
From Inpatient Treatment to Homelessness:

Envisioning a Path Toward Healing and Safe Housing for Young People in Washington State

A Way Home Washington
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A Way Home Washington

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EXECUTIVE SUMMARY

Young people who access inpatient behavioral health treatment—mental health and substance use disorder programs—are incredibly vulnerable. These youth and young adults have been determined to have such serious mental health or substance use disorders that they cannot effectively receive treatment in their communities. Leaving treatment and subsequently becoming homeless or unstably housed compromises these young people’s basic health and safety and puts their educational and vocational progress at enormous risk.

The data underscore this extreme vulnerability. In Washington State, every year about **1,200 young people become homeless or unstably housed within 12 months of their discharge from publicly funded inpatient behavioral health treatment programs.**

Public and private stakeholders working on the issue of youth homelessness are preparing to respond to legislative action—Substitute Senate Bill (SSB) 6560—that requires a statewide plan to ensure that all young people who are discharged from publicly funded systems exit into safe and secure housing. This collaborative planning effort presents a momentous opportunity to prevent and end youth homelessness in Washington State.



A Way Home Washington hopes this report will help guide the SSB 6560 conversations by providing system planners a global view of the complex reasons why young people—those who are under and over 18—held so closely and under such scrutiny in a publicly funded system could

thereafter become homeless. The full report provides a review of the current information available about youth homelessness from the inpatient behavioral health perspective, offers insight into massive system initiatives underway around behavioral health and youth homelessness, and shares the perspectives of stakeholders who interact with the inpatient behavioral health system. The full report also provides more detailed information about the inpatient behavioral health landscape that serves young people in Washington.

This report identifies systemic failures that are not new to families, young people, service delivery professionals, or system agents. It is not intended to comprehensively identify policy, practice, and funding barriers that may need to change so that Washington State can reduce the likelihood that young people leaving inpatient programs experience homelessness or unstable housing.

This report is intended to be a platform for many conversations to come. It was informed by A Way Home Washington's work over the past year with inpatient and community behavioral health providers, homeless youth service providers, state agency leaders, advocates, families, and young people.

Key Findings

- ◆ Of the roughly 1,800 young people leaving all state public systems of care who subsequently experience homelessness or unstable housing every year, **almost two thirds (1,178) of them come from the inpatient behavioral health system**. The remaining one third who experience homelessness come from foster care (130), the state juvenile justice system (132), or the state adult corrections system (384).
- ◆ Of the nearly 1,200 young people who become homeless or unstably housed after an inpatient behavioral health episode, around 85% of them are young adults (ages 18 – 24).
- ◆ There is a general system disconnect between behavioral health and youth/young adult homelessness planning efforts. Behavioral health system leaders and on-the-ground experts engage in regular and intensive dialogue about how to improve the inpatient programs that serve young people, but it does not appear that this work sufficiently connects to homelessness prevention or that youth housing or homeless providers are part of those conversations.
- ◆ The authors were unable to identify any inpatient mental health or substance use disorder programs or specific program design, including discharge planning, that serves the unique developmental needs of young adults.

- ◆ The bed capacity needed for young adults to receive inpatient mental health or substance use disorder treatment is unclear. Likewise, the bed capacity needed for youth (ages 12 – 17) for inpatient mental health or substance use disorder treatment is unclear.
- ◆ Washington does not have enough comprehensive, less restrictive forms of treatment and intensive in-home support that allows young people to stay with their families and avoid institutional care altogether.
- ◆ Families and young people’s support systems experience challenges to meaningful engagement in discharge planning. Facilities accept youth from all regions of the state, and families often struggle to visit and get involved in discharge planning due to transportation barriers and the demands of work and caring for other children in the family. Families also experience ‘burn out’ due to a young person’s intensive and long-term mental health or substance use disorder needs. Additionally, the families of minors may also encounter barriers to engaging in discharge planning due to the youth’s legal right to exclude their caregivers from their behavioral health treatment planning.
- ◆ Washington lacks a comprehensive post-inpatient treatment community-based support system for young people and their families. Caregivers



may not have the skills to assist in post-discharge treatment plans and may not know how to manage problem behaviors at home. Many young people feel abandoned by parents and caregivers who have given up. Young people and their families/ caregivers need access to comprehensive, in-home, skill-based behavior support wraparound services, regardless of the young person’s age or Medicaid eligibility. Peer support to young people and respite care for families are also important components of an ongoing treatment plan.

- ◆ There is no centralized, standardized database that identifies post-treatment services. Inpatient facility providers struggle to find appropriate, community-based or outpatient resources.
- ◆ Washington lacks a comprehensive, post-inpatient treatment housing and step-down program continuum. One example is that there are not

enough recovery-based housing programs available for young adults or minors leaving substance use disorder treatment.

- ◆ Foster youth leaving inpatient behavioral health programs experience significant challenges in finding supportive placements capable of meeting their mental health and/or substance use needs.
- ◆ Young people leaving inpatient behavioral health programs do not have sufficient connections to legal advocacy to ensure they can access housing, supportive services, and public benefits.
- ◆ There are massive initiatives underway that will impact how system partners will interact with each other. It is essential that the system initiatives underway adopt an intentional, dedicated effort to address youth homelessness.

Opportunities & Recommendations

Assign System Ownership

- ◆ Two thirds of young people leaving a state public system of care who become homeless are coming from the inpatient behavioral health system. It is critical to assign some system ownership of this issue. Treatment facilities are in the unique position of having these young people in their care, usually with sufficient time to conduct a comprehensive assessment of their current psychiatric, physical, social, educational and vocational needs, including housing. All this information is vital to successful discharge planning and community reintegration. Facilities need strong partnerships with and support from community providers as well as system ownership over identifying and advocating for cross-system policy, practice, and funding to support the young people in their care.
- ◆ Existing behavioral health work groups must find ways to embed homelessness prevention in their ongoing dialogue and ensure the system leaders who are closest to youth homelessness intervention are part of those conversations. Likewise, youth homelessness work groups

must better understand and identify ways to connect to their work to the inpatient behavioral health system.

- ◆ The statewide planning work through SSB 6560 presents an incredible opportunity to assign ownership of the intersection between inpatient behavioral health and youth homelessness and identify ways to create connections across systems and re-envision existing work groups.
- ◆ As more connections are forged, the behavioral health and youth homelessness worlds must identify ways to increase their collective budget and policy advocacy priorities.
- ◆ The voices and experiences of young people and their families should inform the work once system ownership is assigned.

