Notes

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

August 27, 2024

Glossary of Terms

ASAM: American Society of Addiction Medicine
ATAY: Adolescent and Transition Age Youth
BH: Behavioral Health
EFC: Extended Foster Care
HCA: WA Health Care Authority
ILP: Independent Living Program
IOP/OP: Intensive Outpatient/Outpatient Services
MCO: Managed Care Organization
MH: Mental Health
MOUD: Medications for Opioid Use Disorder
MRSS: Mobile Response and Stabilization Services
OTP: Opioid Treatment Program
SOOR: State Opioid and Overdose Response
SUD: Substance Use Disorder
WISe: Wraparound with Intensive Services
YYA: Youth and Young Adult

Meeting Topics

Presentation: Youth and Young Adult Substance Use Disorder (SUD) services, Amanda Lewis (HCA)
Thematic small group breakout discussions
Large group discussion, including debrief & identification of viable solutions, narrowing scope & identifying issue leads

Discussion Summary

Youth and Young Adult SUD services

1. The presentation on youth and young adult SUD services included the following (refer to slides for more details):
    a. The current state of access to youth withdrawal management services, including:
        i. Withdrawal management and stabilization services:
            1. Sundown M. Ranch in Yakima is the only facility offering this in the state.
            2. There is continued need for these services to accommodate the needs of young people, prior to transitioning to a residential treatment program.
        ii. Four SUD residential programs for youth on Medicaid:

1. The total census of these programs in June revealed that the programs were operating at about half capacity across the board.
2. Madrona Recovery Services is working to open a program in Brush Prairie.
3. Sea Mar Renacer has a 12-bed recovery house.
4. Sea Mar Visions is working to create a recovery house.

iii. Intensive outpatient/outpatient services (IOP/OP):
1. It is more challenging to get a sense of the landscape, census and capacity for IOP/OP statewide because of how the behavioral health (BH) care delivery system functions.
    a. Outpatient programs contract with managed care organizations (MCOs) for those services, not directly with HCA.
2. HCA is analyzing outpatient data that is submitted to them to get a better sense of what these services look like.

iv. Opioid Treatment Programs (OTPs):
1. OTPs are low barrier programs where individuals can be administered or dispensed all three types of medications for opioid use disorder (methadone, buprenorphine products, and naltrexone).
2. OTPs offer a holistic approach to recovery, providing medical and BH services to all patients.
3. HCA has partnerships with OTPs to help provide support and technical assistance in the development of policies and procedures to better serve youth and young adults in these spaces.

v. Medications for Opioid Use Disorder (MOUD):
1. MOUD is an effective evidence-based treatment in addition to BH treatment.
2. Providers may prescribe in-house or can support access to MOUD in the community.
    a. There are various ways to learn about and locate prescribers for MOUD – via BH programs, MCOs, or utilizing the MOUD locator (operated by the recovery helpline).

b. Challenges/service gaps in providing youth SUD services, including:

i. The State Opioid and Overdose Response (SOOR) plan, which was formed in response to the opioid crisis.
1. There are five different workgroups across the plan, each comprised of partners from around the state who work to carry out objectives from state plan in their respective areas.
2. There are learning community meetings held every few months to provide updates and collaborate.

ii. SOOR goal #2 youth and young adult (YYA) treatment subgroup survey:
1. This temporary YYA subgroup was formed to discuss the impacts of the opioid crisis.
2. The group identified four different categories or goals, each with action items they felt would be needed, and then developed a survey for the community to prioritize response efforts.

c. Upcoming changes to American Society of Addiction Medicine (ASAM) criteria, including:
    i. The first adolescent and transition age youth (ATAY) edition of the criteria is being released in early 2026.
    ii. The current information being presented is based on a public draft – so there is a sense of the foundational principles and structures to anticipate, but things may change.
    iii. There are four broad treatment levels of adolescent care, with variations within each level that account for intensity and types of care provided (see diagram in slides for details regarding this continuum of care).
    iv. Dimension changes from the 3rd to 4th edition of ASAM criteria include:
        1. Updating names of dimensions for conciseness and to reflect current terminology.
        2. Explicit consideration of medications for opioid use disorder needs in dimension one.
        3. The removal of dimension 4, along with the shifting and renaming of dimensions 5 and 6.
        4. A new dimension 6 – called Person Centered Considerations – which considers barriers to care, individual and family preferences, and the need for motivational enhancement services.
    v. Next steps for the ATAY ASAM criteria include:
        1. Continued analysis of new edition changes.
        2. Provider and delivery system impacts:
            a. Shift to co-occurring care
            b. Home and community-based services
        3. System needs and supports.

