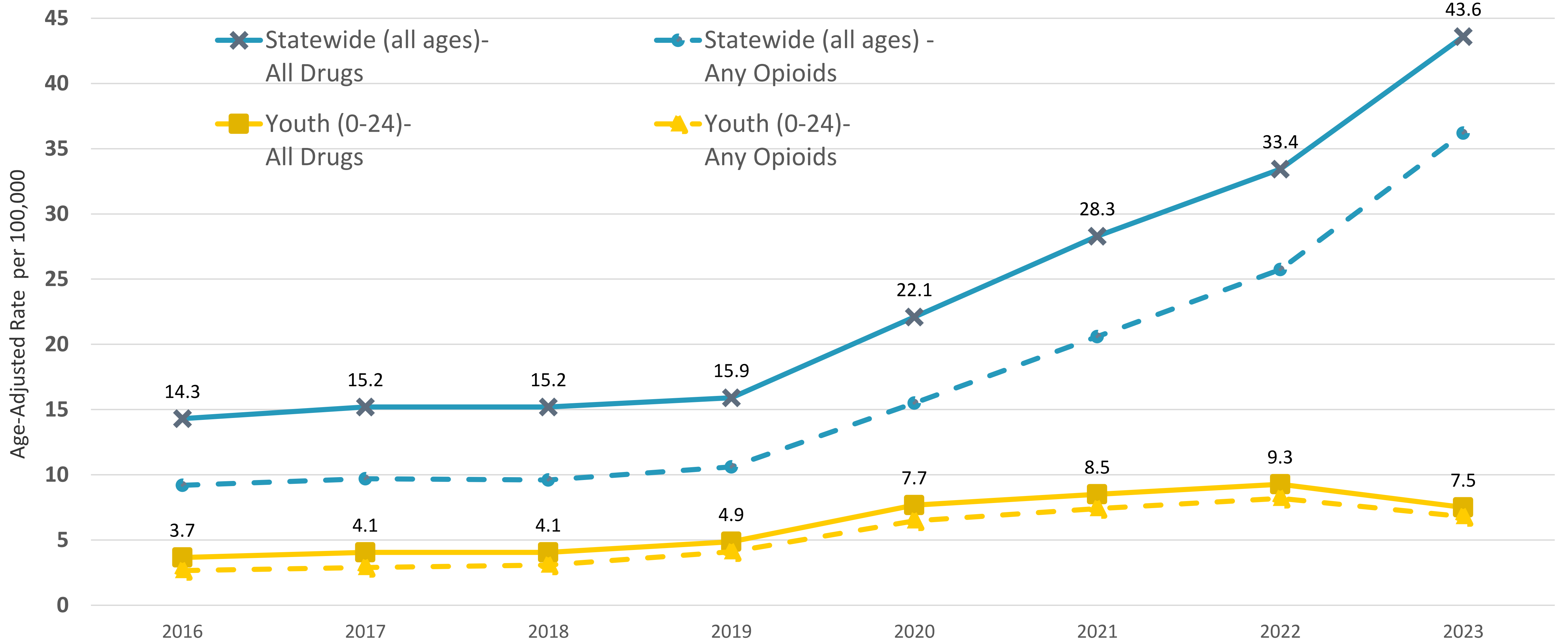
FOR THE CHILDREN, YOUTH, AND BEHAVIORAL HEALTH WORKGROUP

TAO SHENG KWAN-GETT, MD MPH
CHIEF SCIENCE OFFICER
AUGUST 2024

Opioid update

- Data on children and youth
- Centers of Excellence for Perinatal Substance Use
- Naloxone
- Preventing opioid overdose in children and youth

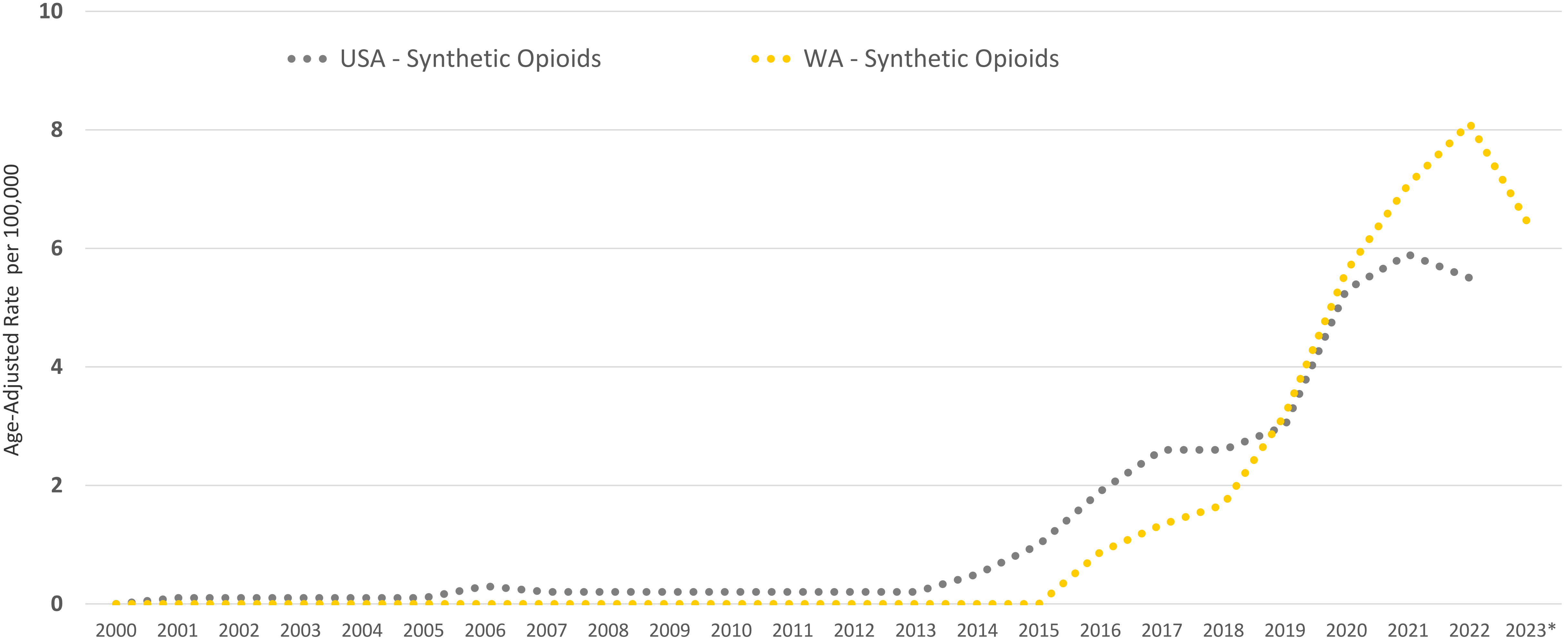
Washington Drug Overdose Death Rates, All Ages and among Youth 2016 – 2023*



WA Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data.
Data Last Updated on: July 29, 2024.

*2023 rates are preliminary and expected to change.
2023 rates are calculated based on 2022 Population Interim Estimates

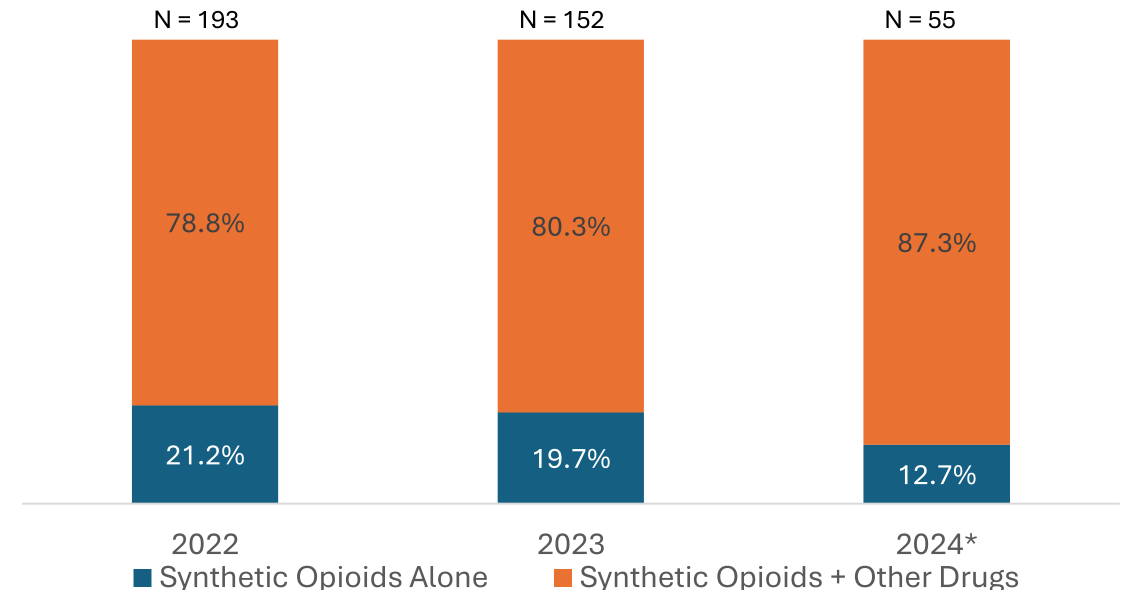
Overdoses involving Synthetic Opioids among Youth (ages 0-24), USA and WA State (2000 – 2023*)



*USA 2023 rates are currently unavailable. WA 2023 rates are preliminary and expected to change.
WA Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data. Data last updated on July 29, 2024.
USA Data Source: CDC WONDER

Polysubstance Use and Drug Combinations among Youth (24 and under), 2022-2024

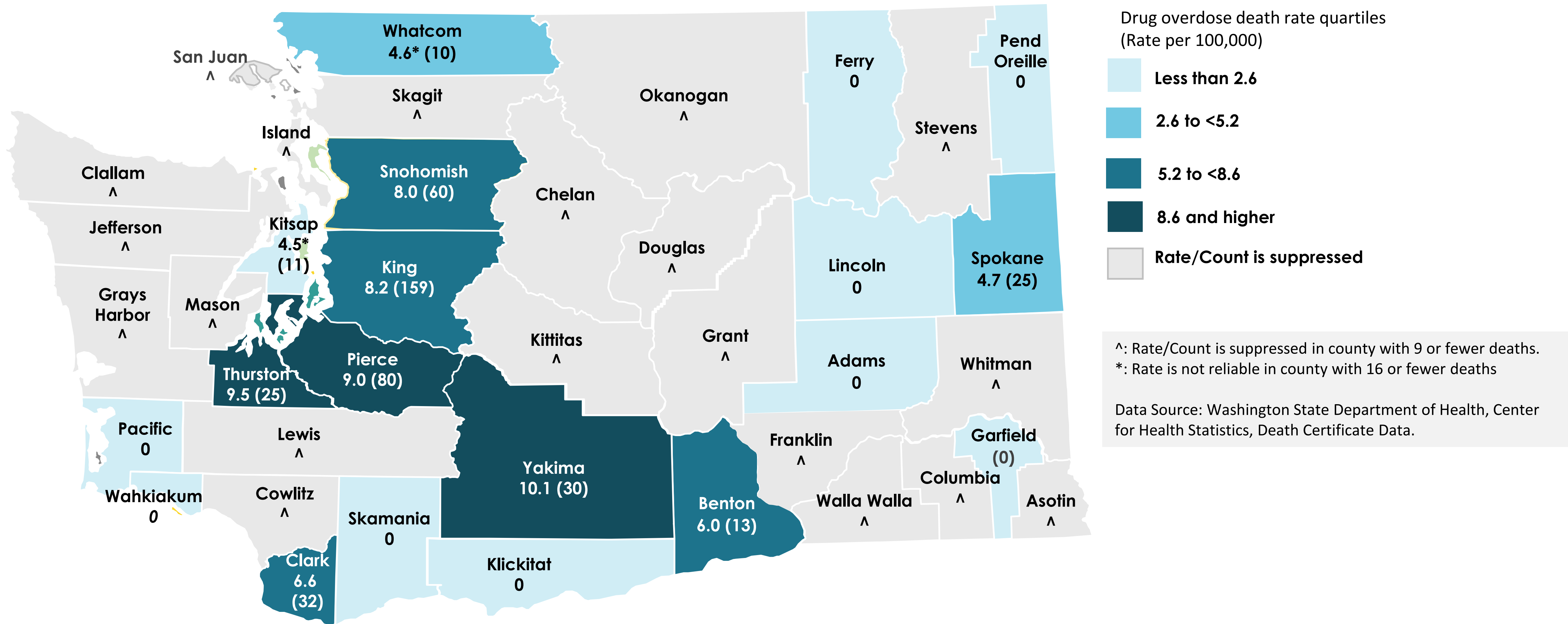
- Among 2022-2024 youth deaths that involved synthetic opioids (predominantly fentanyl):
  - **19.5%** (78) involved only synthetic opioids
  - **80.5%** (322) involved synthetic opioids + 1 or more other drug types



- Top combinations for synthetic opioid involved deaths:
  - Synthetic Opioids + Psychostimulants (72)
  - Synthetic Opioids + Alcohol (20)
  - Synthetic Opioids + Cocaine (15)
  - Synthetic Opioids + Sedatives (12)

*2023 and 2024 data is preliminary and expected to change.
Data Sources: Washington State Department of Health, Center for Health Statistics, Death Certificate Data. Data last updated: July 29, 2024.