Identify Additional Data and Learning Opportunities

There are many opportunities to better understand the circumstances of young people who access and leave inpatient behavioral health programs and subsequently experience homelessness or unstable housing. Gathering the following data could help Washington better understand how to build a robust response system for these young people:

- ◆ The housing or homelessness status of young people prior to entering inpatient treatment, including whether they were homeless with their family, homeless and unaccompanied, unstably housed, in foster care, or have some other housing status.
- ◆ Whether the young people who experienced homelessness or unstable housing post-treatment did so unaccompanied or with their family.
- ◆ The rates of homelessness or housing instability at a point in time closer to program discharge, for example, 30, 60, or 90 days following discharge.
- ◆ The post-discharge rates of homelessness from short-term programs (for example, from psychiatric evaluation and treatment facilities) versus long-term programs.
- ◆ Whether young people are counted in more than one system, for example, if they are in foster care at the time of an inpatient treatment episode.

- ◆ The LGBTQ+ status of the young people who experienced homelessness or unstable housing after an inpatient episode.
- ◆ The racial and ethnic identity of young people who experienced homelessness or unstable housing after an inpatient episode.
- ◆ The number of young people who entered inpatient treatment voluntarily, through a parent-initiated treatment referral (youth), or through an Involuntary Treatment Act referral (young adults) and who subsequently experienced homelessness or unstable housing.
- ◆ The number of young people discharged to various caregivers—including parents, legal guardians, the child welfare system, the juvenile justice system, or others—and who subsequently experienced homelessness or unstable housing.

It is also critical to understand whether young people with certain health statuses or diagnoses are more likely to access homeless services or become homeless or unstably housed after leaving treatment. Specifically,



we need to better understand the post-inpatient treatment outcomes for young people on the autism spectrum or who have another identified intellectual or developmental disability or have received services from the Developmental Disabilities Administration (DDA) providers. System leaders must engage disability data experts and advocates to better understand what data is needed so we know who is entering the system, what is their profile, and what is their intersectionality (disability, race/ethnicity, LGBTQ+, and others) in order to track outcomes.

Identify, Adapt, and Invest in Innovative Programs

Public and private partners must work together to:

- ◆ Identify intensive in-home service supports and less restrictive forms of treatments so that young people can remain home in their communities to address their mental health or substance use disorder needs.

- ◆ Develop comprehensive and developmentally appropriate discharge planning toolkits for inpatient providers so they are better connected to post-treatment housing and other services in the community.
- ◆ Identify service and funding gaps and barriers to accessing post-treatment services—peer support, caregiver respite, intensive wraparound, and others—that provide critical support to young people as they transition from inpatient treatment-to-community.
- ◆ Identify innovative and promising post-inpatient treatment housing programs and determine whether the model can be adapted to serve the unique developmental needs of young adults and/or youth.
- ◆ Look to the significant systems initiatives underway for opportunities to leverage blended funding opportunities.

FULL REPORT

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DISCUSSION

I. Introduction

A Way Home Washington (AWHWA) believes that Washington State's youth have a lifetime of potential. We believe that they will build tomorrow's businesses, shape our public policies, and educate the next generation of children. Investing in young people who have demonstrated the courage to address a mental health and/or substance use disorder crisis is compassionate and will save lives, but also smart and will ultimately save dollars.

We believe that no young person should be forced to sleep outdoors or in unsafe or unstable situations due to lack of resources. We are dedicated to helping all young people in Washington find their way home.

Unfortunately, many young people and their families face significant barriers in reaching these dreams, and many young people fall into homelessness or are at risk of becoming homeless as a result. At least 13,000 unaccompanied young people access homeless housing and support services each year in Washington. These young people are separated from their families and need extra support to survive, let alone thrive. In the

absence of meaningful systemic response, these young people are at high risk for experiencing adult homelessness, dependency on public assistance, poor health outcomes, incarceration, and more.

AWHWA is part of a growing movement dedicated to ensuring these young people receive the support, care, and resources they need to overcome these barriers. We have one goal: Preventing and ending youth and young adult homelessness in Washington State. We believe a critical strategy to reach this goal is to ensure that public systems discharge young people to safe and secure housing. The other three strategies include strengthening the capacities of **schools, local communities, and families** (biological, adoptive, kinship, and chosen). We will achieve this through legislative advocacy, partnership with the state Office of Homeless Youth (OHY), and community organizing.

Background and Scope

At the end of 2017, the Raikes Foundation awarded AWHWA a grant to examine the intersection between Washington State’s residential behavioral health (BH) systems—inpatient mental health (MH) and substance use disorder (SUD) programs—and youth and young adult homelessness.

The Raikes Foundation and AWHWA were motivated to launch this work after the Washington State Department of Social and Health Services Research and Data Analysis Division (RDA) issued a data dashboard in June 2017 that analyzed the housing status of cohorts of youth (12 – 17 years old) and young adults (18 – 24 years old) within six and 12 months after exiting Washington State:

- 1) Foster care;
- 2) Juvenile Rehabilitation (JR) institutions¹ or state adult Department of Corrections facilities; and
- 3) Publicly paid inpatient MH or SUD treatment.

This report focuses on the third group of young people the RDA dashboard examined. Combined, there were 1,178 youth and young adults who experienced homelessness or housing instability² after an inpatient MH or SUD episode in Fiscal Year (FY) 2015 (the most recent data available). Meanwhile, data for the same year indicates that 130 youth who aged out of foster care (at age 18) and 516 youth and young adults who exited state correctional facilities later experienced homelessness or unstable housing.³

This report aims to better understand the circumstances of the nearly 1,200 youth and young adults who accessed residential MH or SUD treatment. It analyzes the RDA data to determine what it does and does not tell us about those young people, and identifies the landscape of residential MH, SUD, and co-occurring facilities that serve youth. It also highlights that the authors were unable to identify any residential MH or SUD programs or specific program design, including discharge planning, that serves the unique developmental needs of young adults (also commonly referred to as Transition Age Youth (TAY)). Finally, this report highlights what AHWHA heard from key stakeholders, including young people and families, regarding why 17 – 28% of young people who access the most intensive forms of MH or SUD treatment thereafter experience homelessness or unstable housing. Those stakeholders shared with AHWHA what changes they would like to see so that vulnerable young people experience better outcomes.

