Washington State Legislature

Chairman Wyden, Ranking Member Crapo, and Members of the Committee on Finance,

As the Washington State Legislative co-chair for our state's Children & Youth Behavioral Health Work Group, I want to thank you for the opportunity to provide the attached input regarding any potential federal legislation on behavioral health.

Since 2016, the Children & Youth Behavioral Health Work Group (CYBHWG) has brought together legislators; providers; representatives from state agencies, managed care organizations, advocacy groups, and tribes; parents and young people who've received behavioral health services; and other stakeholders to identify and address barriers to access for behavioral health services for children, youth and families, and make recommendations to the Legislature. Through its subgroups, approximately 350 stakeholders participated in developing the recommendations submitted to state legislature. In this submittal we have identified 6 of the 12 recommendations with a federal nexus.

Washington State is no exception to the behavioral health crisis facing the nation including our children, youth, young adults, and families. With each recommendation we share data and the problem we are trying to address. It will take federal, state, and local action to meet the needs and demands of our country's behavioral health crisis, providing equitable access to quality timely care when and where it is needed, and a continuum care with strong prevention and early intervention services and tools through recovery support services.

I, along with the support of five the subgroups of the CYBHWG, moved quickly to pull information from our report to the WA State legislature in order to meet your deadline. We have built a strong stakeholder framework in BH Workforce & Rates; Prenatal to age 5; Youth and Young Adults (up to age 25); School based BH; and Behavioral Health Integration with primary care. Please don't hesitate to reach out for more information, a deeper discussion on the nexus of this work to federal action, or with any other way we can support you and your work!

With gratitude for your consideration, time, and service!

Lisa Callan

Lisa Callan
Washington State Representative
Co-Chair, Children & Youth Behavioral Health Work Group

The Washington State Children & Youth Behavioral Work Group ("CYBHWG") was created in 2016 and is tasked by statute to identify barriers to and opportunities for accessing mental health services for children, youth and families and to advise the legislature on statewide mental health services for this population.

In 2020 and 2021, the deficiencies in our mental health system for children and youth became glaringly apparent, as the mental health needs of children and youth reached crisis levels during the Covid pandemic. Many of these needs were long-standing; the pandemic pushed them to the breaking point.

Among the data the work group reviewed were these findings:

- Since the start of the pandemic, calls from families requesting referrals to the Mental Health Referral Service for Children and Teens have more than doubled, with 3 out of 4 requests coming from families with commercial insurance. It currently takes an experienced referral specialist 14-20 days to find a provider. *(Dr. Robert Hilt, Washington Mental Health Referral Service for Children and Teens, Seattle Children's Hospital)*
- Today, in Washington state, more than half of pediatric primary care visits are for behavioral health concerns; up from 25% before the pandemic. (*Washington Chapter of the American Academy of Pediatrics)*
- Almost half of Seattle Children's emergency department beds are filled with patients with behavioral health issues, many of whom could not be discharged safely due to inadequate community supports, or are "boarding" while they wait for inpatient beds. *(Kashi Arora, 10/19/21 testimony at Washington State House of Representatives Children, Youth and Families Committee)*

The CYBHWG undertook a comprehensive process this year to identify critical needs and strategies to improve mental health services for children and youth. While the work group promoted solutions to address the immediate crisis, members also found it imperative to think about the longer term, and how to fundamentally address the barriers and shortcomings in the state's behavioral health system. Its recommendations address many of the questions raised by Senators Wyden and Crapo in their September 21, 2021, letter and include:

- Medicaid rate increase - To stabilize the community behavioral health safety net and improve access to care, implement a 7% Medicaid rate increase directed to community behavioral health agencies, retroactive to January 1, 2022.
- Provide funding to explore alternative models of funding behavioral health care – Specifically, to look at implementation of Certified Community Behavioral Health Clinics (CCBHCs) as a way of stabilizing funding and covering all the activities necessary to deliver good care, including care coordination and navigation.
- Funding for startup costs for pediatric behavioral health integration in primary care – Provide funds for clinics that demonstrate objective and specific readiness to build collaborative care behavioral health integration programs to expand access to early identification and treatment of mental health issues in children and youth.
- Reimbursement for non-licensed staff in primary care settings to support and coordinate behavioral health care – Allow reimbursement for non-licensed staff like community mental

health workers, navigators, and care coordinators to support kids' behavioral health in primary care settings.