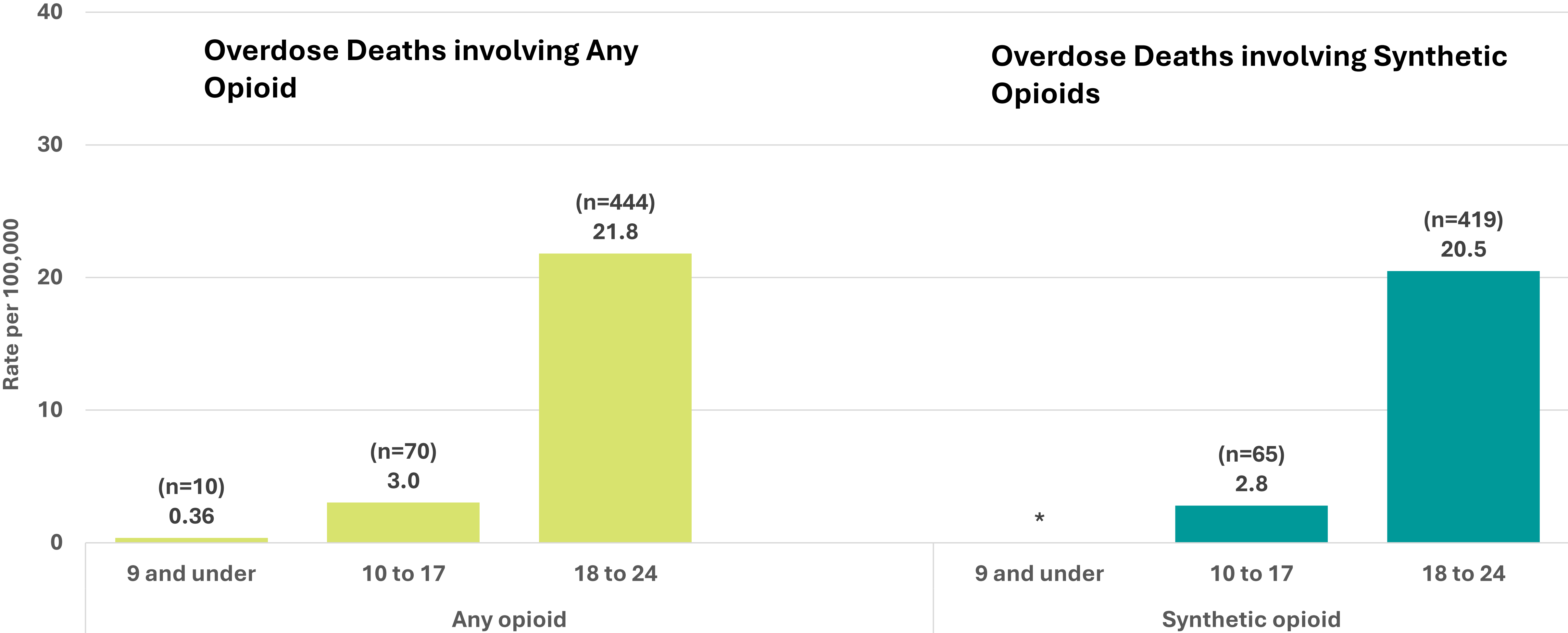
Opioid Involved Overdose Deaths among Youth by County 2020-2022



^: Rate/Count is suppressed in county with 9 or fewer deaths.
*: Rate is not reliable in county with 16 or fewer deaths

Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data.

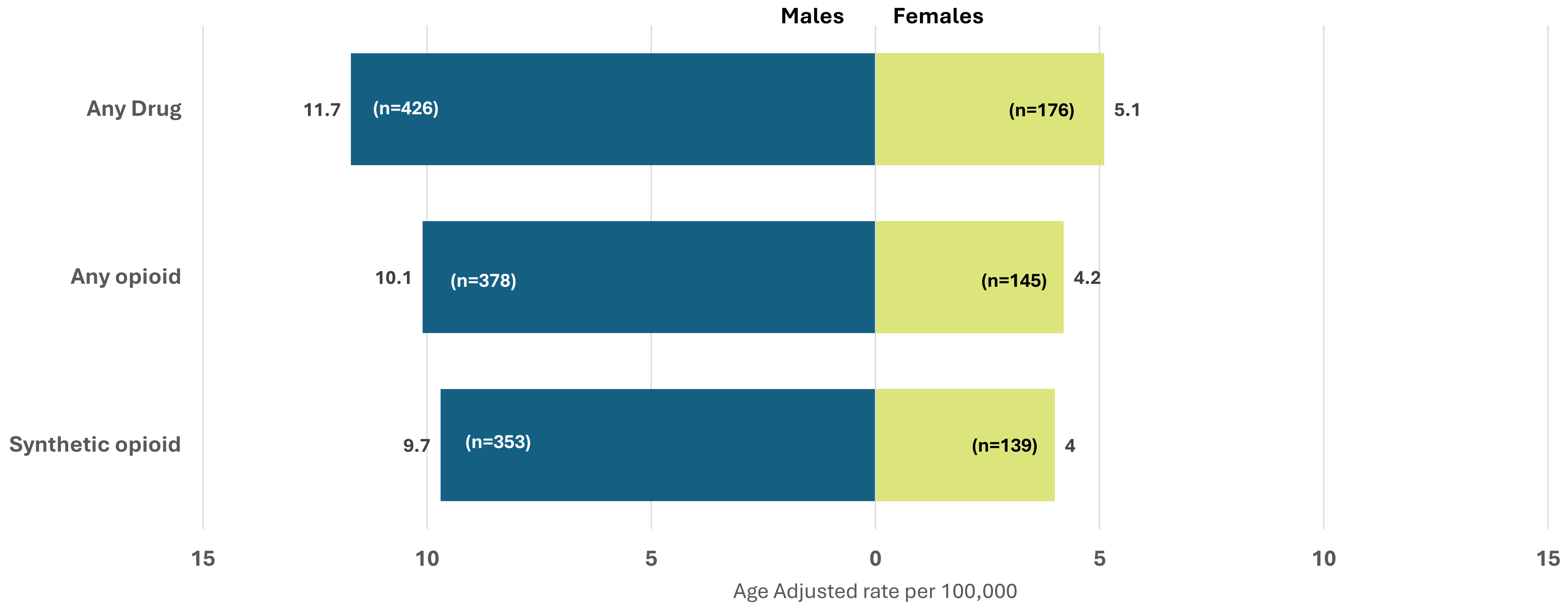
Opioid Overdose Death Rates by Age among Youth 2020-2022



Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data.

* Rate suppressed, count 9 or less
Youth: 0 to 24 years

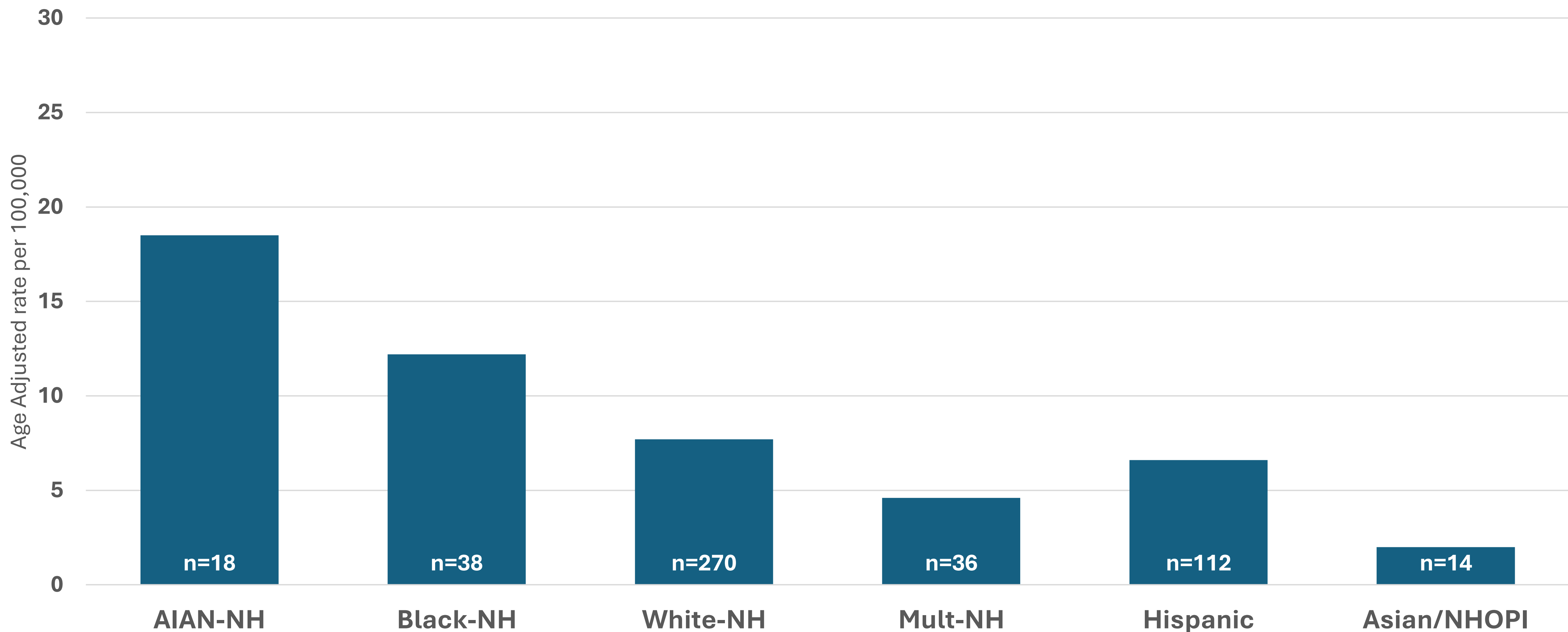
Drug Overdose Deaths by Gender among Youth 2020-2022



*2022 data is preliminary and will change.
Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data.
Data last updated: July 29, 2024

Youth: 0 to 24 years

Rates of Drug Overdose Deaths Involving a synthetic opioid by Race/Ethnicity among WA youth (2020-2022)



Abbreviations: NH: Non-Hispanic; AIAN: American Indian/Alaskan Native; NHOPI: Native Hawaiian/Oher Pacific Islander; Multi: Multiracial
Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data. Data last updated: July 29, 2024

*2022 data is preliminary and may change.
Youth: 0 to 24 years

Notes for drug overdose deaths among children (5 and under) 2022-2024*

- Between 2022 to 2024, 21 children (ages 5 and under) died of a drug overdose.
- Most common drugs involved: Fentanyl (17), Meth (5); Heroin (1); Buprenorphine (2); Methadone (1)
- Common themes
  - Parent waking up to find their child unresponsive (11)
  - Parental drug use leading up to/at the time of the overdose (10)
  - Bed sharing (8)
- Potential routes of exposure included ingestion (10), unknown/no evidence (10), and possible inhalation (1). None of the cases reported that the child was witnessed being exposed to drugs

*2023 and 2024 data is preliminary and expected to change.
Data Sources: State Unintentional Drug Overdose Reporting System (SUDORS)
Washington State Department of Health, Center for Health Statistics, Death Certificate Data. Data last updated: July 29, 2024.

Center of Excellence for Perinatal Substance Use

Background

- Birthing Hospital certification program based on Maternal Mortality Review Panel report recommendations
- Collaboration between DOH, HCA, and WSHA

Purpose

- Improve the care of birthing people and infants affected by substance use
  - Screening for SUD, mood and anxiety disorders
  - Providers with expertise in MOUD on site or by consult
  - Allows birth parent and infant to room together
  - Promote breastfeeding
  - Prioritize nonpharmacologic interventions for infant withdrawal symptoms
- Provide evidence-based information for providers and healthcare facilities
- Offer resources and support for hospitals to make system wide changes to policies and practices (e.g., Plan of Safe Care)

Certified Hospitals

as of July 2024

- UW Medical Center– Northwest
- Providence Sacred Heart Medical Center
- Holy Family Hospital

Naloxone and children & youth

Naloxone is a safe medication that can be given to anyone

- Its only action is to to block the effects of opioids.
- From the American Academy of Pediatrics' parent info website: "There is virtually no downside to giving naloxone to a child or teen, even if you are not sure if they overdosed on opioids."
- The CDC and FDA do not have age limits on who may receive naloxone.

No minimum age for administering it

- Young people can possess naloxone and use it on someone they think is having an overdose.
- Many communities have trained students from elementary through high school age in opioid overdose recognition and use of naloxone.

Overdose Education & Naloxone Distribution Program

- DOH provides naloxone to over 700 entities serving people at high-risk for experiencing opioid overdose, including youth shelters and DCYF Juvenile Rehabilitation facilities.
- DOH partners with Educational Service Districts (ESDs) to offer two naloxone kits and refills to all public high schools and alternative high schools
  - This effort is a complement to, not a replacement for, any existing efforts related to naloxone in schools.
- In the last legislative session, DOH received a budget proviso of $345,000 for the purchase and distribution of intranasal naloxone for barrier-free and cost-free distribution to high school students.
  - DOH is currently working with OSPI, ESDs, and other partners to determine the best way to implement this.

Preventing opioid overdose in children and youth – what's needed

- Aggressive efforts to make MOUD more accessible to parents/caregivers, children, youth
- Expand naloxone distribution and other harm reduction services
- Increase access to diagnosis and treatment for mental and behavioral health services
- Greater social and emotional education starting in early childhood to give youth tools to manage stress
- Aggressive efforts to increase social connection and after school activities that give kids a chance to connect with each other, with adults, and with their communities

Social Connection

Improves your heart and brain health[17]

Humans are social beings. That doesn't mean we all have to be the life of the party, but strong, supportive relationships are proven to boost mental and physical health. Like any new wellness habit, working to improve your social connections and relationships can feel awkward at first. And that's ok! Try something new and see how it goes – the results might surprise you.