During the 2018 legislative session, the Washington State Legislature passed Substitute Senate Bill 6560 (SSB 6560), which requires the Department of Children, Youth, & Families (DCYF) and the OHY to:

“...jointly develop a plan, with specific state agency actions and any legislative recommendations, to ensure that, by December 31, 2020,

no unaccompanied youth is discharged from a publicly funded system of care into homelessness. Publicly funded system of care is defined as the child welfare system, behavioral health system, and juvenile justice system, and OHY programs. DCYF must submit the plan to the Legislature and Governor by December 31, 2019.”⁴



This multi-state agency effort will issue recommendations and actionable steps regarding the issues that result in homelessness following inpatient treatment.

AHWHA hopes this report will help guide the SSB 6560 conversations by providing system planners a global view of the complex reasons why young people held so closely and under such scrutiny in a publicly funded system could thereafter become homeless. It identifies systemic failures that are not new to families, young people, service delivery professionals, or system agents.

This report examines just one segment of the continuum of BH services; it does not address the homelessness experiences for young people engaged in community-based outpatient MH or SUD treatment nor does it provide insight into the homelessness experiences of young people who tried to access inpatient MH or SUD treatment, but were denied or deemed ineligible.

Report Development

This report uses the term “youth who experience homelessness” and “youth homelessness” to refer to young people ages 12 through 24 who are homeless and unaccompanied. When appropriate, the report distinguishes between youth and young adults.

AWHWA’s reflections and recommendations are based on interviews with dozens of young people, families, homeless youth service providers, and MH and SUD providers and advocates who shared insight about the inpatient MH and SUD landscape that young people interact with. A table of the interviewed stakeholders and their affiliations can be found in Appendix VIII(b).

AWHWA also convened a group of Project Advisors, comprised of experts in the areas of youth homelessness, behavioral health, and other specialties to inform the scope and direction of this report. Project Advisors are listed in Appendix VIII(c).

To further inform this report, AWHWA:

- ◆ Held two youth focus groups at Daybreak Youth Services in Brush Prairie, Washington. Daybreak Youth Services is a nonprofit provider of adolescent addiction and mental health treatment services that has inpatient programs for youth ages 12-18 in Brush Prairie and Spokane, as well as outpatient counseling and short-term crisis stabilization services (Evaluation and Treatment or “E&T”). The focus group discussion questions can be found in Appendix VIII(d).
- ◆ Conducted guided telephone interviews with seven individuals involved in discharge planning at five different facilities that serve youth under 18. The guided interview template can be found in Appendix VIII(e).

- ◆ Attended existing stakeholder coalition meetings to hear from BH residential providers, including the Children’s Long-Term Inpatient Program Improvement Team (CLIP-IT) and the Adolescent SUD / co-occurring stakeholder work group.

Finally, AHWHA relied on the expertise provided by state agency staff from the Division of Behavioral Health and Recovery (DBHR) to better understand the inpatient BH landscape, and the researchers at RDA to understand the data that informs this report.

II. The Current Landscape

a. The Numbers

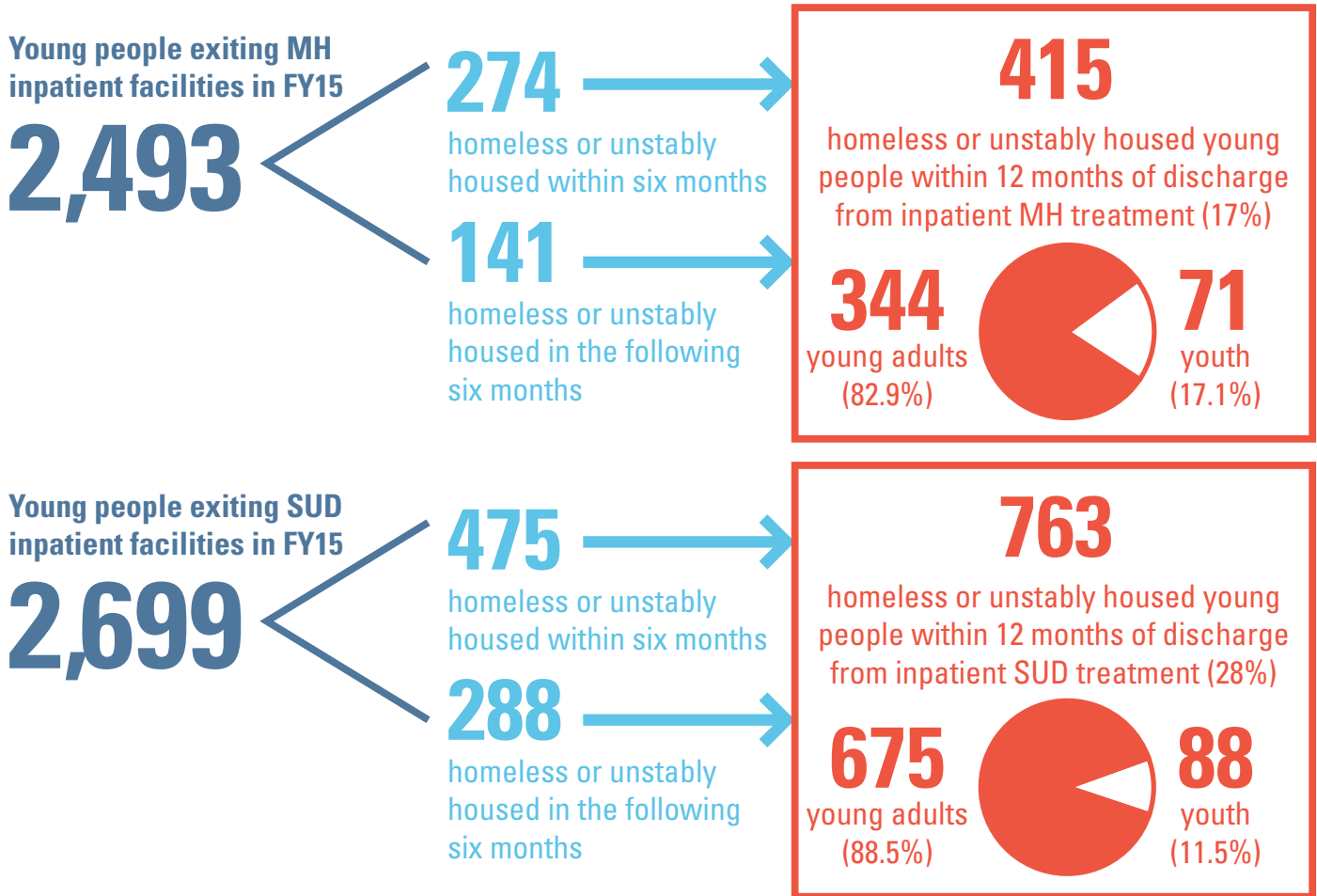
More than ever before, our state has a better understanding of the scope of youth and young adult homelessness. This is due in large part to the OHY’s effort to collect and report data and develop strategic and coordinated responses to youth homelessness. In June 2016, The Raikes Foundation produced a Landscape Scan for AHWHA and the OHY—that report noted that almost 13,000 unaccompanied young people ages 12 - 24 experience homelessness in Washington every year.⁵