d. Resources:
    i. Washington Recovery Helpline 1-866-789-1511 and MOUD Locator
    ii. Friends for Life
    iii. StopOverdose.org
    iv. Helping Families Help – CRAFT (Community Reinforcement Approach to Family Training)
    v. Al-Anon
    vi. SAMHSA
    vii. Parents Helping Parents and COPE Project
    viii. Learnabouttreatment.org
    ix. SUD Family Navigator Training
    x. 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
    xi. Center for Motivation and Change

2. Discussion following the presentation included the following:
    a. Cannabis induced psychosis
        i. This can be temporary or permanent and can lead to a lifelong psychotic disorder.

ii. YYAs use cannabis a lot to decompress and for their mental health (MH), but there is poor education about how cannabis worsens anxiety and can have long-term impacts, including causing psychotic disorders, such as schizophrenia.
iii. HCA has a variety of campaigns – but it is worth taking a deeper dive on this topic and creating materials (or a campaign) that is more specific to this topic and risks.
iv. There is prevention work around this here: Cannabis use and misuse | The Athena Forum.

Large group discussion, including: Debrief & identification of viable solutions, and Narrowing our scope & identifying issue leads

Below are the notes from the session debrief and shareout.

1. **Group 1: YYA workforce**
    a. Focused on peer support professionals in intensive services.
    b. The takeaway from the discussion was positives and challenges with the peer model.
    c. There is something important to do around further support and development of that workforce, but it may not necessarily need to be limited to the intensive service category – it is something that's that's pretty overarching across the entire peer workforce.
    d. There is persistent turnover among peer support professionals, and we need to make these jobs attractive so that people stay in the roles – by increasing wages and training opportunities.
    e. This may crossover with the Workforce and Rates subgroup.

2. **Group 2: YYA services (programming)**
    a. The New Journeys program has an existing ask for $200k to get services to areas that are missing them.
    b. Wraparound with Intensive Services (WISe) – there are a lot of things going well, as well as opportunities for improvement, such as integrating SUD with WiSE.
    c. Geographically, there are big gaps in specific, more remote regions.
    d. There is a gap between intensive services (such as New Journeys and WISe) and outpatient services.
        i. Peer services may help address this gap.
        ii. Adressing this gap is very important.

3. **Group 3: YYA homelessness**
    a. One of the key discussion items was fiscal support for families or caregivers that are unstably housed.
        i. Recommendations from the WA Landscape Report on Youth & Young Adult Homelessness align with this issue, including:
            1. Using flexible funds and direct cash transfers to provide young people with financial support to prevent homelessness, and supporting unstably housed folks.

2. The expansion of the Host Homes program, which doesn't require formal placements.
    a. There is also support for tracking these sitatuions to assess status.

b. New idea from the discussion, that aligns with other items:
    i. Creating private housing or rooms (Master leasing) - someone holds the lease for the home and the rent can be paid for through IOP dollars.
    ii. This is known as an Independent Living Program (ILP).
        1. Extended foster youth or youth who are coming out of the juvenile rehabilitation system could use IOP dollars to rent those homes, have wrap support, and build tenant history and credit.
        2. This meets the needs of a population with low treatment rates and high housing instability.
        3. This type of program leverages existing funding resources, and facilitates relationship building with landlords - providing them with longterm tenants and residency.
    iii. Youth who are in Extended Foster Care (EFC) receive Supported Independent Living subsidy monthly, which is separate from ILP.
        1. There is also the Foster Housing Assistance Program which has contracted providers who can help access housing.
        2. They are working hard to leverage federally available vouchers as a sustainable source of rental subsidy.

c. Providing ongoing funding to the WA homeless student stability program:
    i. The subgroup invested in supporting this initially, to reduce student homelessness, improve educational outcomes.

d. If this breakout group had to choose only one of these items, they would prioritize expanding the Host Homes program, as it provides a family environment and is more culturally appropriate.