Bewellwa.org

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Lauren Kula, MSW, SUDP

Amanda Lewis, BA, SUDP

August 8, 2024

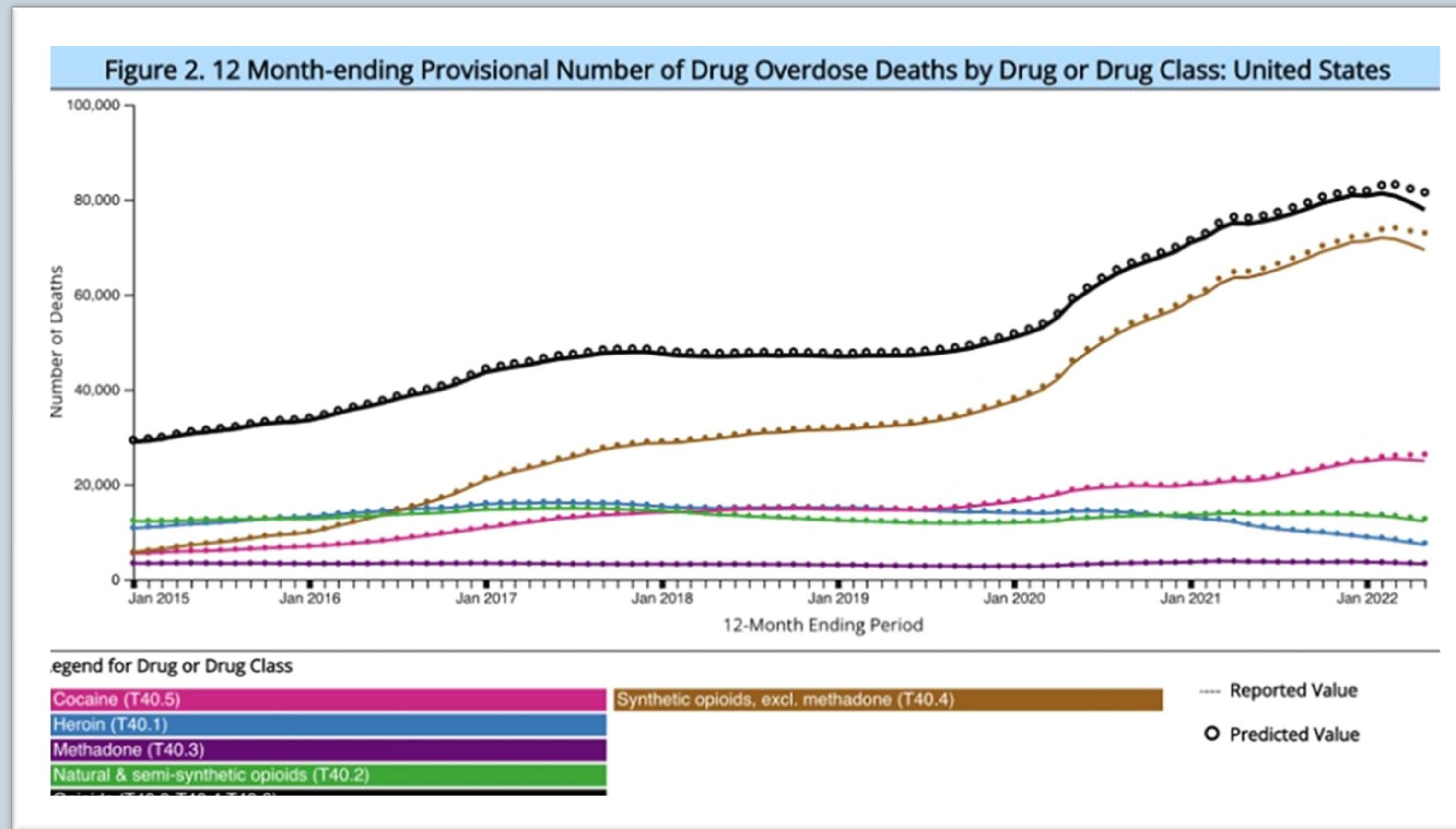
Washington State Health Care Authority

Introductions

- Lauren Kula (she/her), MSW, SUDP
  - HCA/CQCT, State Opioid Treatment Authority Team, Opioid Treatment Quality Improvement Program Manager

- Amanda Lewis (she/her), BA, SUDP
  - HCA/DBHR, Prenatal to 25 Lifespan Behavioral Health Section, Youth Substance Use Disorder, Co-occurring Treatment

Opioid epidemic



https://www.psychiatry.org/patients-families/opioid-use-disorder

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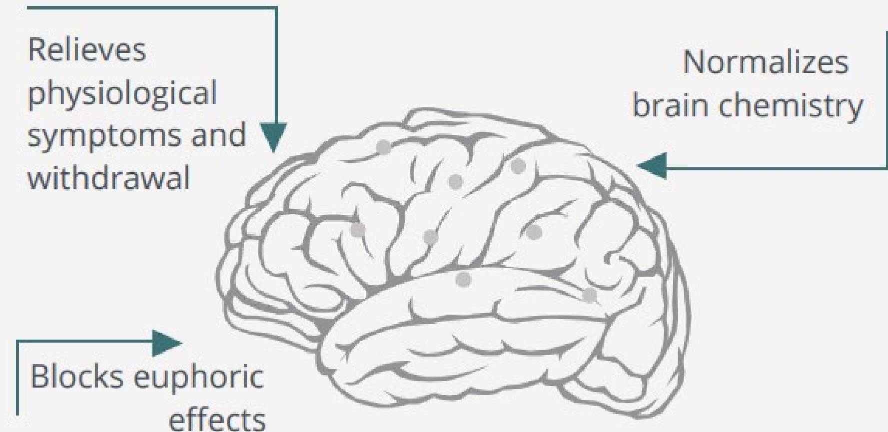
Stigma

Language Matters to Reduce Stigma		
Instead of…	Use…	Because…
• Opioid substitution replacement therapy • Medication-assisted treatment (MAT)	• Opioid agonist therapy • Pharmacotherapy • Addiction medication • Medication for a substance use disorder • Medication for opioid use disorder (MOUD)	• The term MAT implies that medication should have a supplemental or temporary role in treatment. Using "MOUD" aligns with the way other psychiatric medications are understood (e.g., antidepressants, antipsychotics), as critical tools that are central to a patient's treatment plan.

Medications for Opioid Use Disorder (MOUD)

- FDA-Approved medications for opioid use disorder:
  - Methadone
  - Buprenorphine products (suboxone, Sublocade, Brixadi)
  - Naltrexone products (naltrexone)



https://www.addictionpolicy.org/post/medications-for-opioid-use-disorder-infographic
https://www.psychiatry.org/patients-families/opioid-use-disorder

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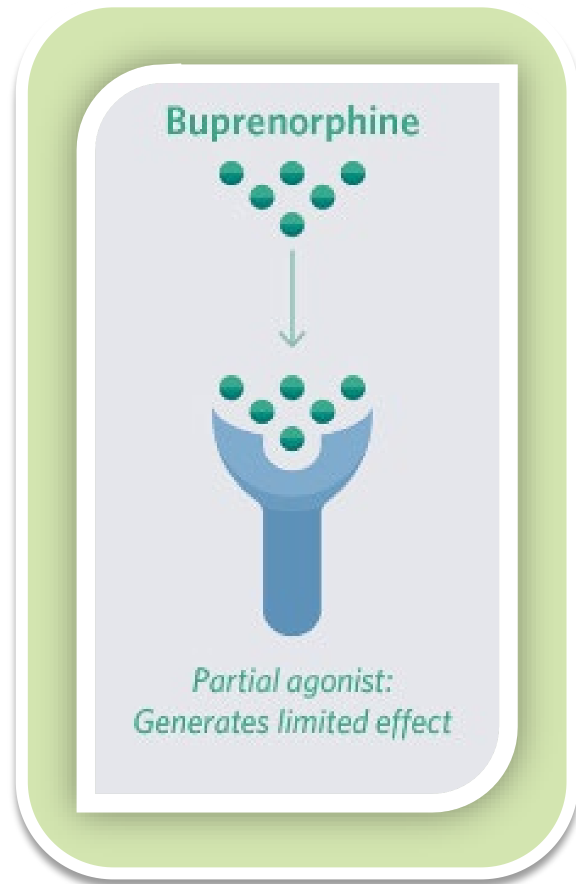
Methadone

- Full opioid receptor agonist
- Manages craving and withdrawal symptoms
- Lowers risk of death by 50%
- Lasts about 24 hours, oral medication
- Only dispensed at Opioid Treatment Programs (OTPs)
- Youth – 18 and older, there are exceptions, no need for Medicaid prior authorization.

https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes
MOUD-Brochure-2023-1_ENG_Web.pdf (stopoverdose.org)

Buprenorphine



- Partial opioid agonist - buprenorphine and naloxone
- Has a ceiling effect, high unlikelihood of overdose
- Lowers risk of death by 50%
- Oral and injectable
- Can be prescribed by a medical provider and picked up at a pharmacy or given as an injection by a medical provider
- Youth - FDA labeling for 16 and older, providers can make their own clinical decisions, no need for Medicaid prior authorization.

https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes
MOUD-Brochure-2023-1_ENG_Web.pdf (stopoverdose.org)

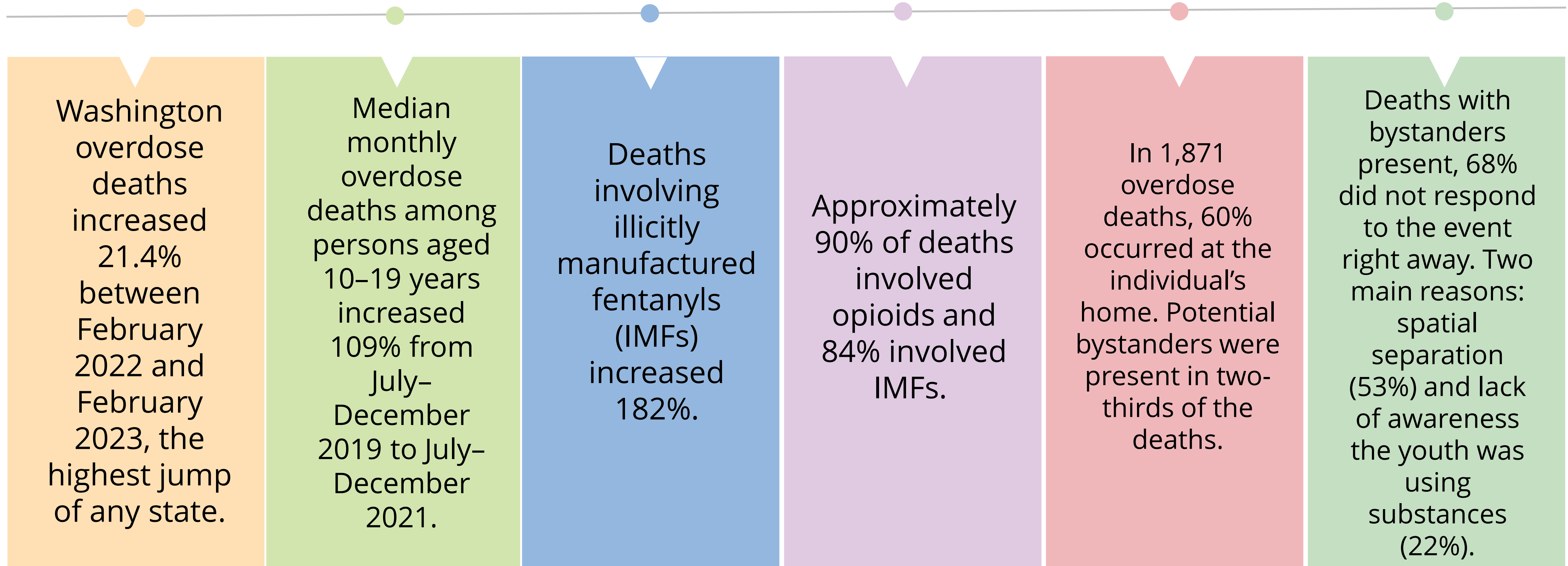
Naltrexone

- Opioid antagonist, blocks opioid receptor
- Helps manage cravings
- Injection formulation
- Prescribed and given by a medical provider
- Must not have any opioid in system prior to injection
- Youth - 18 and older, providers can make their own clinical decisions, no need for Medicaid prior authorization.

https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes
MOUD-Brochure-2023-1_ENG_Web.pdf (stopoverdose.org)

Youth considerations

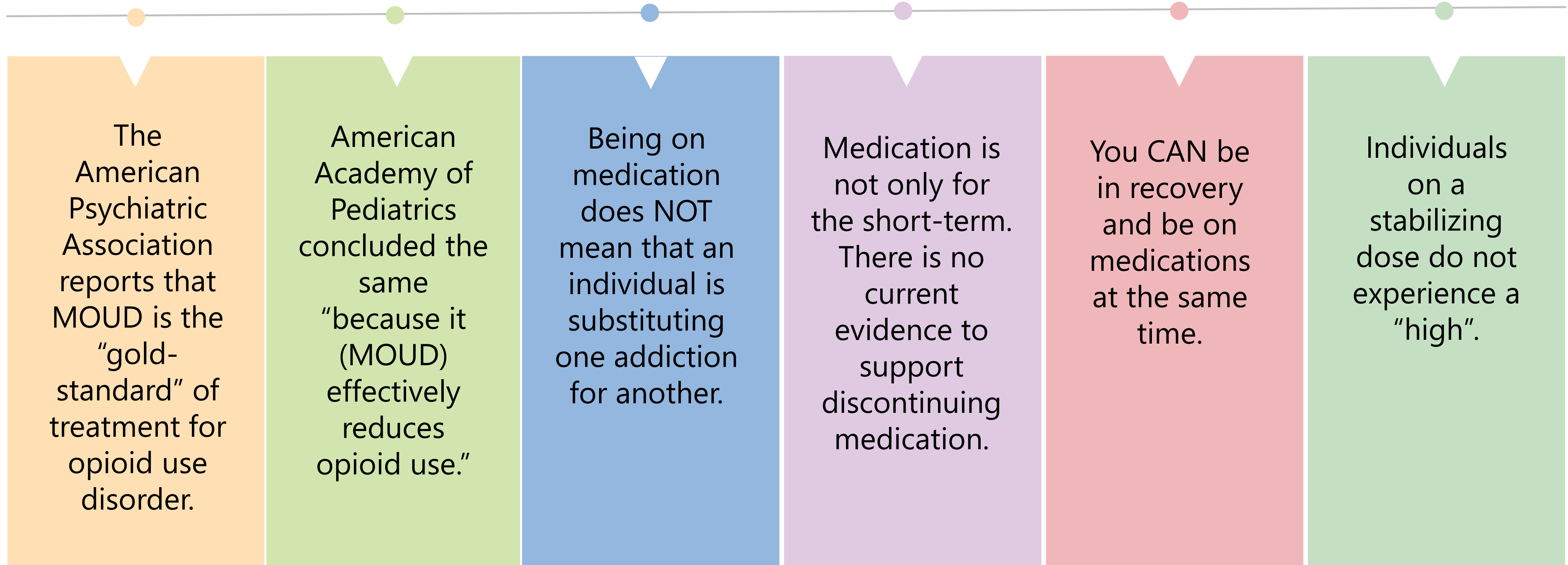
Statistics from the CDC December 2022



https://www.cdc.gov/mmwr/volumes/71/wr/mm7150a2.htm#:~:text=Median%20monthly%20overdose%20deaths%20among,opioids%20and%2084%25%20involved%20IMFs