Homeless youth are often fearful of engaging with public systems and, until a legislative change in 2018, state law prohibited providers from collecting data from minors who are homeless.⁶ AHWHA believes the 13,000 number is an undercount and expects the number to be higher now that we can more accurately collect data.

The Raikes Landscape Scan provided a brief glimpse into the connection between behavioral health services and youth homelessness, but it did not have the RDA dashboard data available now.

What we now know is that of the 2,493 young people exiting inpatient MH facilities in FY15, **415 (17%)** were homeless or unstably housed within 12 months of discharge.⁷ Of these young people, **344 (82.9%) were young adults and 71 (17.1%) were youth.**⁸

And, of the 2,699 young people exiting inpatient SUD facilities in FY15, **763 (28%)** were homeless or unstably housed within 12 months of discharge.⁹ Of these young people, **675 (88.5%) were young adults and 88 (11.5%) were youth.**¹⁰



The young people’s age was calculated at the time of their inpatient MH or SUD exit, meaning that if they were discharged from an inpatient program at age 17, but experienced homelessness or unstable housing after turning 18, RDA classified them as minors for the data dashboard.

The data dashboard also provides a glimpse into the racial and ethnic identity of the young people across all three public systems of care. Of the young people who experienced homelessness or unstable housing within 12 months of exiting from residential BH programs, foster care, and criminal justice, **18% were Black and 16% were American Indian or Alaska Native.**¹¹

The dashboard does not, however, disaggregate race or ethnicity data by system—we do not know the racial or ethnic identity for young people who experienced homelessness after an inpatient MH or SUD episode.

Additionally, the RDA dashboard currently does not indicate:

- Whether young people who experienced homelessness or unstable housing post-treatment did so unaccompanied or with their family.
- The housing or homelessness status of young people prior to entering inpatient treatment, including whether they were homeless with their family, homeless and unaccompanied, unstably housed, in foster care, or have some other housing status.
- The rates of homelessness or housing instability at a point in time closer to system discharge, for example, 30, 60, or 90 days following discharge.
- The post-discharge rates of homelessness from short-term programs (for example, E&T) versus long-term programs.
- Whether young people are counted in more than one system, for example, if they are in foster care at the time of an inpatient BH treatment episode.
- The LGBTQ+ status of the young people who experienced homelessness or unstable housing after an inpatient episode.
- The diagnoses and health status of young people who leave treatment, including those on the autism spectrum or who have another identified intellectual or developmental disability or have received services from the Developmental Disabilities Administration (DDA) providers.
- How young people entered inpatient treatment, for example, voluntarily, through a parent-initiated treatment referral (youth), or through an Involuntary Treatment Act referral (young adults).
- The type of caregiver young people were discharged to (including parents, legal guardian, the child welfare system, juvenile justice system or others).

Finally, the RDA's dashboard provides insight into homelessness and unstable housing only for those young people who were in publicly funded MH or SUD programs—it does not include rates of homelessness for young people who accessed inpatient treatment through private insurance. And, the dashboard only includes youth who access those social and economic services that routinely collect information on housing status such as Temporary Assistance to Need Families (TANF), Basic Food, and Medicaid, children's services, and homeless services. RDA can only characterize the housing status of youth who access at least one of these services.

Thus, the reported number of young people who experienced homelessness or housing instability after an inpatient MH or SUD episode is most certainly an undercount.

Some young people may not be discharged from treatment directly to the streets, but it certainly is to the curb.

– Homeless Youth Service Provider

b. The Young People

The RDA data illustrates the scope of the problem, but young people and families told AHWHA what it actually feels like to experience homelessness, and providers talked about the courage they see in the daily struggle of young people and families to cope.

AHWHA heard of youth who entered treatment from unstable situations such as county detention, foster care, couch surfing, and the streets. AHWHA heard that young people are fearful about leaving the relative safety and security in a structured treatment environment and re-entering the community where their addiction began.

In preparing to leave SUD treatment, some youth were eager to seek out programs like boot camps, wilderness camps, or Job Corps, where they believed they could maintain their sobriety in a structured environment. Some expressed a desire to live with family or friends who maintained a sober living environment, while others were looking ahead to age 18 so they could find clean and sober housing environments and live independently. They all shared concern that if they became homeless, their sobriety and/or MH treatment plan would be threatened.

Families shared stories of not feeling prepared for young people to return home, while others admitted being emotionally and mentally 'done' with trying to support young people with overwhelming mental health needs and substance use disorders.

AHWHA shares stories throughout this report so that the experiences of young people are centered in the statewide planning work ahead. We want our community to feel a sense of urgency and respond to the thousands of homeless young people struggling with mental health and substance use disorders.

A 17-year-old is in SUD treatment for a second time. After the first episode, he was discharged to his mother's house, but was concerned about maintaining his sobriety because of his mother's struggle with addiction. He left home, was living on the street, and relapsed. He got connected to a homeless youth shelter and through the support of a shelter case manager, he was re-admitted to SUD treatment. He is about to turn 18 and is nearing the end of his treatment program. He does not know what his post-treatment housing situation will be, but he knows he cannot return home. He is afraid he will end up back at the homeless shelter.

c. Inpatient MH and SUD Programs for Young People

Young people are being admitted and discharged from inpatient and residential facilities across Washington State every day. The length of stay ranges from a few days to many months, and youth are admitted from cities and rural areas of Washington State and also from other states. Referrals come from emergency rooms, juvenile justice system providers, outpatient behavioral health providers, and others.