4. **Group 4: YYA crisis services/facilities**
    a. Youth stuck in hospitals is getting worse not better.
        i. From personal experiences, it is very difficult to get into the hospital, and patients end up waiting in the waiting room indefinitely.
            1. It can be nearly impossible to find treatment for co-occuring conditions, such as autism and schizophrenia, and parents have to navigate the system largely on their own.
            2. Families spend a lot of time in the hospital waiting room, and then are "warehoused" there with nowhere else to go.
        ii. Ideally, there would be a centralized expert group that guides people through the process and next steps.
            1. There needs to be coordinated care, as well as a larger provider network.
    b. The crisis bottleneck is caused by upstream issues – the system doesn't help people until they are really sick, they sit in the emergency department, and then there is a lack of downstream services afterwards.

i. Mobile response and stabilization services (MRSS) is an upstream intervention if implemented to fidelity.
ii. Services are siloed, not well advertised, and underfunded.

c. How to prioritize a funding request or legislative ask:
   i. There are huge gaps and a lack of connectivity and robustness of supports and services.
   ii. We should prioritize requiring the HCA to map out where mobile crisis services are available and where they are lacking, and locate funding to fill those gaps.
      1. These responses should be a medical response rather than law enforcement response.
      2. This should also require outcome tracking for every request for mobile crisis and the outcome.
   iii. How do we define crisis?
      1. Crisis is something that requires a mobile crisis response - and meets the 988 criteria of needing someone to show up for care (such as being suicidal, homicidal, damaging property, etc.).
      2. In MRSS, crisis should be defined by the caller/caregiver or youth.
   iv. In rural areas of the state, it can take 1-1.5 hours for an emergency response.
      1. Once there is mobile response and someone is taken to hospital - they end up just waiting there.

d. There is a proposal submitted for HB 1580 (2023) to extend the timeline to ensure the team can fully build a process to support children who remain hospitalized unnecessarily due to barriers to discharge.

5. **Group 5: YYA substance use**
   a. Recovery High Schools work, as proven by a lot of research.
      i. Step 1 is to follow Oregon's playbook – and create a committee that we fund to develop a strategic plan on how to implement more recovery schools.
         1. This includes longterm stable funding for the schools, thinking about where to put schools (urban vs rural), and beyond.
         2. Oregon has 3 different funding sources for their schools.
            a. We don't want to compete for funds for more public high schools or take away resources from other kids.
            b. These should be state-sponsored schools that don't threaten other public institutions.
      ii. It is important to think about how to serve kids who are historically underserved, and work with kids who have trouble getting into treatment.
         1. Recovery high schools create connection and community for young people and attract other young people to them.

Look Ahead: 24/25 Schedule

- Submit new proposals by Friday, August 30th.
  - They will be handed to the workgroup for consideration by Tuesday, September 3rd.

Youth substance use disorder treatment services

Amanda Lewis, BA, SUDP

August 27, 2024

Washington State Health Care Authority

Introductions

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

Objectives

- Current state of access to youth withdrawal management services and ongoing efforts to address the crisis
- Challenges/service gaps in providing youth SUD services
- Upcoming changes to ASAM patient placement

Current state of youth SUD treatment

- Withdrawal management and stabilization
  - 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
- Intensive outpatient/outpatient (IOP/OP)
- Opioid treatment programs (OTP)
- Medications for opioid use disorder (MOUD)

State Opioid and Overdose Response (SOOR) plan

- Statewide efforts in response to the opioid crisis.

- The Health Care Authority (HCA) and partners across the state work to implement the SOOR plan, focusing efforts on five priority goals/areas:
  1. Prevent opioid misuse
  2. Identify and treat substance use disorder
  3. Ensure and improve the health and wellness of individuals that use drugs
  4. Use data to detect opioid misuse/abuse, monitor illness, injury and death, and evaluate interventions.
  5. Support individuals in recovery

Washington State Health Care Authority

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 2023 for two weeks. A total of 552 responses from varied behavioral health partners throughout the state.