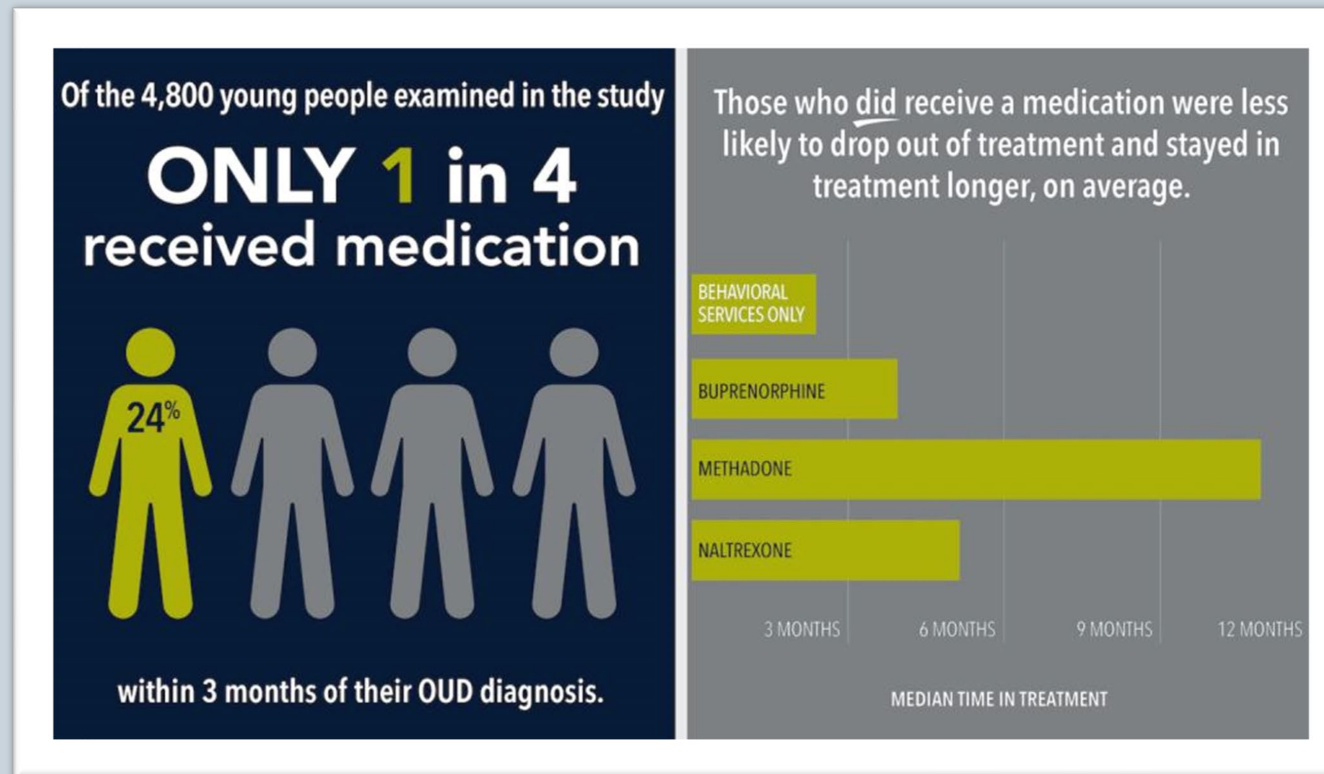
Youth considerations

Statistics from the CDC December 2022



https://publications.aap.org/pediatrics/article/143/2/e20182752/37310/Youth-and-the-Opioid-Epidemic
https://www.psychiatry.org/patients-families/opioid-use-disorder

Youth considerations



https://jamanetwork.com/journals/jamapediatrics/article-abstract/2698965?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamapediatrics.2018.2143

https://healthcity.bmc.org/research/few-youths-receive-recommended-meds-addiction

Additional considerations

- Yale study in Connecticut and the Drug and Alcohol Dependence journal noted that "compared with no treatment at all, methadone and buprenorphine reduced the risk of death by 38% and 34%; non-medication-based treatments increased the risk of death compared to no treatment by over 77%."
- They assessed how many of Connecticut resides who died from opioid poisoning in 2018 had sought medications, abstinence-based treatment, or not treatment for OUD at any point in the 6 months prior to their deaths.

> Terms like 'getting clean' and even 'recovery' stigmatize use of proven medications, hindering willingness to receive effective treatment.
>
> —ROBERT HEIMER

https://news.yale.edu/2023/12/19/treating-opioid-disorder-without-meds-more-harmful-no-treatment-all
https://www.sciencedirect.com/science/article/pii/S0376871623012784?via%3Dihub

MOUD discrimination

- Federal and Washington State law (ADA and WLAD) protects individuals for the treatment of their mental health and substance use disorders against discrimination in all health care setting environments.
  - WAC 246-341-1108(8)
  - WAC 182-502-0016(4)

Substance Use Disorder is a Disability

Discrimination against people with disabilities is unlawful. Substance use disorder is a condition that results in impairment in daily lift. *Accordingly, under the Washington Law Against Discrimination ("WLAD"), RCW 49.60.040(7) the definition of "disability" covers substance use disorder.

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SOOR Goal #2 YYA Treatment Subgroup Survey

- State Opioid and Overdose Response Plan Treatment Workgroup formed a temporary youth and young adult subgroup
- A survey was distributed asking respondents to prioritize response efforts that were in the form of goals and activities
- Survey was distributed in October 2024 for two weeks. A total of 552 responses from varied behavioral health partners throughout the state.

SOOR Goal #2 YYA Treatment Subgroup Survey

- Results by goal, top priorities are highlighted in blue.

COMMUNICATIONS | Develop and implement a communications plan related to youth and young adult access to care, identification and treatment of substance use, co-occurring disorders.	Prioritization (Avg ranking)
Parent and caregiver education for OUD, including harm reduction principles and access to naloxone.	1.9
Better understanding of existing MOUD prescribers, what substance use disorder (SUD)/opioid use disorder (OUD) services and supports are available state-wide.	2.3
Creating partnerships with adult providers for peer-to-peer learning.	2.8
Technical assistance, provider support, and guidance protocols.	3.1

CONTINUUM OF CARE | Identify and build needed services across the continuum of care that are developmentally appropriate, easy to access and available statewide.	Prioritization (Avg ranking)
Early intervention, identification, and referral to services.	2.5
Crisis services.	3.4
Referral pathways to behavioral health care via juvenile justice, education, healthcare, parents/loved ones.	3.5
Co-occurring residential treatment, intensive outpatient treatment.	3.8
Withdrawal management and stabilization.	4.1
Discharge, transition planning for different levels of care.	5.2
Caregiver (respite) support.	5.7

INCREASE ACCESS | Establish low barrier access to MOUD treatment options in every region of the state, increasing number of young people referred to and accessing MOUD and behavioral health treatment services. This also includes access to naloxone and drug overdose prevention and education.	Prioritization (Avg ranking)
Access to naloxone and training in schools.	2.3
Training and education for behavioral health, health care providers, and families (i.e. age of consent, ability to prescribe to youth).	2.3
Screening and referral to MOUD treatment from juvenile justice system, emergency department post opioid overdose, outpatient, etc.	2.6
Increase number of youth prescribers statewide	2.9

USE OF EVIDENCE-BASED, RESEARCH-BASED (E/RBP), PROMISING PRACTICES AND THE EFFECTIVENESS OF SERVICES | Analyze and assess current behavioral health landscape and treatment being provided to determine effectiveness of services and long-term social determinants of health outcomes.	Prioritization (Avg ranking)
Assess the effectiveness of treatment services and programming	2.7
Training for behavioral healthcare professionals for the implementation of E/RBPs	2.7
Treatment and MOUD retention	3.1
Measuring social determinants of health, including personal and family functioning	3.1
Analyze the use of E/RBPS and promising practices	3.4

https://www.samhsa.gov/find-help/harm-reduction

Current state of youth treatment

- Withdrawal management facilities
  - Sundown M. Ranch – Yakima
- SUD residential treatment facilities
  - Healing Lodge of the Seven Nations – Spokane
  - Sea Mar Visions – Bellingham
  - Sea Mar Renacer - Seattle
  - Sundown M. Ranch – Yakima
- IOP/OP
- OTP
- MOUD

Harm reduction and Naloxone

- Harm reduction is an evidence-based approach that incorporates community-driven public health strategies to empower people who use drugs with the choice to live health, self-directed, and purpose-filled lives.
- [WA Friends for Life]

https://www.samhsa.gov/find-help/harm-reduction

Youth MOUD fact sheets

Fact sheet for caregivers:
Youth medications for opioid use disorder

- Overdoses involving fentanyl in Washington State increased dramatically in recent years[1] for people across the age continuum including teens and young adults.
- Fentanyl is a high-potency synthetic opioid. Illicitly manufactured fentanyl has infiltrated the drug supply, particularly in fake pills and powders.
- Fentanyl is causing large increases in opioid overdoses, hospitalizations, and deaths.
- Fentanyl use leads to a faster onset of opioid use disorder compared to heroin or pharmaceutical opioids and more OUD among youth.
- All 3 Medications for Opioid Use Disorder (MOUD) are available to youth – Methadone, Buprenorphine, and Naltrexone – and are reimbursed by Washington Medicaid with no prior authorizations.
- Methadone and buprenorphine products reduce overdose risk by 50% or more[2] and support recovery.
- Naloxone (brand name Narcan) is a life-saving medication that can help reverse an overdose from opioids. Sometimes several doses are needed due to the high potency of fentanyl.
  - Naloxone is an extremely safe medication with no case reports of allergic reaction.[3]
- Potential bystanders are present[4] in 2/3 of overdose deaths among adolescents.
- There is no pre-determined time frame for an individual to continue the use of MOUDs. As with other medications, they should continue use as long as it provides more benefit than harm. It is important to keep individuals on the treatment of their choosing to support their recovery.[5]
- Inpatient residential treatment or withdrawal management/detoxification are sometimes thought of as the default treatment option. However, these one-time intensive interventions cannot cure an opioid use disorder and may increase the risk of overdose. OUD cannot be cured, it can be managed and
  - Medications are the standard of care for youth with opioid use disorder.
  - The evidence for inpatient treatment for OUD without the use of medication is poor.[6]
  - Counseling and other supports can be critical for recovery but should not be preconditions for medications.
  - Youth taking MOUD are more likely to start and remain engaged in counseling and social supports treatment.

- HCA MOUD Website
- Youth MOUD Fact Sheet - Providers
- Youth MOUD Fact Sheet – Caregivers

Washington State Health Care Authority

Resources for family & caregivers

- Washington Recovery Helpline 1-866-789-1511 and MOUD Locator
- Friends for Life
- StopOverdose.org
- Helping Families Help – CRAFT (Community Reinforcement Approach to Family Training)
- Al-Anon
- SAMHSA
- Parents Helping Parents and COPE Project
- Learnabouttreatment.org
- SUD Family Navigator Training
- Book: Beyond Addiction: How Science and Kindness Help People Change (2014) by Jeffrey Foote, PhD, Carrie Wilkens, PhD, and Nicole Kosanke, PhD, with Stephanie Higgs
  - Center for Motivation and Change

Thank you & questions

- Lauren Kula
- Amanda Lewis

Washington State Health Care Authority

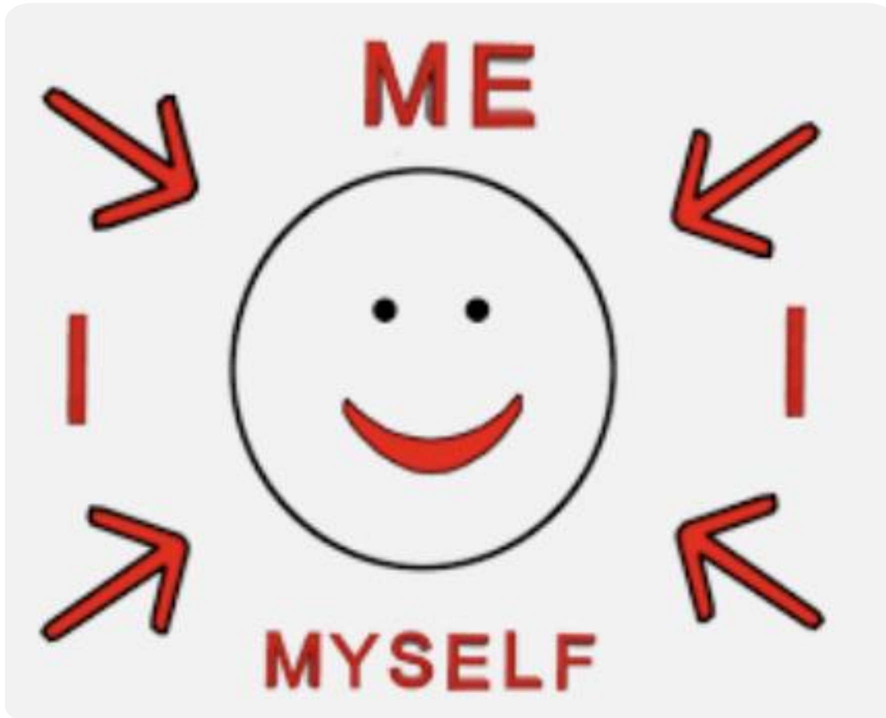
MOUD in Adolescents and Young Adults: A Provider Perspective