AWHWA collated information from a number of sources about the inpatient MH and SUD programs that serve youth and found that the number of beds available to youth is constantly changing. Therefore, the information collected over the summer of 2018 may be outdated by the time of publication (see: Appendix VIII(f) / Table I).

As noted above, in AWHWA's review of inpatient programs, there appears to be no residential MH or SUD programs that specifically serve the unique developmental needs of young adults in Washington State.

Methodology¹²

All MH and SUD child and adolescent residential programs listed in available directories were compiled and cross referenced, along with all the basic information provided by the original source directory. Program information was cross-checked if there was only one source, if the sources were inconsistent, or if the original source did not include key information, such as the number of beds available. Cross checking consisted of looking at the facility website and/or calling the facility for further information. Some directories and facilities make a clear distinction between MH treatment and SUD treatment, while others do not. Facilities are sometimes reimbursed differently depending on the primary diagnosis, but in clinical practice mental health programs do, in fact, address both mental health and substance use in adolescents.

For the purposes of this report, facilities were divided into the categories of MH treatment, SUD treatment, or both. In fact, SUD programs address the spectrum of behavioral health needs, and all residential programs address the physical and dental health needs of residents.

Facilities

A total of 554 MH/SUD beds for children and adolescents were identified. These programs represent a continuum of care.

Acute psychiatric facilities (also known as Evaluation and Treatment or E&T programs) are at the high-need end of the continuum and treat adolescents who are, for example, suicidal or experiencing hallucinations or delusions. Acute psychiatric services may be free-standing but are often part of a medical center. The length of stay is typically less than a week.

Five providers are part of the Washington State Children’s Long-Term Inpatient Program (CLIP), which provides the most intensive inpatient services to children and youth ages 5-18 with significant psychiatric disorders. According to DBHR, approximately one third of the children and youth in CLIP beds are privately insured, on average, *prior* to admission to CLIP. The length of stay varies among CLIP programs, but averages approximately 8.5 months. There are 93 CLIP beds across the five CLIP providers, with locations in Lakewood, Seattle, Tacoma, Spokane, and Yakima. The state’s CLIP system is expected to expand significantly by 2020, with as many as 115 total CLIP beds.



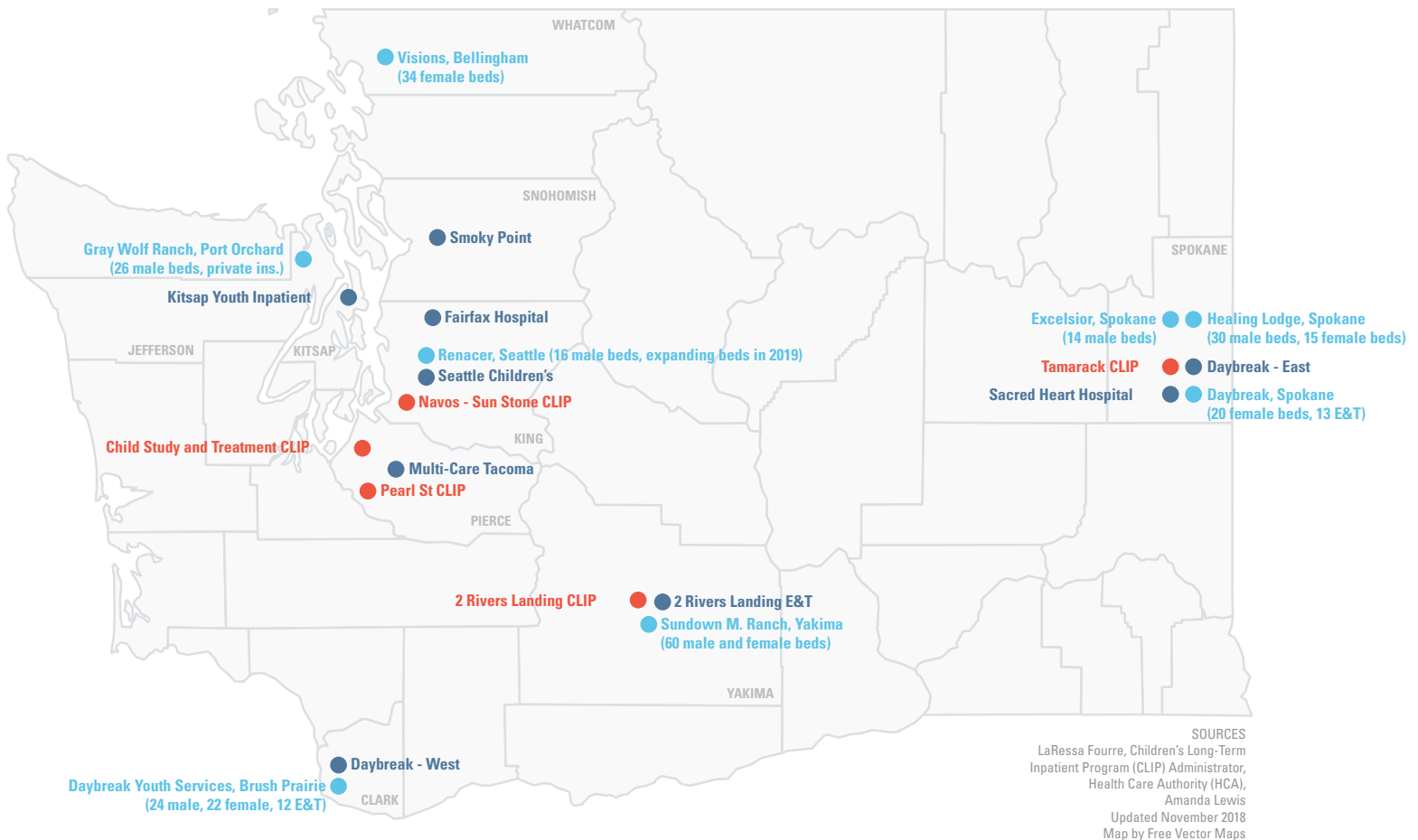
Seven providers offer ten residential SUD programs. Only one provider (Gray Wolf Ranch) accepts private insurance exclusively, so that most of the statewide SUD capacity is available to children and adolescents eligible for Medicaid. Gender-specific programming appears to be more common in SUD programs than in inpatient psychiatric settings, for example, the Healing Lodge of the Seven Nations has separate programs for males and females. MH and SUD programs may use different cottages, wings, or other arrangements to separate children by gender or age range, but these arrangements are based on current caseload and may be fluid. Programs that self-identified as being for males or females only are indicated in Appendix VIII(f) /Table I. SUD treatment

program lengths of stay usually last for several months. It is generally accepted that over half of individuals with SUD have co-occurring MH problems, so SUD programs screen for and treat depression, anxiety, and post-traumatic stress disorder.