SOOR Goal #2 YYA Treatment Subgroup Survey (continued)

- 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

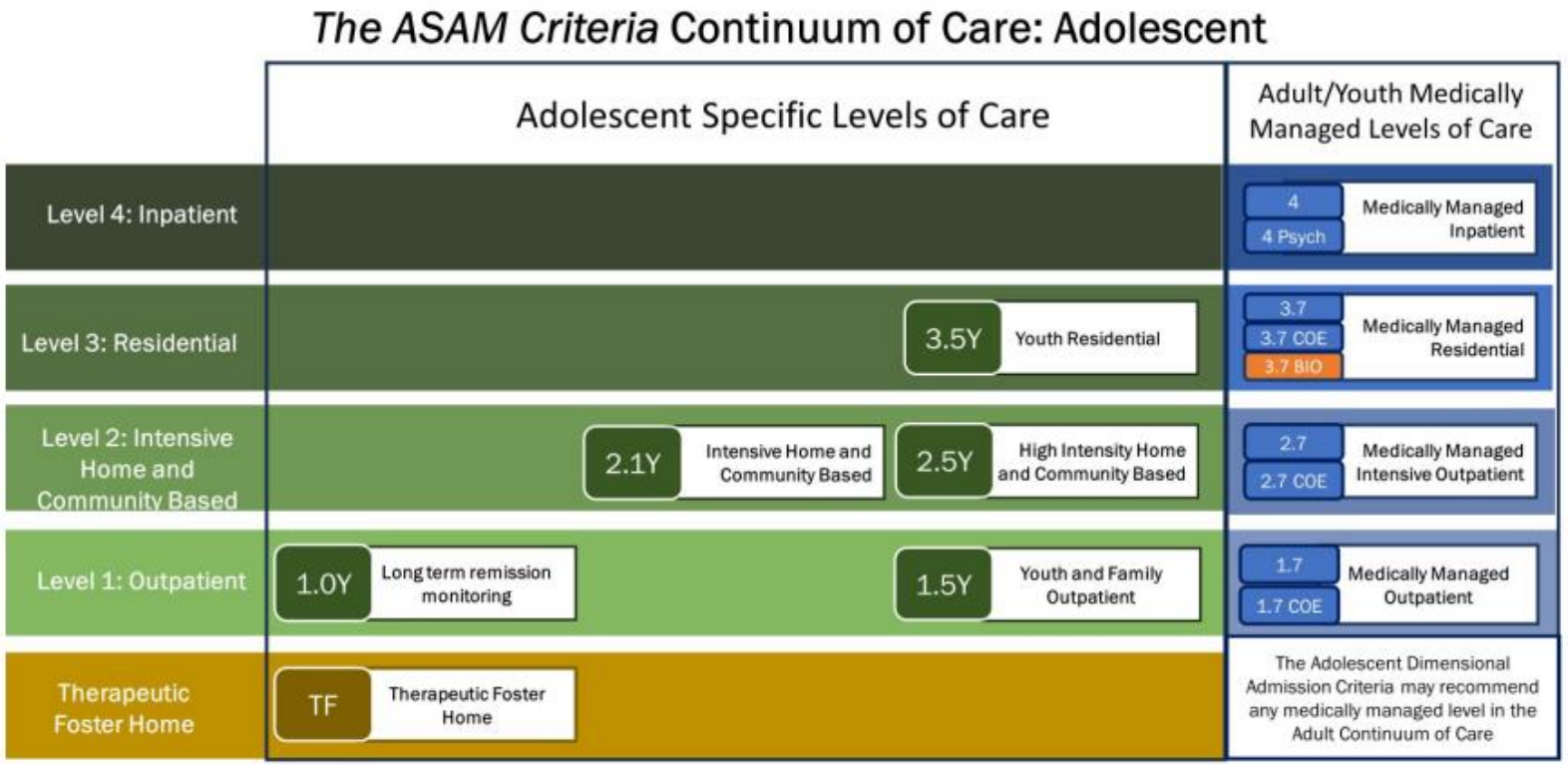
INCREASE ACCESS | Establish low barrier access to MOUD treatment options in every region of the state, increasing number of young people referred to and accessing MOUD and behavioral health treatment services. This also includes access to naloxone and drug overdose prevention and education.	Prioritization (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

Upcoming ASAM Criteria 4th edition changes

- What is American Society of Addiction Medicine (ASAM) –
  - National standards for conducting a comprehensive multidimensional assessment and determining the appropriate level of SUD treatment.
- **First** adolescent and transition age youth (ATAY) edition
  - standards for ATAY that reflects science and best clinical practice and the unique developmental needs of these populations.
  - Promote integrated care for co-occurring, mental health conditions.
  - Individualized, patient centered care.
- Release date – Early 2026