Kym Ahrens, MD, MPH

Medical Director, DCYF JR

Professor of Pediatrics and Adolescent Medicine, UW/Seattle Children’s

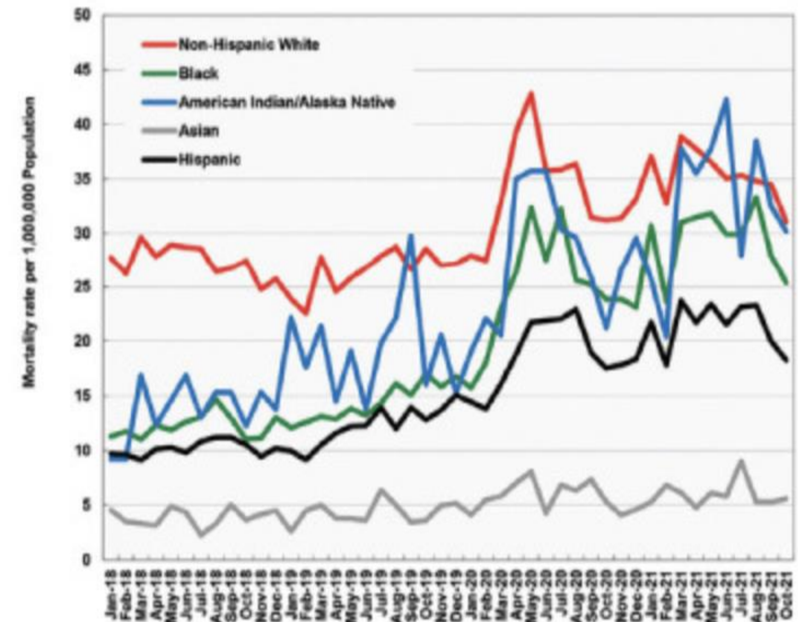
About me



- Adolescent Medicine physician with primary appointment at UW/Seattle Children's
- Medical Director/Clinician in Washington State Juvenile Rehabilitation (2 larger institutions and 8 Community Facilities with youth ages 12-25 years) – post-adjudication
  - About 1 in 3-4 youth have OUD
- Have provided consultation at Seattle Children's for integration of MOUD into inpatient care

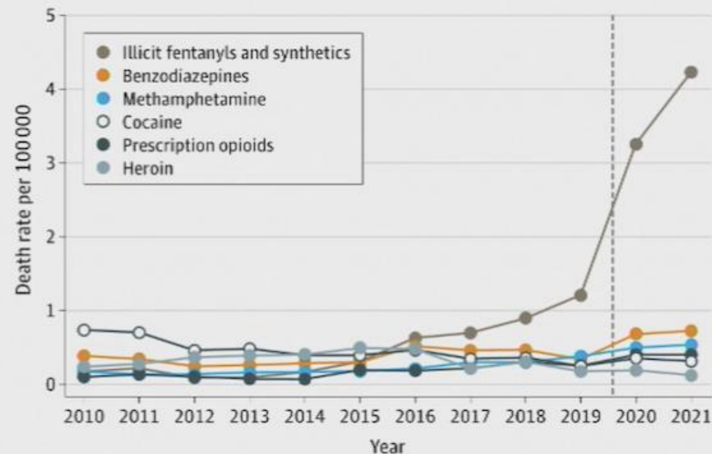
US Youth Overdose Trends: COVID + Fentanyl = Disproportionate Effects on BIPOC Youth

- Overall, substance use is down in teens BUT....
- Overdose rates have at least doubled AND....
- Hospitalizations/healthcare visits have also significantly increased.
- Non-Hispanic white youth still have highest rates of overdose BUT...
- Rates have increased at the fastest pace in Indigenous and Black youth during/after COVID pandemic



Ball et al, 2024; Lee et al, 2022; Hammond et al, 2024

Youth Overdose – Putting it into Context



About a classroom's worth of youth die of overdose every week

2 out of 3 had no <u>known</u> prior opioid use

Most were at home, with another person present in the house

Less than a third received naloxone

DSMV-TR Criteria for OUD

Way too long

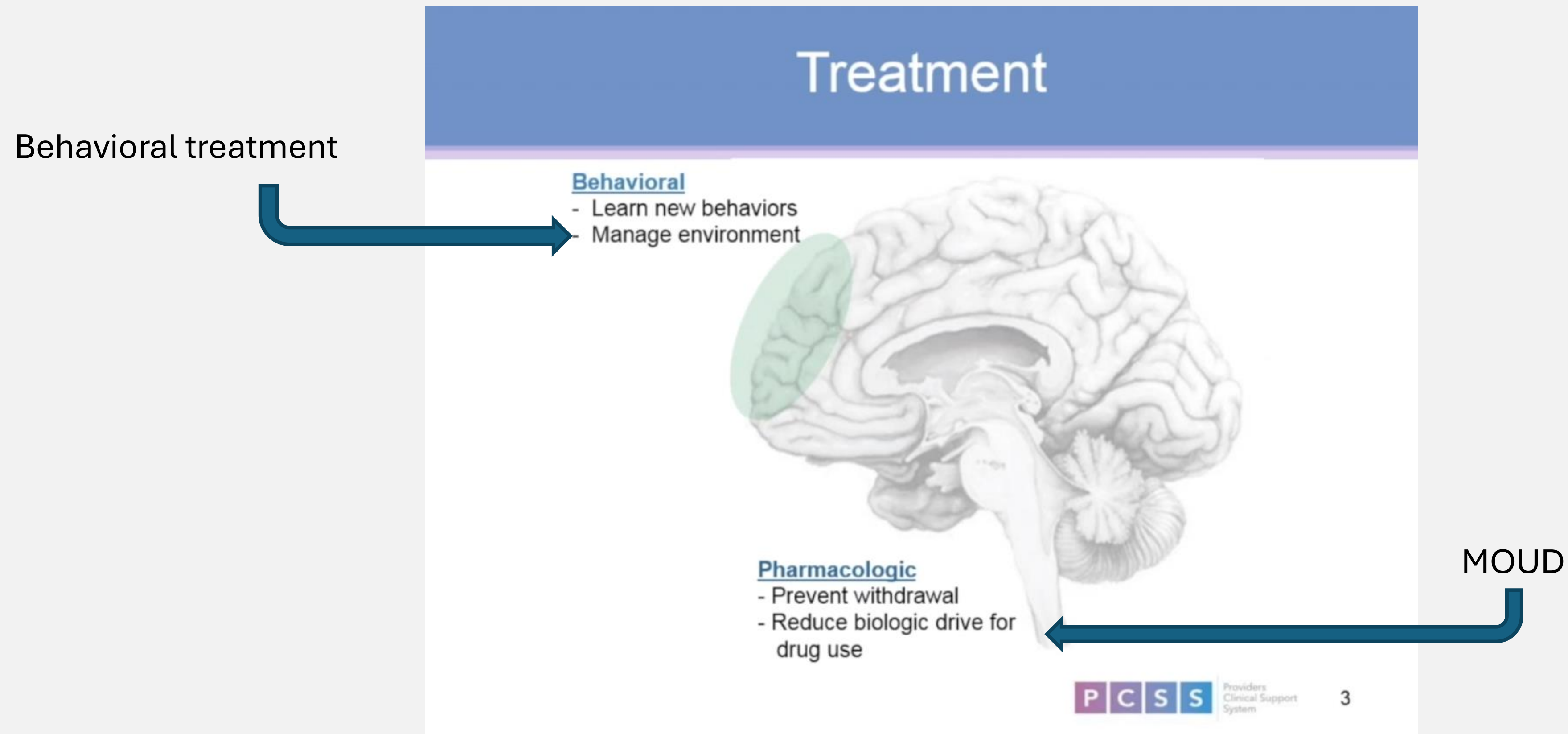
Repeated opioid use ~~within 12 months~~ leading to problems or distress with **2 or more of the following occurring:**

1. Continued opioid use despite worsening physical or psychological health
2. Continued opioid use despite social and interpersonal consequences
3. Decreased social or recreational activities
4. Difficulty fulfilling professional duties at school or work
5. Excessive time is taken to obtain or recover from taking opioids
6. More opioids are taken than intended
7. Opioid cravings occur
8. Inability to decrease the amount of opioids used
9. Tolerance to opioids develops
10. Opioid use continues despite the dangers it poses to the user
11. Withdrawal occurs, or the user continues to take opioids to avoid withdrawal

4-5 = moderate

>=6 = severe

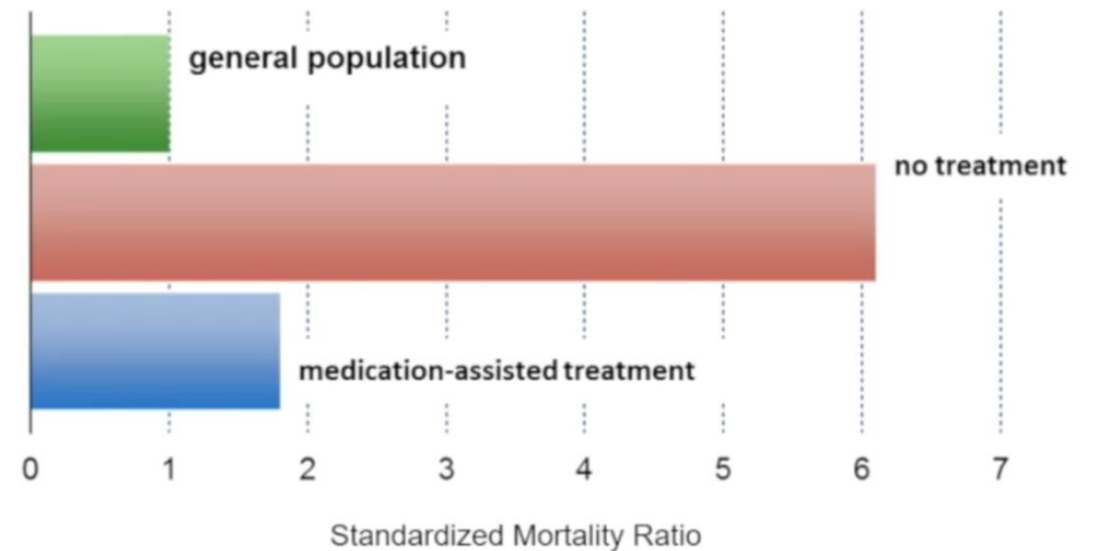
Behavioral Tx and MOUD – Separate Goals



MOUD in Adults: Reduces Deaths

Benefits of MAT: Decreased Mortality

Death rates:

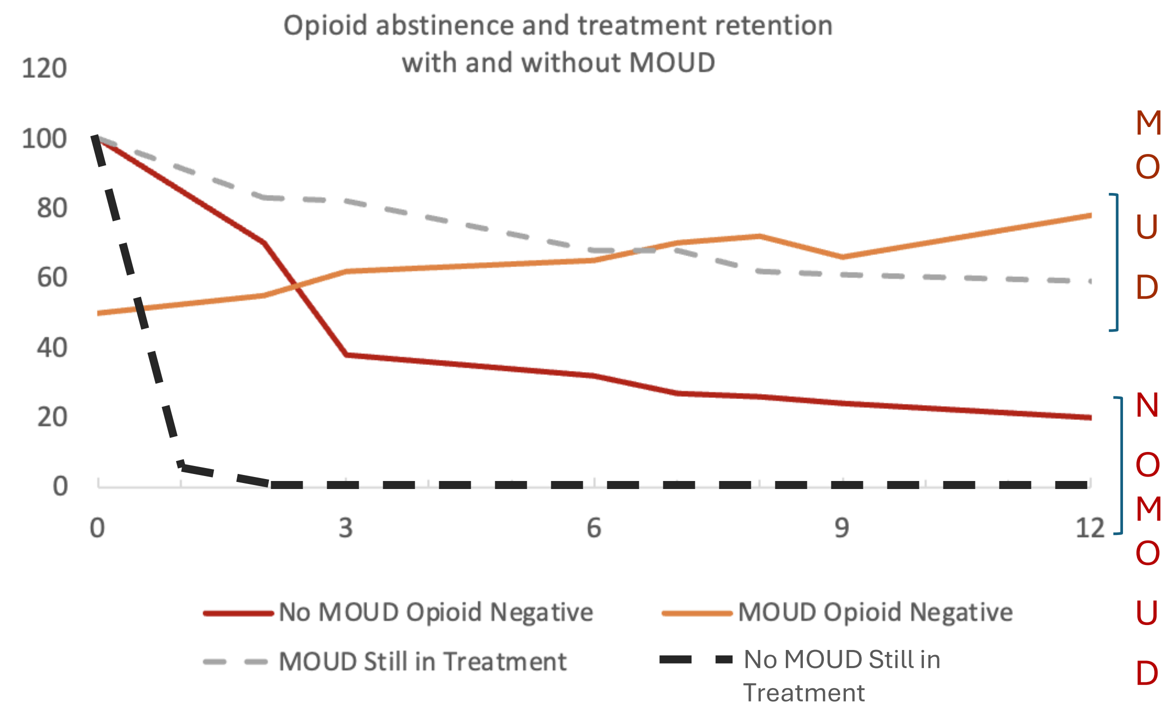


Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

PCSS Providers Clinical Support System 23

MOUD in Adults: Increased Treatment Retention, Decreased Use

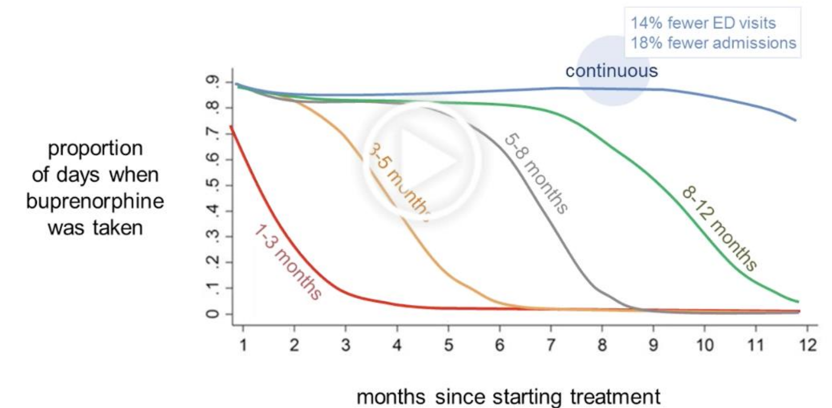
Buprenorphine promotes retention, and those who remain in treatment become more likely over time to abstain from other opioids



Hunt et al 1971, Kakko et al 2003, Soeffing et al 2009

Length of Treatment

- As long as patient is receiving benefit
- Generally, more = better
- **Typically years not months or weeks**



MOUD in Adolescents and Young Adults: It Works in Youth Too

- Longer retention in MOUD treatment associated with:
  - Decreased opioid use (Ramey et al, 2023; Pilarnos 2022)
  - Fewer ED visits, decreased health care utilization (Ramey et al, 2023)
- Most adolescent data = with buprenorphine products (vs. naltrexone, methadone)

MOUD is endorsed by both major pediatric associations (AAP, SAHM)

AAP, 2016

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Medication-Assisted Treatment of Adolescents With Opioid Use Disorders

COMMITTEE ON SUBSTANCE USE AND PREVENTION

abstract

Opioid use disorder is a leading cause of morbidity and mortality among US youth. Effective treatments, both medications and substance use disorder counseling, are available but underused, and access to developmentally appropriate treatment is severely restricted for adolescents and young adults. Resources to disseminate available therapies and to develop new treatments specifically for this age group are needed to save and improve lives of youth with opioid addiction.