Inpatient MH/psychiatric programs as well as residential SUD programs are concentrated in large population centers along with other specialty medical care, with most programs located in Seattle, Spokane, and Tacoma.

Youth-serving Inpatient BH facilities

- **CLIP Programs (Children's Long-Term Inpatient Program)**
- **Psychiatric Short-Term Acute Inpatient Facilities**
- **Adolescent SUD, co-occurring Residential Treatment Providers**



Withdrawal management and stabilization programs (commonly known as ‘detox’) are not included in the overall bed count. These are short-term programs designed to stabilize individuals and make referrals to appropriate programs. There are currently three withdrawal management centers that accept adolescents in Washington State. The Spokane Treatment and Recovery Services has 22 beds—it accepts adolescents as young as 14 and dedicates four of the 22 beds for youth. The Tacoma Detoxification Center has one bed for a total of five dedicated beds in the state. Youth and young adults are also seen in emergency rooms and other medical facilities for withdrawal management and stabilization services.



d. The Changing Landscape: Major Systems Changes Underway & Ahead

Washington State’s BH system and other state partners are engaged in transformative system work. AWHWA provides the information below so that system planners look to these initiatives for learning opportunities when examining the recommendations herein and next steps in SSB 6560 planning efforts.

Behavioral and Physical Health Insurance Integration

Washington State is undergoing a major system change by bringing together how Medicaid recipients access physical and behavioral health services. Historically, Medicaid clients navigate the physical health, mental health, and substance use disorder delivery systems separately. As part of the transition to an integrated managed care system, the DBHR moved from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA) (July 1, 2018). The state’s largest CLIP program did not move to HCA—the Child Study and Treatment Center (CSTC) is a state-operated and funded psychiatric hospital for children and youth and will remain at DSHS through the transition. HCA and DSHS have executed a Memorandum of Understanding to ensure the System and Care

Coordination between all CLIP facilities remains the same despite being housed within two different state agencies.

As integration progresses, BH providers will need to show their program's efficacy in serving young people, negotiate payment rates, and contract with a managed care organization (MCO) through HCA rather than Behavioral Health Organizations (BHOs). Some counties have already moved to an integrated MCO. Statewide managed care integration is slated to be complete by January 1, 2020.¹³

Behavioral Health Supportive Housing Administrator

In the 2017-19 biennial budget, the Legislature allocated funds to the Department of Commerce to create a BH supportive housing administrator "to coordinate development of effective behavioral health housing options and services statewide to aide in the discharge of individual from state psychiatric hospitals."¹⁴The Administrator's role has involved contracting private market rental assistance for individuals and matching those individuals with community-based Housing and Recovery through Peer Support (HARPS)¹⁵ funded through DBHR.¹⁶The Administrator role has paved the way for Commerce to be represented on the HCA BH Advisory Committee for the first time, and connected Commerce with state psychiatric hospitals to better understand and plan for the housing and transition needs of individuals leaving those facilities.

Healthier Washington Medicaid Transformation (Section 1115 Medicaid Waiver)

In 2017, Washington State entered a five-year agreement with the Centers for Medicare and Medicaid Services (CMS) that will provide up to \$1.5 billion federal investment for system transformation projects that benefit Washington's Medicaid clients.¹⁷ Foundational Community Support (FCS) is one of the three Medicaid Transformation initiatives that Washington has implemented during the five-year waiver period—approximately \$180 million is authorized for FCS over the waiver period.

The FCS focuses on assisting Medicaid clients with complex needs with finding and maintaining stable housing and employment.

Supportive Housing services is a Medicaid benefit providing pre-tenancy and tenancy sustaining services that include "wrap-around supports that assess housing needs, identify appropriate resources, and develop the

independent living skills necessary to remain in stable housing.”¹⁸ It does not pay for rent or other room and board related costs. To qualify for Supportive Housing, individuals must be Medicaid-eligible, be 18 or older, and meet at least one health criterion and one risk criterion.¹⁹

Supported Employment services is a Medicaid benefit through FCS that provides pre-employment and employment sustaining services that “help individuals with barriers to employment get and keep a job, including: (1) Employment assessments; (2) Assistance with applications, community resources and employer outreach; (3) Education, training and coaching necessary to maintain employment. Supported employment does not pay for wages or wage enhancements.”²⁰ To qualify, individuals must be Medicaid-eligible, be 16 or older, and meet at least one health and one risk criterion.²¹

At the end of the five-year demonstration project, an independent evaluation will determine whether the FCS initiative met the goals to reduce costs and improve health, housing, and employment outcomes. The State Legislature and CMS will have an opportunity to sustain these services by providing the appropriate authority and resources to continue the program.

Statewide WISe Implementation

WISe (Wraparound with Intensive Services) is a voluntary, intensive mental health service available to Medicaid eligible children and youth (ages birth to 21) that aims to avoid or reduce costly and disruptive out-of-home placements.²²

WISe is a team-approach service designed to support children, youth, and their families in achieving wellness, safety, and strengthening their relationships within their communities. It is best suited for young people who frequently use crisis lines, crisis services, or emergency rooms, frequently run away or are arrested, display an elevated risk of harm to themselves or others, and are engaged in multiple systems (child welfare, mental health, juvenile justice, developmental disabilities, and SUD treatment). WISe is a more intensive and individualized approach to treatment. Although the most recent WISe program data does not yet measure its effectiveness as a homelessness prevention or housing stabilization tool, the data indicates that youth who participate in WISe experience reductions in mental health needs and other risk factors.²³ Statewide WISe rollout was completed in June 2018.

Ricky's Law Implementation

In 2015, Washington passed Ricky's Law which is legislation aimed to align the SUD involuntary treatment process with the MH involuntary treatment process.²⁴ Ricky's Law became effective April 1, 2018, and allows for adults and youth (ages 13-17) to be involuntary detained for SUD treatment at a Secure Withdrawal Management and Stabilization facility (SWMS or 'secure detox') or approved substance use disorder treatment program. A Designated Crisis Responder (DCR) determines if the young person presents a likelihood of serious harm or is gravely disabled and meets criteria for involuntary commitment. Ricky's Law also requires Washington to ensure that at least one 16-bed SWMS facility is operational by April 1, 2018, and that another 16-bed facility is operational by April 1, 2019.