- Provide grants to put more behavioral health clinicians in schools to meet urgent needs of students – Funding is requested to add 100 clinicians in schools in 2022.
- Ensure stable housing and care coordination for youth exiting inpatient treatment - Potential solutions include (1) implementing peer bridgers for transition age youth (TAY), (2) expanding behavioral health housing vouchers and earmark for TAY, (3) grant funding to develop TAY-specific SUD and mental health recovery housing and (4) expanding behavioral health supports in youth shelters.

These recommendations would have a significant impact on mental health services for kids relatively quickly and all would benefit greatly from federal support. We explain below how these recommendations are responsive to the questions raised in your letter and share some of the other recommendations and findings of the work group during the past two years.

Workforce

In recent years, every one of the CYBHWG's subcommittees – no matter what population they serve and what parts of the system they focus on – have identified workforce shortages as the single biggest factor affecting access to care. There simply is not capacity within the system – for both Medicaid/Medicare and private insurance – to meet the burgeoning need.

Chronically low Medicaid rates leave community behavioral health agencies (BHAs) unable to offer competitive salaries and compensation to their employees. This historical baseline reality has been exacerbated by a growing national behavioral health workforce shortage and the simultaneous loss of workers due to pandemic-related concerns (e.g., no childcare, family illness). Competition for behavioral health workers is extreme and accelerating, and the compensation gap is growing.

> Rate increases are urgently needed to address the behavioral health workforce crisis and to improve access for children and youth

Currently, access is severely limited across Washington state. In an unprecedented development, BHAs are limiting or closing admissions for basic outpatient services to new patients. In addition, clinic branch offices are closing; treatment bed capacity has been significantly reduced; and waitlists are growing. Clinics cannot respond promptly to individuals and families needing behavioral health care. People cannot receive routine, ongoing treatment. Therefore, crisis calls are surging, as are referrals for more intensive services.

A recent survey conducted by the Washington Council for Behavioral Health[1] documented these alarming trends:

- Over half of surveyed provider agencies have closed or limited access to outpatient services.

[1]Washington Council for Behavioral Health, workforce survey of licensed behavioral health agencies completed in August 2021.

- Vacancies for master level clinical staff average 30% and are as high as 60% in rural communities.
- All-staff vacancy rates have increased by 38% in the past five months.
- Annual turnover rates have climbed to 30%.
- Treatment beds have been taken offline and branch office sites have closed.

Ironically, limits on the availability of outpatient care result in the use of more costly acute care resources, including emergency room visits, hospitalization, and encounters with law enforcement.

Further, the quality of outpatient care is impacted as a result of such effects as staff turnover and multiple changes in assigned clinician, longer waits between appointments, and loss of same-day appointments.

> Solving the behavioral health workforce crisis will contribute to ensuring equitable access to and quality of care for minority populations

BHAs primarily serve Medicaid enrollees and other very low-income individuals and families. These communities represent an underserved population in which significant health disparities exist, including among children, youth, and adults with serious emotional disturbances, serious mental illness, and/or addiction disorders. These communities experience premature mortality with life expectancy reductions of 10–25 years.

In addition, people of color are disproportionately represented in the public behavioral health system due to the impacts of poverty, racism, and other social determinants of health. By providing upstream identification and intervention to children, youth, and families, BHAs can get help to patients sooner. However, the current workforce crisis is reducing capacity and limiting access.

Recommendation (immediate relief)

Increase Medicaid rates for behavioral health providers

Implement a 7% Medicaid rate increase directed to community behavioral health agencies, retroactive to January 1, 2022, to stabilize the community behavioral health safety net and improve access to care. ***(Recommendation to Washington State Legislature for 2022)***

While a 7% rate increase will not ultimately address the disparities in salaries between clinicians in the public behavioral health system and those working in other settings, and the resulting workforce challenges, this is an immediate action that can be taken to address the problem.

Recommendation (longer-term solution)

Provide funding to explore implementation of Certified Community Behavioral Health Clinics (CCBHCs)

Develop a sustainable alternative payment model for comprehensive community behavioral health services by studying the CCBHC model, conducting related actuarial analysis, and proposing a pathway for statewide implementation. ***(Recommendation to Washington State Legislature for 2022)***

Community mental health centers, when originally established in 1975, were supported by federal funding, with a goal of providing access for all. In the 1980s, the community mental health portion was deregulated and block-granted to the states, leaving these agencies heavily dependent (85-95%) on Medicaid reimbursement. (Other parts of the system receive 52% of their funding from Medicaid.)