ELSEVIER

SAHM, 2021

JOURNAL OF ADOLESCENT HEALTH

www.jahonline.org

Position paper

Medication for Adolescents and Young Adults With Opioid Use Disorder

The Society for Adolescent Health and Medicine

A B S T R A C T

Opioid-related morbidity and mortality have risen in many settings globally. It is critical that practitioners who work with adolescents and young adults (AYAs) provide timely, evidence-based treatment for opioid use disorder (OUD). Such treatment should include medications for opioid use disorder (MOUD), including buprenorphine, naltrexone, and methadone. Medication treatment is associated with reduced mortality, fewer relapses to opioid use, and enhanced recovery and retention in addiction care, among other positive health outcomes. Unfortunately, the vast majority of AYAs with OUD do not receive medication. The Society for Adolescent Health and Medicine recommends that AYAs be offered MOUD as a critical component of an integrated treatment approach. Barriers to receipt of medications are widespread; many are common to high-, middle-, and low-income countries alike, whereas others differ. Such barriers should be minimized to ensure equitable access to youth-friendly, affirming, and confidential addiction treatment that includes MOUD. Robust education on OUD and medication treatment should be provided to all practitioners who work with AYAs. Strategies to reduce stigma surrounding medication—and stigma experienced by individuals with substance use disorders more generally—should be widely implemented. A broad research agenda is proposed with the goal of expanding the evidence base for the use and delivery of MOUD for AYAs.

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MOUD in Adolescents: Significant National Access Issues

- Buprenorphine prescribing for adolescents decreased 25% from 2015 to 2020
- Pediatricians provide fewer buprenorphine prescriptions than other specialties (i.e., family medicine)
- Only 10.6% of addiction residential treatment facilities initiate and continue buprenorphine (King et al, 2023).

→Less than 5% of youth receive timely pharmacotherapy after an OUD diagnosis or opioid overdose (Alinsky et al, 2018; Hadland et al, 2020).

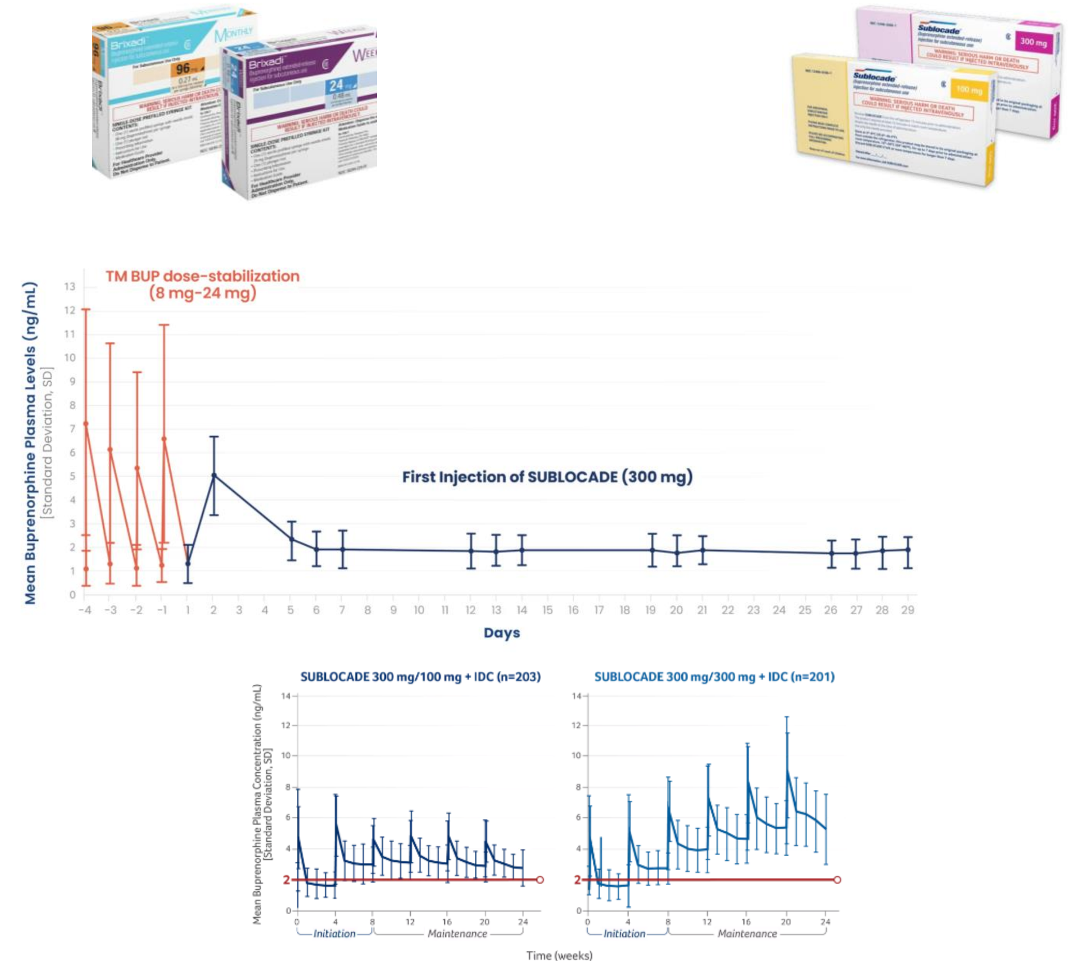
→Persons with OUD (and likely especially adolescents) are also typically underdosed in the fentanyl era (Lei et al, 2024)

Specific Access Barriers for Teens in WA State

- Very few residential programs allow/prescribe MOUD
- Even with Waiver eliminated, uptake in pediatric-serving primary care providers is low
- Parents/caregiver misinformation can be a barrier
  - Common interpretation of RCW 70.96A.096, 230 is that adolescents over 13 years can consent for their own care BUT…
  - It is really difficult to stay in treatment as a teen without adult support especially with shortage of providers
- Normal development can be a barrier
  - Adolescence and young adulthood = a time of particularly poor medication compliance (Campagna et al, 2020)

What Can Help? Access to Bupe XR

- Sublocade: Monthly shot for approved for persons on 8-24mg of buprenorphine SL
- Brixadi: Weekly to Monthly shots for persons on any dose of buprenorphine.
- Both are SQ, but turns into a depot/solid once injected
- Reduces diversion potential to zero
- Keeps blood levels more even compared with sublingual
- No/minimal withdrawal on treatment cessation because slowly leaves body
- Pro tips: Using ice, lidocaine, Buzzy Bee can help reduce fear around needles!



What Can Help? Shared Decision-Making

Provider/patient congruence in choice of treatments can influence outcomes for youth with OUD (Monico et al, 2024)

Providers need training in respectful, evidence-based shared decision making models:

https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tool/resource-9.html#:~:text=What%20is%20shared%20decisionmaking%3F,is%20best%20for%20the%20patient.

What Else Can Help? My Editorial Ideas

Increased provider, parent supports for pediatric prescribing

Advocate for evidence-based inpatient models that include MOUD

Virtual, mobile models that meet patients where they are at

Harm reduction until they are ready

Harm reduction for youth who use

- Never use alone
- Designate a sitter each time you use and rotate
- Carry naloxone and always call 911 if you use it
- Consider test strips, testing your drugs ahead of use
- Know the Good Samaritan Law in your jurisdiction – neither a person who aids an suspected overdose victim nor the victim can be prosecuted for possession if help is sought → it is safe to call 911 (WA RCW 69.50.315)
  - Tribal laws: some have their own, some honor Washington State, some do not

Questions?

References

1. Alinsky RH, Zima BT, Rodean J, *et al.* Receipt of addiction treatment after opioid overdose among medicaid-enrolled adolescents and young adults. JAMA Pediatr, 174 (2020), Article e195183.
2. Ball A, Hadland S, Rodean J, Hall M, Mendoza J, Ahrens K. Trends in Substance-Related Visits Among Youth to US Children's Hospitals, 2016-2021: An Analysis of the Pediatric Health Information System Database. J Adolesc Health. 2024 Jul;75(1):76-84. doi: 10.1016/j.jadohealth.2024.02.016. Epub 2024 Mar 25. PMID: 38530681.
3. Calihan JB, Bagley SM. Injectable Buprenorphine: An Opportunity to Improve Treatment Access for Youth With Opioid Use Disorder. Journal of Adolescent Health, Volume 75, Issue 1, 2024, Pages 13-14.
4. Campagna BR, Weatherley K, Shemesh E, Annunziato RA. Adherence to Medication During Transition to Adult Services. Paediatr Drugs. 2020 Oct;22(5):501-509. doi: 10.1007/s40272-020-00414-2. PMID: 32889685; PMCID: PMC7474320.
5. Dupouy J, Palmaro A, Fatséas M, Auriacombe M, Micallef J, Oustric S, Lapeyre-Mestre M. Mortality Associated With Time in and Out of Buprenorphine Treatment in French Office-Based General Practice: A 7-Year Cohort Study. Ann Fam Med. 2017 Jul;15(4):355-358. doi: 10.1370/afm.2098. PMID: 28694272; PMCID: PMC5505455.
6. Evans E, Li L, Min J, Huang D, Urada D, Liu L, Hser YI, Nosyk B. Mortality among individuals accessing pharmacological treatment for opioid dependence in California, 2006-10. Addiction. 2015 Jun;110(6):996-1005. doi: 10.1111/add.12863. Epub 2015 Mar 15. PMID: 25644938; PMCID: PMC4452110.
7. Friedman J, Godvin M, Shover CL, Gone JP, Hansen H, Schriger DL. Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021. JAMA. 2022 Apr 12;327(14):1398-1400. doi: 10.1001/jama.2022.2847. PMID: 35412573; PMCID: PMC9006103.Hadland SE, Bagley SM, Rodean J, *et al.* Receipt of timely addiction treatment and association of early medication treatment with retention in care among youths with opioid use disorder. JAMA Pediatr, 172 (2018), pp. 1029-1037.
8. Hammond CJ, Van Eck K, Adger H. Impact of the COVID-19 Pandemic on Youth Substance Use and Substance-Related Risk Factors and Outcomes: Implications for Prevention, Treatment, and Policy. Pediatr Clin North Am. 2024 Aug;71(4):653-669. doi: 10.1016/j.pcl.2024.05.002. Epub 2024 Jun 11. PMID: 39003008.
9. Kakko J, Svanborg KD, Kreek MJ, Heilig M. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. Lancet. 2003 Feb 22;361(9358):662-8. doi: 10.1016/S0140-6736(03)12600-1. PMID: 12606177.

References (cont)

10. King C, Beetham T, Smith N, *et al.* Treatments used among adolescent residential addiction treatment facilities in the US, 2022. JAMA, 329 (2023), pp. 1983-1985
11. Lee H, Singh GK. Monthly Trends in Drug Overdose Mortality among Youth Aged 15-34 Years in the United States, 2018-2021: Measuring the Impact of the COVID-19 Pandemic. Int J MCH AIDS. 2022;11(2):e583. doi: 10.21106/ijma.583. Epub 2022 Dec 7. PMID: 36506108; PMCID: PMC9730739.
12. Lei F, Lofwall MR, McAninch J, Adatorwovor R, Slade E, Freeman PR, Moga DC, Dasgupta N, Walsh SL, Vickers-Smith R, Slavova S. Higher First 30-Day Dose of Buprenorphine for Opioid Use Disorder Treatment Is Associated With Decreased Mortality. J Addict Med. 2024 May-Jun 01;18(3):319-326. doi: 10.1097/ADM.0000000000001300. Epub 2024 Apr 10. PMID: 38598300.
13. Lim JK, Earlywine JJ, Bagley SM, Marshall BDL, Hadland SE. Polysubstance Involvement in Opioid Overdose Deaths in Adolescents and Young Adults, 1999-2018. JAMA Pediatr. 2021 Feb 1;175(2):194-196. doi: 10.1001/jamapediatrics.2020.5035. PMID: 33226412; PMCID: PMC7684514.
14. Lo-Ciganic WH, Gellad WF, Gordon AJ, Cochran G, Zemaitis MA, Cathers T, Kelley D, Donohue JM. Association between trajectories of buprenorphine treatment and emergency department and in-patient utilization. Addiction. 2016 May;111(5):892-902. doi: 10.1111/add.13270. Epub 2016 Jan 30. PMID: 26662858.
15. Monico LB, Fletcher JB, Ross T, Schwartz RP, Fishman MJ, Gryczynski J, Mitchell SG. Patient and provider medication preferences affect treatment outcomes among adolescents and young adults with opioid use disorder. J Subst Use Addict Treat. 2024 Jul;162:209334. doi: 10.1016/j.josat.2024.209334. Epub 2024 Mar 24. PMID: 38531508; PMCID: PMC11163270.
16. Pilarinos A, Fast D, Nosova E, Kwa Y, Joe R, Buxton JA, DeBeck K. Initiation of opioid agonist treatment and subsequent substance use and other patterns among adolescents and young adults in Vancouver, Canada. Drug Alcohol Depend. 2022 Jun 1;235:109441. doi: 10.1016/j.drugalcdep.2022.109441. Epub 2022 Apr 7. PMID: 35427979; PMCID: PMC9872979.
17. Ramey OL, Bonny AE, Silva Almodóvar A, Nahata MC. Retention in Office-Based Opioid Treatment and Impact on Emergency Department Use in Adolescents and Young Adults With Opioid Use Disorder. J Adolesc Health. 2023 Jul;73(1):148-154. doi: 10.1016/j.jadohealth.2023.02.016. Epub 2023 Apr 7. PMID: 37032210.