As of October 2018, Washington had two operating adult SWMS facilities that have 45 total beds (one facility in Eastern and one in Western Washington). Another 32 adult beds are scheduled to open in Western Washington in February 2019. There are three youth SWMS facilities pending state approval, with the hope they will open in 2019 and offer 13-14 total youth beds in both Eastern and Western Washington.

As Washington establishes more SWMS beds for adults and opens a SWMS facility for youth, our state may be able to better track serious substance use disorders among youth and young adults.

Department of Children, Youth, and Families (DCYF)

In July 2018, the Children's Administration (Washington's public child welfare program), folded into the DCYF along with the Department of Early Learning.²⁵ The Office of Juvenile Justice will move from DSHS to DCYF on July 1, 2019. The OHY will stay within the Department of Commerce unless legislation passes to shift the OHY to DCYF. This seismic shift in how Washington State delivers holistic services to children, youth, and families, may require HCA / DBHR to form fresh collaborative partnerships across multiple state agencies.

State Implementation of the Family First Prevention Services Act (FFPSA)

In early 2018, Congress passed the FFPSA and it was signed into law in February.²⁶ The FFPSA has the potential to impact the child welfare system in many ways, but primarily in how it will change the way states can spend

federal child welfare financing dollars, both Title IV-E and Title IV-B of the Social Security Act. Before FFPSA, those federal funds could be spent on foster care payments and services—to support children only after they were placed into foster care.

Under FFPSA, states will now be able to use federal funds for services for “candidates for foster care” so that children may stay with their families or relatives while receiving services to avoid out-of-home placement. The services may include mental health and substance abuse prevention and treatment services and in-home parent skill-based programs. The federal funds can be used to support children and families for up to 12 months.

III. Community Stakeholder Reflections

In its community interviews AWHWA asked stakeholders to share their perspectives on the overall intersection of inpatient BH experiences and subsequent homelessness, the inpatient MH and SUD discharge planning process, and post-discharge housing and other support services available to youth and young adults. Below are summaries of information AWHWA gathered through those interviews.

There is an inherent link between youth experiencing homelessness and the dearth of behavioral health services and long-term supports. On the front end, we have so many young people who cannot access the care they need—and suffer the extended trauma of homelessness because they cannot get the behavioral health services that would prevent homelessness or save their lives. On the back end, we have young people who are departing from behavioral health services, but who face homelessness because there isn't a bridge or ongoing support to stay well in the community.

– Homeless Youth Service Provider

a. Reflections on System Coordination

Central to most stakeholders' reflections was that the inpatient behavioral health and homelessness and housing systems are disconnected.

Interviewees often noted that the two systems speak 'different languages,' resulting in inpatient providers struggling to plan for young people's housing and homeless providers struggling to understand the inpatient treatment and discharge planning process.

While stakeholders observed a genuine desire on the part of providers to work across systems, the lack of time, capacity, and funding prevent holistic system collaboration to concurrently address young people's acute MH and SUD and housing transition needs.

A 22-year-old is well known to his small, rural community, as he has been publicly struggling with mental health issues and homelessness for many years. During his time at a young adult shelter, his mental health quickly declined due to his refusal to take his medication. His physical hygiene and health also declined.

The shelter was able to work with him to go to the local hospital to address his mental health needs, but once there he was told there were no beds available and to come back the next day. He was released back to the young adult shelter, and he returned to the hospital the next day. He was evaluated and transferred to an intensive psychiatric program. He was discharged from that intensive program back to the young adult shelter because his family refused to take him home and the shelter was his last 'residence.'

While at the shelter on the most recent round, he refused to cooperate with his treatment plan and his mental health again deteriorated to the point that he presented a health and safety threat to the staff and other shelter residents. The shelter had to dismiss him from the program, and he now wanders the community with occasional and temporary housing with relatives and friends, but he is otherwise homeless. There are not enough mental health facilities in his area so that he can be served there and remain connected to his community.

b. Reflections on Inpatient System Capacity

Inpatient system capacity was another central theme among stakeholders. AWHWA heard that there simply are not enough long-term MH inpatient beds for youth under 18. Homeless service providers reported that many youth in their shelters or housing programs have acute mental health

needs and cycle in and out of short-term E&T facilities, but sometimes may experience lengthy wait times due to current limited CLIP bed capacity. The need for more CLIP beds for youth was a broadly shared sentiment.

Stakeholders added that for some youth CLIP is not an appropriate placement, but that a less restrictive form of inpatient treatment or significant intensive in-home service supports is needed beyond treatment received in a short-term E&T facility. Interviewees noted that there exists a need for a 'middle ground' inpatient option for youth who are not a good

fit for CLIP, but whose MH needs cannot be met at home or with the current level of available in-home and community-based supports or in the homeless youth shelter and housing system.



In the SUD inpatient context, stakeholders echoed what the 2016 Raikes Landscape Scan identified as a homelessness diversion strategy and specifically the need for more secure withdrawal management and stabilization beds for both youth and young adults.²⁷ Stakeholders shared concern that absent designated secure detox beds for young people,

they are at increased risk for family disruption, homelessness, illness, overdose, and death. While Ricky's Law gives providers and families hope for detox beds in the future, it gives little solace if a young person is struggling right now.

Stakeholders further shared that there are not enough SUD long-term inpatient beds for youth under 18, and that youth must often leave their communities (sometimes the state) to access SUD treatment.

Finally, AHWHA heard that there appear to be no inpatient MH or SUD beds or inpatient programming specific to the developmental needs of young adults. Brain development extends beyond the adolescent years and many MH issues present in late adolescence and early adulthood. Interviewees offered that inpatient programming and discharge planning specifically for TAY is critical.

No matter how you slice the pie, there are simply not enough resources for young people around behavioral health services or meaningful transitions from care--and we're setting them up to fall into homelessness for the long run. It is a preventable fate.

– Homeless Youth Service Provider

c. Reflections on Inpatient Discharge Planning

AWHWA consistently heard that timely care coordination is critical, and that discharge planning should, and often does, begin upon a young person's arrival at a MH or SUD inpatient program. Planning should involve all key people involved in the young person's life including family, friends, community treatment providers, teachers, employers, mentors, and other caring and supportive adults.