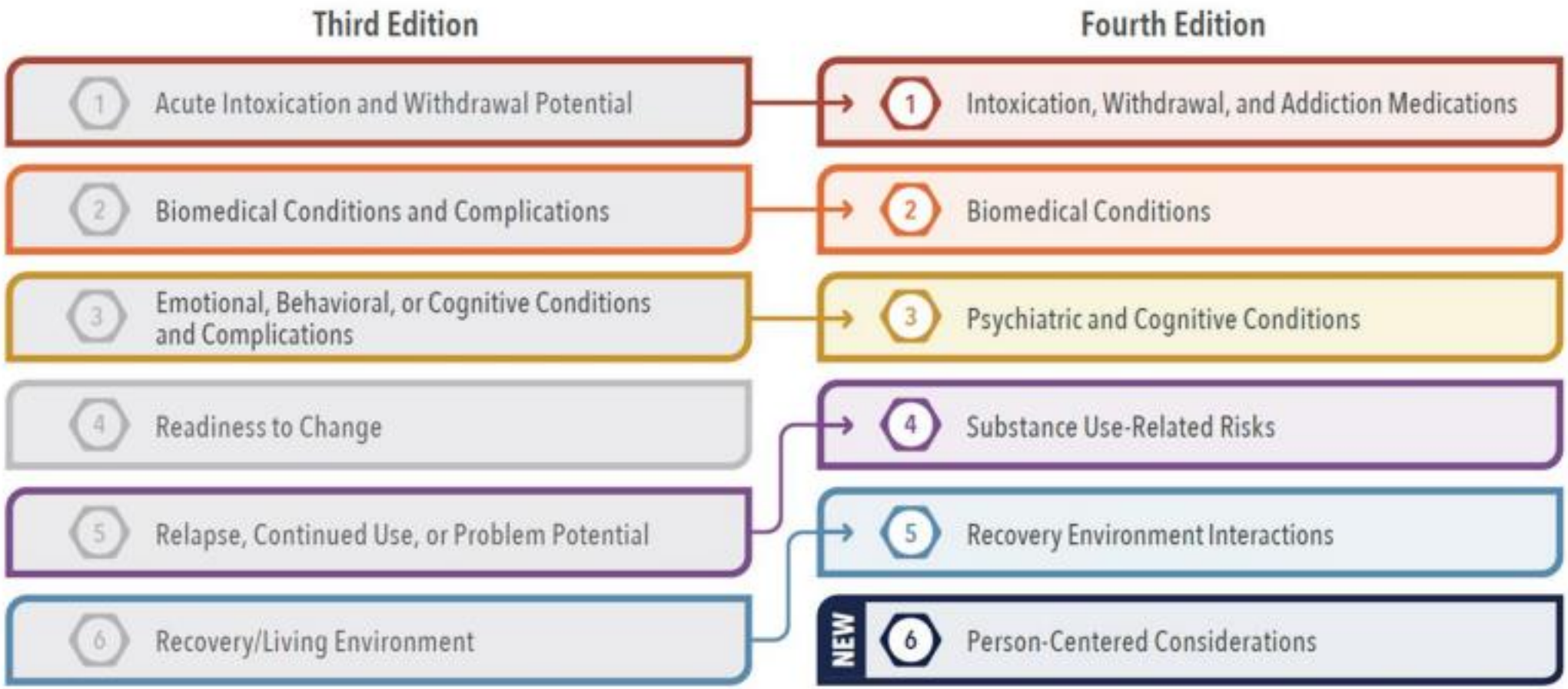
Changes to continuum of care outlined in draft framework**



Anticipated release date early 2026.

**Adolescent specific levels of care (LOC) outlined in ATAY ASAM Criteria 4th edition draft framework may be updated or revised before its final version is released.

Dimension changes



ATAY ASAM Criteria – what's next

- Continued analysis of new edition changes
- Provider and delivery system impacts
  - Shift to co-occurring
  - Home & community-based services
- System needs and supports

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
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  - Center for Motivation and Change

Thank you & questions

- Amanda Lewis

Washington State Health Care Authority