States that have implemented CCBHCs have increases in access to care and decreases in hospitalizations, readmissions, and behavioral health emergency department usage. (TheNationalCouncil.org.) The success of this approach depends on sustained, adequate funding of the CCBHC model at the federal level.

Behavioral Health Integration and Access to Care

> Children, youth and families need multiple access points to behavioral health care, especially in the settings they already frequent and trust

Before the COVID-19 pandemic, behavioral health disorders affected about one in five children. Pre-pandemic the National Health Interview Survey found unmet mental health needs for 80% of Black, 82% of Hispanic, and 72% of white children. Today, needs have grown substantially:

- During the pandemic, 11-17-year-olds have been more likely than any other age group to have moderate to severe anxiety and depression.
- In September 2020, over half of teens reported frequent or even daily thoughts of suicide or self-harm.
- Children's significant Emergency Department (ED) use and steeply rising hospitalizations for behavioral health reasons are now well-documented in Washington State.
- At Mary Bridge Children's Hospital in Tacoma, Washington, the current length of stay in the ED for patients with behavioral health issues is 30 hours. (The range of stays runs 6 hours to 6 weeks.) This often means that a room in the ED is taken offline for children's medical needs while behavioral health patients are boarding.
- A November 2020 study by the Washington Chapter of the American Academy of Pediatrics found typical waits of 1-2 months for children and youth to receive an intake with a behavioral health provider.
- Before the pandemic, over 25% of pediatric primary care visits were for behavioral health concerns – today more than half of primary care appointments are for behavioral health needs. Primary care is not currently resourced to rapidly provide behavioral health care or to coordinate the services children and youth need.

The needs of these children are too often being met in emergency departments and in specialty clinics after long waiting periods, when the child is in crisis. The purpose of integrating behavioral health services into primary care is to identify those needs early on and intervene with treatment before their condition spirals into serious mental health challenges and crisis. Yet, in Washington State, only limited access to assessment or behavioral health treatment is available from a child's pediatrician.

Integration helps ensure equitable access to care and improves access for children and young people generally

Primary care is the first place many families turn for help with children and teens' symptoms, worries, anxiety, or depression and nearly 100% of children under age three regularly visit primary care, affording a unique and important opportunity to support parents of the youngest children. Primary care settings are a critical link to aid in identifying and addressing mental health problems for BIPOC. *(Toward Culturally Centered Integrative Care for Addressing Mental Health Disparities among Ethnic Minorities (nih.gov))* Yet behavioral health integration in primary care for children and youth is the exception not the norm, and significant unmet needs exist for timely, effective treatment and coordination of care with schools, specialty behavioral health clinics, and other places where kids are seen.

Pediatricians, family physicians and other primary care professionals play a critical role in screening, early identification, and timely support for kids' behavioral health needs. Importantly, addressing behavioral health issues in regular well child visits in primary care normalizes behavioral health as a part of whole-person care, and reduces the stigma that in many communities attaches to raising a behavioral health concern.

Further, lengthy waits for appointments at behavioral health clinics could be reduced if a portion of their caseload – patients with mild to moderate problems – were treated in the primary care setting. However, many primary care clinics are overburdened and are not set up to address children and teen's rapidly rising behavioral health needs. It is a critically important time to invest in transformative efforts to maximize our primary care and behavioral health workforce.

Best practices for integrating behavioral health with primary care and federal payment policies that would best support implementation of integrated programs

Based on our experience in Washington State, we know behavioral health integration in primary care can be well-executed and achieve results for kids. In 2021, the Work Group's Behavioral Health Integration Subgroup learned that Washington clinics implementing collaborative care for children and youth are achieving measurable improvements for patients and programs are financially viable, if carefully implemented.

Further, integrated programs at clinics in both urban and rural areas, and in clinics where Medicaid insured families predominate have been handling hundreds of cases with generally good outcomes. In one urban program that has been operating since January of this year, there have been no ED visits for behavioral health reasons by any of the youth enrolled in their integrated behavioral health program. In all clinics with integration programs, both providers and families express a high degree of satisfaction with this method of behavioral health care delivery.