References (cont)

18. Ramey OL, Bonny AE, Silva Almodóvar A, Nahata MC. Urine Drug Test Results Among Adolescents and Young Adults in an Outpatient Office-Based Opioid Treatment Program. J Adolesc Health. 2023 Jul;73(1):141-147. doi: 10.1016/j.jadohealth.2023.02.013. Epub 2023 Apr 6. PMID: 37031090.
19. Terranella A, Guy Jr GP, Mikosz C. Buprenorphine dispensing among youth aged ≤19 years in the United States: 2015–2020. Pediatrics, 151 (2023), Article e2022058755
12. Soeffing JM, Martin LD, Fingerhood MI, Jasinski DR, Rastegar DA. Buprenorphine maintenance treatment in a primary care setting: outcomes at 1 year. J Subst Abuse Treat. 2009 Dec;37(4):426-30. doi: 10.1016/j.jsat.2009.05.003. Epub 2009 Jun 23. PMID: 19553061.
13. Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, Ferri M, Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017 Apr 26;357:j1550. doi: 10.1136/bmj.j1550. PMID: 28446428; PMCID: PMC5421454.

Fentanyl/Opioid Education

The Team

- Annie Hetzel, MSN RN
- Rebecca Purser
- Brisa Sanchez Cornejo
- Tammy Bolen

Agenda

- **Opioid Overdose Response in Schools, SB 5804** – Annie Hetzel
- **Tribal Schools Opioid Education Pilot Project** – Rebecca Purser
- **Training and Update to Health Standards**– Brisa Sanchez Cornejo
- **Future Work** – Tammy Bolen

Washington Office of Superintendent of
PUBLIC INSTRUCTION

Opioid Overdose Response in Schools SB 5804

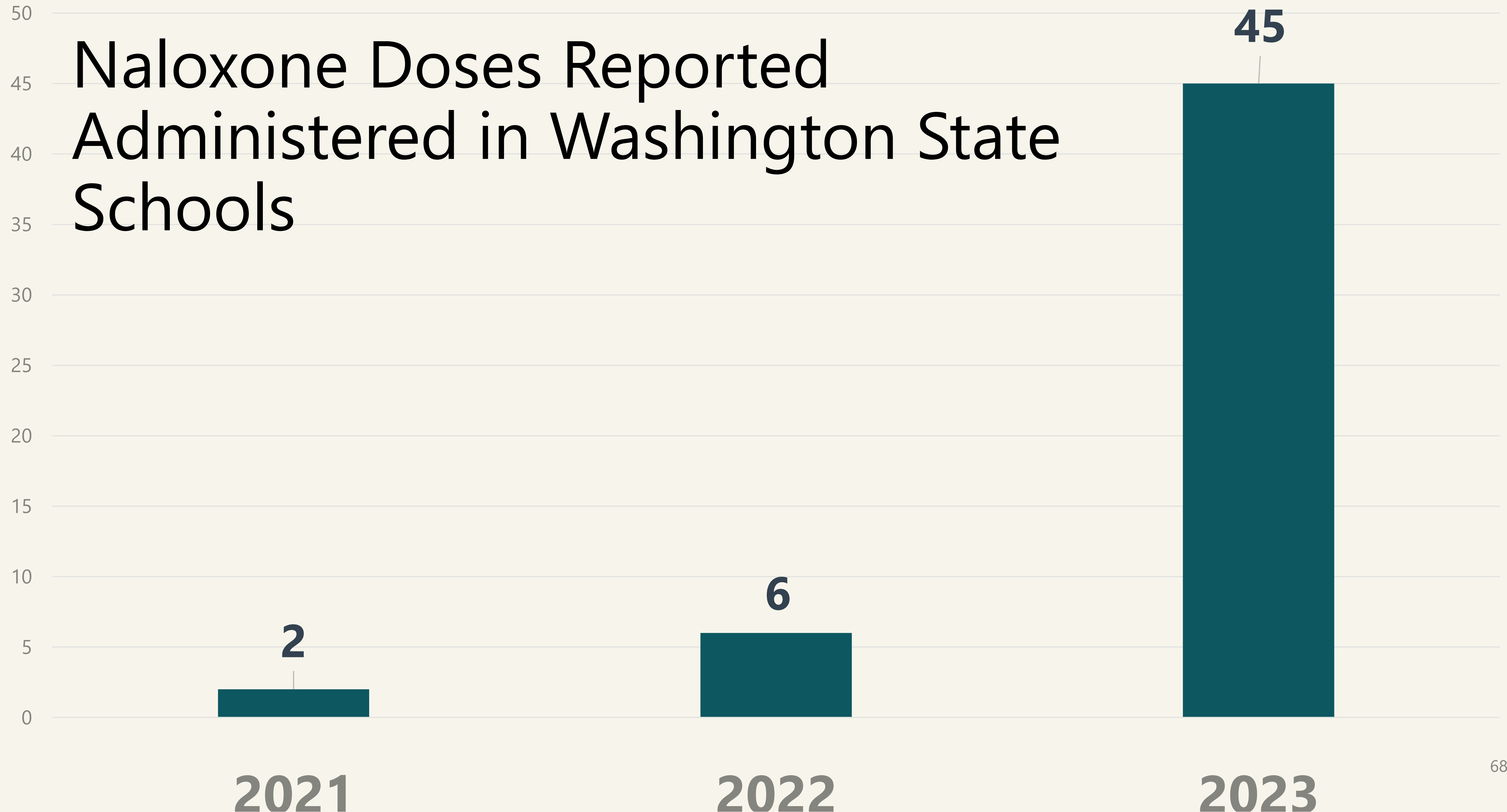
Annie Hetzel, MSN, RN

Opioid Overdose Response in School

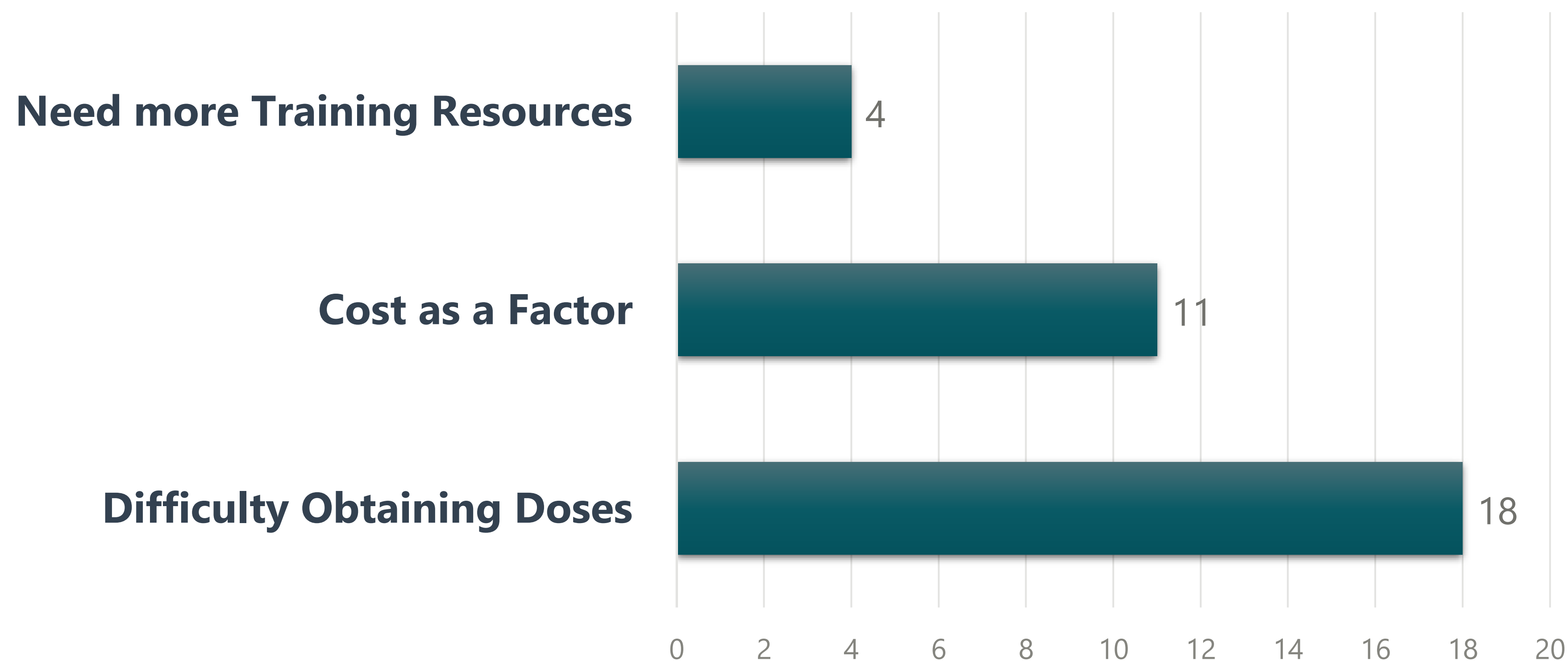
- SSB 5804 amends RCW 28A.210.390 to require all school districts to have a policy and maintain at least one set of opioid overdose reversal medication doses in each of its schools.
- Requires WSSDA, OSPI, and DOH to update policy by September 1, 2024
- OSPI Opioid-related overdose policy guidelines & training in the school setting will be updated in alignment with policy

Exemption

"If the district documents a good faith effort to obtain and maintain opioid overdose reversal medication through a donation source, and is unable to do so, the district is exempt from the obligation to have a set of opioid reversal medication doses for each school."


Naloxone Doses Reported Administered in Washington State Schools
50
45
40
35
30
25
20
15
10
5
0
2
6
45
2021
2022
2023

Survey Comments: Identified Needs



"The cost to restock may not be sustainable for the school district."

Community Engagement on Policy

Community input into the opioid overdose response policy and procedure and OSPI Guidelines was sought in the following ways May-June 2024:

- **Statewide Virtual convening**
- **Open Office Hours**
- **Youth Panel**
- **High School Forum**
- **Online survey May 1 through May 30**

Washington Office of Superintendent of
PUBLIC INSTRUCTION

Community Engagement Key Themes

- Student self-carry
- Expanding storage options
- Training for staff and students
- Debrief & support after an incident
- Equitable access
- Field trips out of state
- Burden on schools

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Policy Update Highlights

- Alignment with RCW
- Student Self-Carry
- Storage
- Post-incident debrief and support

Policy Guidelines:

- Alignment with RCW & policy
- Out of State field trips
- Delegation
- Legal basis for student self-carry

HB 1230

Requiring school districts and other public education entities to make information from the department of health available.

OSPI HB 1230 Resources

- House Bill 1230
- Youth Behavioral Health, OSPI | Spanish
- Youth Mental Health, OSPI | Spanish
- Social Media Safety, OSPI | Spanish
- Safety at Home, OSPI | Spanish

DOH Schools webpage

Schools | Washington State Department of Health

Tribal Schools Opioid Education Pilot Project

Rebecca Purser

HB1956 Addressing fentanyl and other substance use prevention education.

E2SHB 1956-K-12 learning standards and develop classroom materials aligned with DOH/HCA prevention and awareness campaign

- 334,000 FY25 & $125,000 FY26 Office of Superintendent of Public Instruction

Directs the Secretary of Health to annually develop and deploy a statewide multimedia substance use prevention and awareness campaign
that meets specified requirements.

Requires the Office of the Superintendent of Public Instruction to develop, periodically update, and actively distribute school and classroom substance use prevention and awareness materials

https://youtu.be/waQ4eK7wfb8

Proviso 5950 522(4)(v) Tribal Schools Opioid Prevention Pilot

- (v)(i) $900,000 of the opioid abatement settlement account—state appropriation is provided solely for the office of the superintendent of public instruction to administer a pilot program for volunteering state-tribal education compact schools and before and after school programs offered by tribes to adopt opioid and fentanyl abuse prevention materials and resources during the 2024-25 school year. Of the amounts provided in this subsection, $900,000 of the opioid abatement settlement account—state appropriation is provided solely for the volunteering state-tribal education compact schools to implement the pilot program.