Based on presentations from Washington clinics who have adopted integrated care and from academic centers who support care integration, our Work Group learned that effective models of care integration include:

- A primary care champion or proponent of the program
- A behavioral health professional located at the clinic
- An arrangement for psychiatric consultation and supervision
- A registry tracking the symptoms and outcomes of patients
- A team approach to care
- Universal screening for behavioral health issues and social determinants of health
- Provision of care coordination, including coordination with schools, ED's, hospitals, and other points of care
- Ensuring "closed-loop" referrals and engagement in specialty behavioral health care when indicated

To enable primary care practices to implement behavioral health integration for children and youth, the following start-up costs must be funded:

- Training, including in such operational elements of integration as developing work flows to ensure that team-based care is provided, and in evidence-based practices, including brief interventions for children with mild to moderate behavioral health challenges
- Development of reliable and systematic workflows, including a multi-disciplinary team approach to screening parents post-natally and children and teens ages 11 and older, as indicated by Bright Futures standard of care
- On-boarding of behavioral health professional, with salary support during training and while developing a caseload
- On-boarding of psychiatric support person (M.D. or ARNP), including initial salary support
- Development of partnerships with community mental health centers for referral of patients with higher level needs
- IT infrastructure, including necessary EHR adjustments and creation of a registry
- Space needs for additional staff

Best practices also include training for behavioral health professionals in evidence-based brief interventions such as First Approach Skills Training for Anxiety (FAST A) and First Approach Skills Training for Behavior issues (FAST B), and in Cognitive Behavioral Training, (CBT). These methods are well suited to helping families in the primary care setting relatively quickly and effectively.

The biggest barrier to implementing behavioral health integration in primary care settings is funding start-up costs. Currently codes that allow reimbursement under either the collaborative care model or fee for service billing (FFS) do not pay for the start-up costs of implementing BH integration incurred in the first two years. They only provide retroactive payment for patient services that have been provided; they don't pay for the transformation of primary care that must happen to provide truly integrated

behavioral health care. Based on reports from clinics that have successfully moved to an integrated model, our Work Group determined that cost to be approximately $200,000 for one clinic adding one behavioral health professional/care manager to its staff.

Recommendation

Fund startup costs for behavioral health integration in primary care clinics

Provide start-up funds to clinics which demonstrate objective and specific readiness to build collaborative care behavioral health integration programs in primary care settings to expand access to early identification and treatment of mental health issues in children and youth. ***(Recommendation to Washington State Legislature for 2022)***

> Federal and state payment mechanisms need to change for integration to be sustainable

The Work Group also determined that Medicaid payment systems as they now exist do not adequately recognize or reimburse all of the activities that are involved in providing team-based care, and care that is coordinated with schools and other providers. For that reason, our work group has been working with our Medicaid agency on developing Value Based Payment mechanisms that would do away with the existing more rigid categories of covered services and requirements for payment.

Recommendation

Reimbursement for non-licensed staff to perform tasks for which a license is not required

Allow reimbursement for non-licensed staff like Community Health Workers, navigators, and care coordinators to support kids' behavioral health in primary care settings. ***(Recommendation to Washington State Legislature for 2022)***

> Non-clinical staff can play a significant role in reducing burnout of behavioral health workers, addressing inequities in care, and connecting children and families with key non-clinical services

Currently, behavioral health professionals not only provide counseling and care management services, but typically also do a great deal of work to connect families with needed services, as well as paperwork and administrative tasks. Our Work Group supports "rational redistribution of tasks among health workforce teams" whereby specific tasks are delegated to non-licensed health workers to make more efficient use of our very stressed health professional and behavioral health workforce. "This study confirms partially the existing evidence on the effectiveness of CHW interventions as a strategy to address mental health in primary healthcare" (Int J Environ Res Public Health).

There is a growing body of knowledge of the qualities and functions that make community health workers or family navigators effective supporting families' and children's social determinants of health and mental health needs. In addition, these roles can be critical in advancing health equity and supporting clinics to be culturally and linguistically responsive and anti-racist.

> Community health workers…are an integral part of the medical home team and serve as a bridge between the practice and the community and as a foundational point of trust and engagement with families and their children. The challenge now is to spread, scale, and sustain such efforts across many more medical homes and to incorporate their financing into public (and private) health coverage.[2]

Removing the barrier of requiring that staff be licensed to qualify for Medicaid payment will enable clinics to hire qualified workers from the communities they serve, including workers who have lived experience and have the cultural background and competence to serve those communities.

Specific Activities that a non-licensed support staff can do to support BH in primary care include:

- Identify behavioral, developmental, and/or social determinants of health using a validated instrument
- Connect families with services addressing social determinants of health, such as financial assistance, food, and housing
- Connect families with newborn and early childhood services, such as WIC, Head Start, and school district services
- Support care navigation and care coordination process for primary care, community mental health clinics, ED care, inpatient behavioral health care, and schools
- Follow up on birth to three referrals to ensure connection for children needing early intervention
- Offer patient education, including coaching in mental health coping strategies, for parents and children and in parenting strategies and skills.

Federal and State funding mechanisms need to change to fund these critical support services. Currently, billing codes do not cover many of the services that are vital to the delivery of coordinated and effective behavioral health care to children and families, particularly if they are performed by non-licensed "navigators" or community health workers.

In Washington State, private philanthropy is funding training for bachelor's level behavioral health workers to perform these jobs. Thus, there will be workers who can provide navigation assistance to needed services and can provide coaching to parents and children in resiliency and coping skills, but there will be few jobs for them unless these activities are reimbursable by Medicaid.

Our Work Group has determined that a system that provides funding on a per member per month basis for children insured on Apple Health/Medicaid adequate is an appropriate mechanism to enable clinics to provide these critical support services.

> Significantly more clinicians are needed in schools, to meet children where they are, with culturally responsive services

Our subcommittee on School-based Behavioral Health & Suicide Prevention identified the need for a significant increase in the number of behavioral health professionals in schools. There is an urgent need to provide ready access to services for youth who may be unable to voice their mental health concerns

[2] Bruner, C.H., M, et al., Dismantling Racism: 10 Compelling Reasons for Investing in a Relational/Community Health Workforce for Young Children and Their Families. 2021: Des Moines, IA.

to parents or primary care providers, or who find it difficult to take the step of seeking out a behavioral health provider. School-based services have proven effective at reaching students with significant emotional challenges, including suicidal ideation, and at increasing social and emotional competency among students and at schools generally. Because students usually attend school in their neighborhoods, school-based services provide an opportunity to implement culturally responsive behavioral health services, targeted at that community's needs.

Among the models that this subcommittee looked at is South Carolina, which provides state funding for master-level clinicians embedded in schools; school districts are responsible for a portion of the funding for these positions.

There are substantial structural barriers to funding school-based services

Complex and fragmented funding systems and limits on billable services under both Medicaid and private insurance plans greatly limit the availability of behavioral health services in school settings. The subcommittee recommended that funding be appropriated to provide "coverage-blind" services and supports. This will ensure more equitable access and will allow providers to coordinate their services with school staff through co-location, care coordination, and participation in Multi-Tiered System of Supports (MTSS) teams, IEP teams and other meetings which are not typically billable as behavioral health services.

Recommendation (immediate)

Provide grants to put more behavioral health clinicians in schools in response to urgent needs of students in schools.
Provide base-level funding grants for 100 school-based licensed behavioral health clinicians in 2022 at $65,000/FTE. To be eligible, school districts would need to designate matching funds from another source to fund full-time positions, including other district funds, grants, Medicaid billing, etc.
(Recommendation to Washington State Legislature for 2022)

The subcommittee proposed funding grants for school-based behavioral health positions, grants that are not tied to fee-for-service billing. The goal is for funds to be available to serve students without coverage, students with coverage who cannot receive behavioral health services in a timely manner, and to allow the clinician to coordinate services with school staff (e.g., through MTSS team meetings, Individualized Education Plan (IEP) meetings, and other methods. Insurance-blind services will also help decrease the stigma associated both with accessing behavioral health care and with identifying as a Medicaid recipient that can be a barrier to accessing care.

Each clinician should be a masters-level clinician and a licensed behavioral health providers or be supervised by a licensed clinician and/or a licensed agency.

Recommendation (longer term)

Support capacity building for MTSS in Washington school districts.
Build the capacity for school districts to implement a Multi-Tiered System of Supports (MTSS), including effective collaboration with behavioral health systems through an Integrated Systems Framework (ISF).
(Recommendation to Washington State Legislature for 2023 and beyond)

> Mobile crisis response teams, with specialized training in serving children and youth, can meet families where they are and reduce emergency department visits

Recommendation

Expand youth mobile crisis services statewide and ensure existing teams can meet increased demand. *(Recommendation to Washington State Legislature for 2021; passed)*

A minimum of 6 new youth mobile crisis teams will be established by June 30, 2022, so each region in the state has one.

Telehealth

Recommendation (immediate)

Development of best practices to ensure that care provided is high-quality, cost-effective, and appropriate for children, youth, and their families.