State-Tribal Education Compact Schools (STECs) and Tribal Before & After School Programs Grant Opportunity

- Participation is Voluntary
- One Year Pilot Project
- Office of Native Education
  - Facilitates Grant Award / Implementation
  - Provides technical support to grantees
  - Data and Reporting Requirements / Timelines
  - Prepares August Report
  - Prepares End of the Year Report
  - Shares Promising Practices with Districts serving AI/AN Youth

Training and Update to Health Standards

Brisa Sanchez Cornejo

Communications and Connection Points

	Audience	Frequency
Engage Newsletter	School building teams, community partners, admin	Monthly
Engage/SES Newsflash	School building teams, community partners, admin	Weekly
SEL	Community organizations, families, SEL network	Monthly
Counseling	School leadership, ESD, Counseling program staff	Monthly
School Health Services	School leadership, nurses	Monthly
PE/Health	School leadership, PE/Health educators	Monthly

- Newsletters
- GATE Equity Webinars
- TA Support
- Continued Inter-agency Collaboration

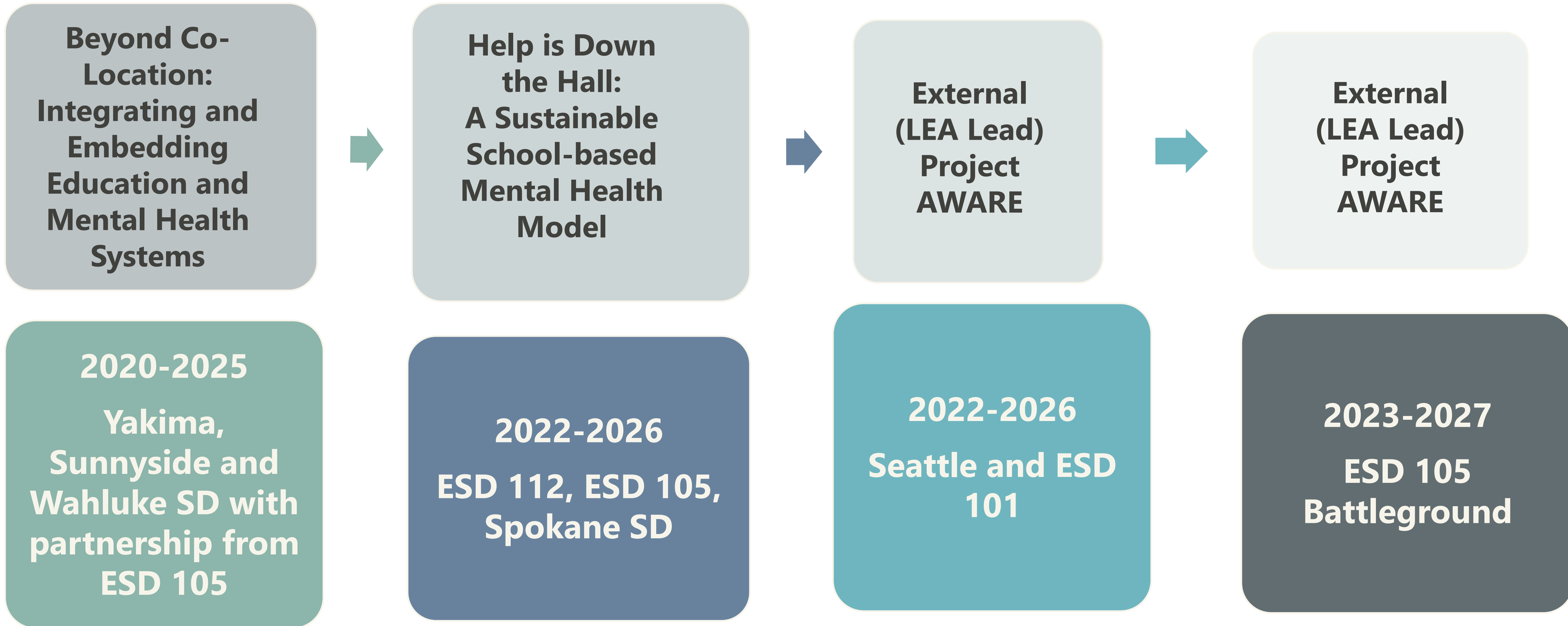
HB 1956 – on learning standards

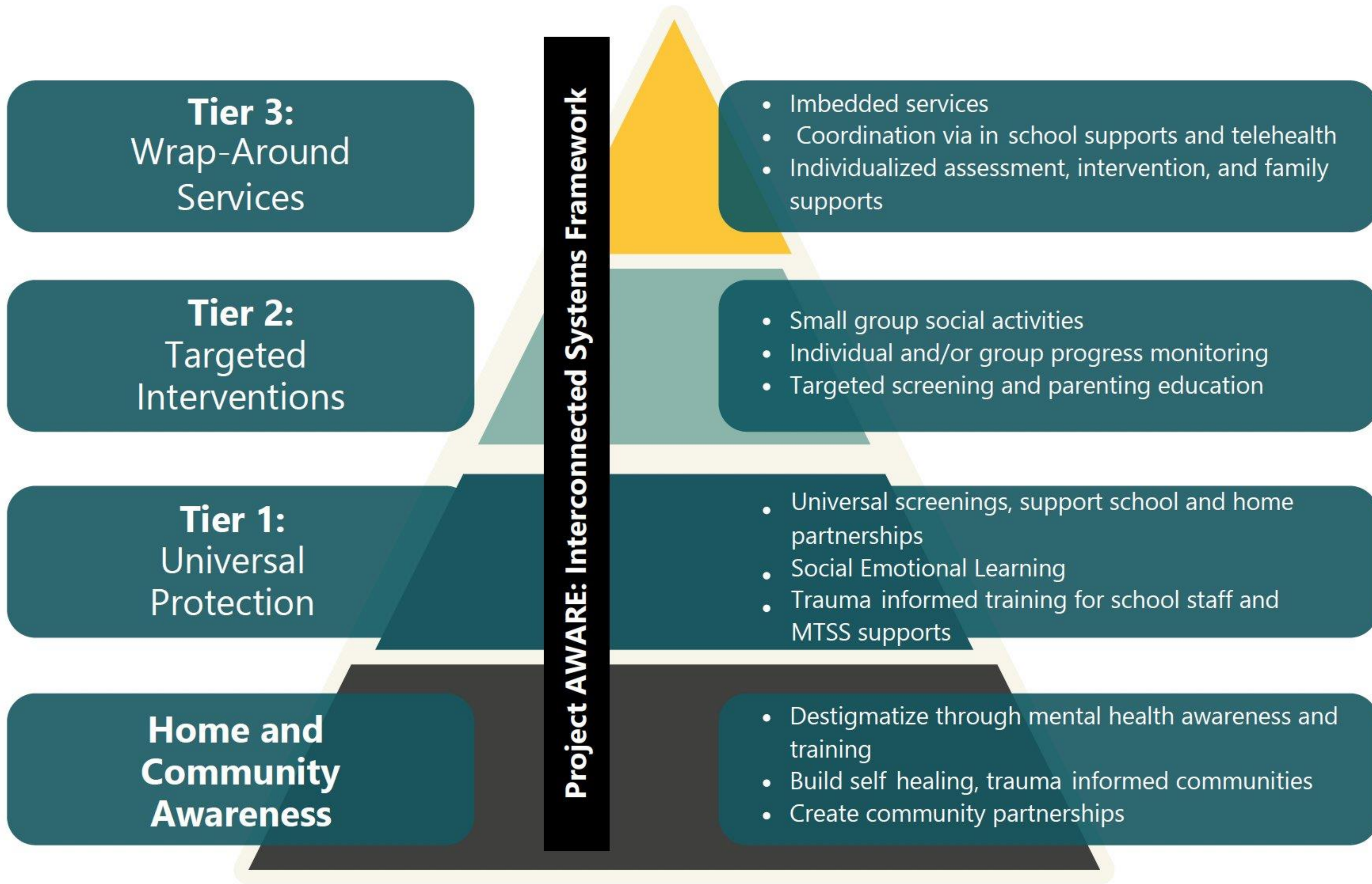
" By December 1, 2025, the office of the superintendent of public instruction shall adjust the state health and physical education learning standards for middle and high school students to ***add opioids*** to the list of drugs included in drug-related education "

Project AWARE:

Advancing Wellness and Resilience in Education

Project AWARE Across Washington




Tier 3:
Wrap-Around Services
Imbedded services
Coordination via in school supports and telehealth
Individualized assessment, intervention, and family supports
Tier 2:
Targeted Interventions
Small group social activities
Individual and/or group progress monitoring
Targeted screening and parenting education
Tier 1:
Universal Protection
Universal screenings, support school and home partnerships
Social Emotional Learning
Trauma informed training for school staff and MTSS supports
Home and Community Awareness
Destigmatize through mental health awareness and training
Build self healing, trauma informed communities
Create community partnerships
Project AWARE: Interconnected Systems Framework

Expansion to Support SU Prevention

Internally

- Project expanded capacity
- OSPI interdepartmental support and collaborations
  - Model Policy Update – Overdose Response
  - Health & PE learning standards – Fentanyl/Opioid Education
  - Collection, collation and selection of Opioid/Fentanyl Materials
  - Office of Native Education – Opioid prevention, awareness and education. Collecting promising practices from tribal schools

Externally

- TA substance use prevention/intervention
- Collaboration and learning
  - WA state Rural Network Prevention Providers
  - Washington Healthy Youth Coalition
  - State Prevention Policy Consortium
  - UW's Motivating Campus Change Study (Project MC2)
  - Prevention Research Coalition(UW/WSU)
  - Tribal Opioid/Fentanyl Prevention, Education and Awareness Campaign Workgroup (DSHS)

Future Work

Tammy Bolen

HB 1956 Work

Collect current Washington resources and curricula

Bring agencies and ESDs together to review the resources and curricula

Identify and narrow down resources and curricula for middle school and high school.

HB 1956 Future Work

Hold community listening sessions to review the resources and curricula and identify what is missing or needed

Develop any resources that are determined from listening sessions as needed

Create webnar training on how to use the resources and curricula in the classroom

HB 1956 Work

Provide professional development to districts and ESDs

Create an OSPI Fentanyl Education webpage

Partner with OSPI to create and implement a communication plan

Additional Work

- Contract with regional organizations that will work directly with students to review/create messaging and/or lessons
- Provide subgrants school districts to pilot the curricula and train educators
- Integration of the Fentanyl support with social emotional learning

Contact Information for OSPI Staff

Annie Hetzel, MSN, RN
School Health Services Consultant
Annie.hetzel@k12.wa.us

Rebecca Purser
Tribal Schools Opioid Education Pilot Lead
Rebecca.purser@k12.wa.us

Brisa Sanchez Cornejo
Substance Use Prevention Intervention Program Supervisor
brisa.sanchezcornejo@k12.wa.us
(564) 233-5022

Tammy Bolen
Assistant Director
Tammy.bolen@k12.wa.us

Department of Community and Human Services

Interagency Recovery Campus: WA's only sober public high school

Washington Health Care Authority, Children and Youth Behavioral Health Work Group (CYBHWG)
August 8, 2024

Presenters:

Seattle Public Schools, Interagency Recovery Campus:

- Jessica Levy, MSW
- Student

King County Department of Community and Human Services, Behavioral Health and Recovery Division:

- Jennifer Wyatt, LMHC, MAC, SUDP

The Interagency Recovery Campus educates students up through age 21 who are working recovery programs in a sober setting.

- Partnership between Seattle Public Schools Interagency Academy and King County Behavioral Health and Recovery Division (BHRD) since 2015
- Established after a 2013 DSHS report[1] found low graduation rates for youth in publicly-funded SUD treatment:
  - Only 25% graduated
  - With a co-occurring mental health disorder, only 17% graduated

[1] Source: https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-194.pdf

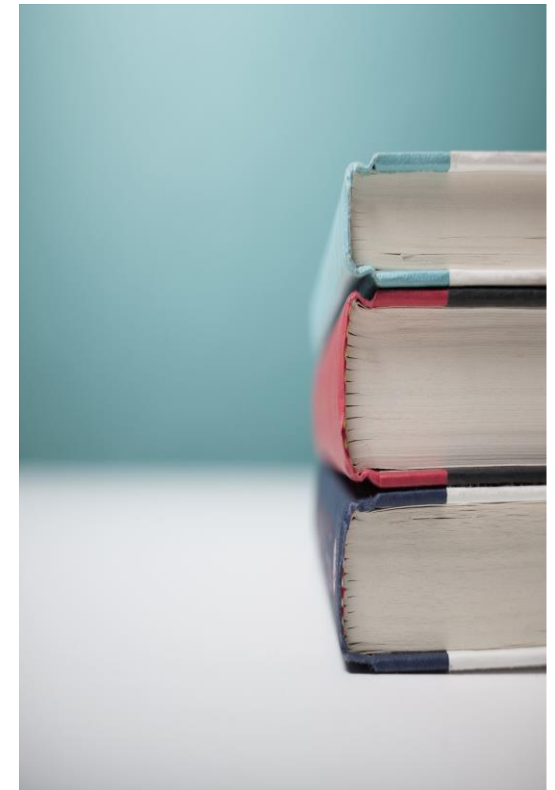
The Interagency Recovery Campus fills an important gap in the continuum of care for youth.

- *Core principle*: Opposite of addiction is connection and community
- One of few publicly-funded youth-specific recovery resources for youth in action and maintenance
- Only public recovery school in WA, for now
- In contrast to traditional high schools, recovery high schools are uniquely equipped to guide students and families through the critical stage of early recovery.

A Student's Story

Learn more about Interagency Recovery Campus.

- *Website*: https://interagency.seattleschools.org/about/campus-locations/interagencys-recovery-academy/
- *Recovery Campus Enrollment Brochure*: Two-page flyer orienting prospective students, parents, and referral sources to the program approach and enrollment process.
- *Recovery Campus Introductory Brief*: Describes the need for recovery schools in supporting high school graduation for young people in recovery from substance use disorders, drawing from national and local sources.
- *Recovery Campus Data Brief*: Summarizes student characteristics and outcomes regarding graduation and recovery of students who have attended Interagency Recovery Campus for 90 days or more from 2015-2022.



Contacts

- Jessica Levy: jrlevy@seattleschools.org
- Seth Welch: spwelch@seattleschools.org
- Jennifer Wyatt: jwyatt@kingcounty.gov

CHILDREN AND YOUTH BEHAVIORAL HEALTH WORK GROUP MEETING

Washington State Department of Health
Office of Healthy and Safe Communities
Division of Prevention and Community Health
988 Program
8/8/2024

Context: Washington 911-988 Cross System Initiatives

2024												2025			
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr

Mental Health Crisis Call Diversion Initiative Pilot Projects

(January-December 2024)

- *Partnership between Washington's 988 Lifeline crisis centers and three (3) of the state's 65 Primary PSAPs/911 centers.*

Statewide 911-988 Warm Transfer Protocols – Transformation Transfer Initiative (July 2024 – April 2025)

- *Environmental scan (Summer 2024)*
- *Community and Tribal Engagement (Summer 2024)*
- *Workshops to develop warm transfer protocols (Fall 2024)*
- *Develop train-the-trainer program for 911 staff (Spring 2025)*

MHCCDI Pilot Partnerships Call Volume

988 Call Centers/911 PSAPs	Number of calls received by 911 and transferred to 988 (diversion calls)				
	February	March	April	May	June
Crisis Connections/Valley Com 911	No data	99	156	58	28
Frontier Behavioral Health/Spokane Regional Emergency Management	448	344	295	308	341
Volunteers of America Western Washington/South Sound 911	65	5*	33	36	18

*Call volume may not be accurate due to a reporting issue that occurred that month.

Request for Input

Please email **Brooke Zollinger:** bzollinger@healthmanagment.com to provide your feedback on the MHCCDI and TTI project.

Specifically, we are looking for feedback on the following:

- ✓ Considerations to explore in the environmental scan
- ✓ Processes or perspectives to explore in the warm transfer protocols development workshops
- ✓ Considerations for the train-the-trainer program for 911 staff
- ✓ Other feedback or perspectives we should be aware of as we continue this work