Support current efforts to assess and improve telehealth, including audio-only, to reduce racial and income disparities in behavioral health service access and ensure that virtual services are clinically effective and provide relief to children and families. *Recommend review of data and research focused on prenatal to age 25 and development of best practices with stakeholders.* *(Recommendation to Washington State Legislature for 2021; passed)*

In 2021 the WA State legislature included funding in their 21-23 biennial budget to embark upon a process of developing best practices related to the use of telehealth with the 0-25 year old population. Funding for the work was contracted to the University of Washington-based Behavioral Health Institute to work in partnership with the Evidence Based Practices Institute and stakeholders to develop best practices. This work, while focused on children, youth and young adults, will likely lead to an examination of the use of telehealth across other age groups. We would gladly share the findings from this work with the Finance Committee or others you believe might be interested.

Improving access for children and young people

The work group has included focus on two lifespan populations that have specialized needs and face specific barriers to access – infants and very young children, and their families; and transition age youth and young adults (ages 18-25).

> *Our current behavioral health system has not been designed or optimized for assessing infant and early childhood mental health needs.*

Approximately 9.5-14.2 percent of children birth to 5-years-old experience emotional, relational, or behavioral disturbance.[3]

The current system was designed for older children and adults, with many mental health clinicians relying on the *Diagnostic and Statistical Manual of Mental Disorders (DSM 5),* which includes diagnostic criteria applicable to children and adults above age 6. Its use for young children makes misdiagnosis and selection of the wrong treatment more likely due to the lack of age-appropriate developmental symptom mapping with disorders. Some diagnoses that show up in early childhood aren't even found in the DSM. Minimally, it may provide inaccurate care or unnecessarily prolong treatment. At worst, it substitutes the wrong treatment because the diagnosis was wrong in the first place (for example, treating phantom ADHD or autism rather than trauma).

Recommendation

Change Medicaid policy to match best practices for mental health assessment and diagnosis of children 0-5, including allowing 3-5 sessions for intake/assessment, in children's homes and other natural settings.

Require clinicians to use the developmentally appropriate standard of practice for diagnosing children 0-5, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5), rather than the Diagnostic and Statistical Manual of Mental Disorders.
(Recommendation to Washington State Legislature for 2021; passed)

Youth and young adults need strong supports after exiting inpatient care

Currently, 2 out of 10 youth and young adults (ages 18-24) in Washington state who exit inpatient treatment are homeless within a year.[4]

Safe, quality, supportive housing is essential to help transition-age youth (TAY) remain in recovery from mental health and substance use challenges post-release from inpatient behavioral health settings. Of TAY who experienced homelessness within a year of exiting a system of care (foster care, juvenile rehabilitation, and behavioral health inpatient), two-thirds were discharged from the behavioral health system. Our system should support and encourage youth who have the courage to seek help, not kick them to the curb.

It is unrealistic to expect transition-age youth to maintain symptom remission, follow through on outpatient treatment, and pursue recovery goals while experiencing the daily traumatic experience that is homelessness and housing instability. TAY living with behavioral health challenges who are experiencing homelessness are much more likely to be re-hospitalized, to visit the emergency department and to encounter the criminal legal system—all at great expense to governments at all levels.

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[3] Yaari, M., Treyvaud, K., Lee, K.J., Doyle, L.W., Anderson, P.J. (July 2019). Preterm Birth and Maternal Mental Health: Longitudinal Trajectories and Predictors. Journal of Pediatric Psychology. Volume 44, Issue 6, July 2019, Pages 736–747. https://doi.org/10.1093/jpepsy/jsz019).

[4] Report: Homelessness Among Youth Exiting Systems of Care in Washington, Washington State Dept. of Commerce, Office of Homeless Youth, July 2020

Recommendation

Ensure stable housing and care coordination for youth exiting inpatient settings.
(Recommendation to Washington State Legislature for 2022)

Potential solutions to build supports for youth exiting inpatient treatment

Our Subgroup on Youth and Young Adult Continuum of Care looked at what would be needed for transition-age youth to avoid homelessness upon discharge from residential treatment programs and identified these potential solutions:

- Earmarking behavioral health housing vouchers for youth
- Grant funding for the development of TAY-specific SUD and mental health recovery housing, including both start-up and operating expenses
- Flexible funds to prevent TAY homelessness upon discharge, i.e., create a pot of flexible funds to fund such things as plane or bus tickets, short-term hotel stays, etc.
- Expand behavioral health supports in youth shelters.
- Require and fund care coordination that includes ensuring that transition-age youth discharged from inpatient hospitalization are placed in safe, stable housing with appropriate supports for their behavioral health needs.