Some providers noted, however, that it is challenging to locate family or caring adults who may be able to offer placement or housing options upon a young person's discharge from treatment. Providers noted that young people often lose their family and community connections due to their MH or SUD issues. Losing those connections increases a young person's likelihood of experiencing homelessness. In the child welfare system, the search for relatives is an early and critical activity to locate supportive and caring adults. The inpatient BH system lacks this tool that helps facilitate relationship maintenance for young people in crisis.

Interviewees also noted that discharge planning typically happens at the facility, but that young people's support community is often geographically scattered, especially because many young people are in facilities outside their home communities. This makes travel to and meaningful engagement in discharge planning challenging.

Finally, many stakeholders noted that because youth 13 or older can consent to inpatient or outpatient MH and SUD treatment without a parent or guardian, supportive parents and guardians can be left out of critical discharge planning conversations. Families may feel ill-equipped to welcome a young person home from inpatient treatment if they are not fully prepared to manage the youth's behaviors, aware of what is the youth's exact diagnosis, what medications they have been prescribed, what are the side effects of prescribed medications, and who a youth has named as crisis support persons upon discharge.

d. Reflections on Post-Inpatient Support

Young people whose MH and SUD needs result in inpatient treatment have been through a lot. Their families have been through a lot alongside them.

Stakeholders shared that due to the trauma young people and families experience, families are often 'done' by the time a young person needs inpatient treatment. For young people who are nearing or are over age 18, many families have reached the upper limit to what they can manage and may not want the young person to come home. AWHWA heard this

is especially true for young people who were adopted. Stakeholders reported a trend for adoptive families to disengage from planning and support as a young person is close to discharge. Providers have seen this occur with even very young adopted children.



Foster youth who are in inpatient BH facilities experience significant challenges transitioning back into care, as there is a shortage of foster homes in Washington, especially foster homes willing or able to take older youth with acute MH or SUD needs.

AWHWA heard stories of futile placement searches for foster youth leaving inpatient programs, which may result in young people staying beyond their necessary treatment time, experiencing multiple placement changes after treatment, or running from care because of placement disruptions and lack of support.

When young people do transition home, stakeholders noted that post-discharge support varies due to geographic location (more services available in urban versus rural areas), insurance coverage (Medicaid versus private insurance), and other factors.

For example, young people who access inpatient treatment and who are Medicaid eligible may be eligible for WISE upon discharge if they meet the criteria; however, privately insured young people are not eligible for WISE, regardless of their diagnosis. AWHWA heard stories of frustrated families who spent hours piecing together some form of wraparound support that private insurance would cover.

Our systems rely on homeless youth shelters and housing programs to be all things to all people, but they do not have the staffing or the funding to do that.

– Homeless Youth Service Provider

Even if a young person is eligible for WISe, they may not be connected to their WISe team until close to or after discharge from treatment—it varies from region-to-region and from case-to-case and whether billing codes allow for engagement while a young person is still in treatment. If a WISe team is unable to engage well before a young person’s discharge, the transition from treatment to safe and stable housing is at risk.

Stakeholders further noted that WISe is only available for young people age birth to age 21—many young adults who would benefit from WISe’s intensive services are left without that option.

Ultimately, absent comprehensive post-treatment support to youth and families, a young person’s MH and SUD treatment plan is at risk, and the young person and their family may experience further trauma. Though rare, stakeholders reported that some families lose their housing due to a young person’s behavioral health issues after leaving inpatient treatment.

Youth and their families are often terrified of discharge due to the trauma they already experienced, which is made worse by a lack of strong social support systems, lack of predictable foster and adoptive families, support for families post-adoption, and the inherent social stigma that is associated with trauma, abuse, and mental health issues. This issue needs a panoramic lens to look closely at what all of our child-serving systems can do better to support youth and their families.

– Adolescent Inpatient provider

Stakeholders identified the following critical post-inpatient supports to young people and their families upon discharge:

- ◆ Peer Support to Young People: Support provided by other young people with lived experience is critical to bridge the inpatient-to-community transition.
- ◆ Peer Support to Families: Engage Peer Support Specialists to work closely with families before and immediately after discharge.
- ◆ Respite Care: Families and caregivers need a break. Respite care after discharge from treatment was a consistent theme because the transition home is challenging regardless of the level of planning and preparation.
- ◆ Support for Siblings: Siblings of young people who have experienced inpatient treatment can feel isolated due to the level of care a sibling in treatment requires and may have experienced trauma because of a sibling's MH or SUD issues.
- ◆ Early Identification: Early identification and intervention programs that partner with primary care and schools can empower the young person and parents, plot a normal developmental and academic course, and keep parents and youth engaged.

The youth focus group echoed the sentiments reflected above and also shared these specific reflections on post-SUD inpatient support:

- Some youth need more intensive outpatient services and others are ready for less. Youth need to be able to move up and down outpatient support levels depending on their progress.
- Youth need day treatment programs that offers outpatient support alongside education, employment, and housing support.
- Youth want and need advocacy support so they can access housing and other benefits that will help them maintain the sobriety they have worked hard to achieve. Navigating housing and public benefits programs is overwhelming, especially if you have a juvenile offender record.

The most critical support the youth identified was having a caring support system and peer support to help them maintain sobriety.

e. Reflections on Post-Discharge Housing

AWHWA heard loud and clear that a comprehensive housing continuum to meet the needs of youth or young adults leaving inpatient MH and SUD facilities does not exist, resulting in many young people cycling through the homeless service system.

Not enough transitional living programs exist for youth under 18 whose families are unable to care for their acute MH or SUD needs, but who are not eligible for Child Protective Services or out-of-home placement. In particular, no post-inpatient SUD recovery-based facilities exist for minors who leave treatment.

A 17-year-old spent nearly a year alone on the streets struggling with addiction. While she was homeless, she had a broken ankle that went untreated because she was afraid that going to health services would result in her being returned to an unsafe home environment. Working through a homeless youth case manager, she was able to access inpatient SUD treatment. As she nears the successful end of her treatment program and is about to turn 18, she is worried about what her post-treatment housing situation will look like—she knows that she wants and needs to live in a sober environment, but she does not believe that type of housing program exists for young adults in her home county. She is worried about her housing stability and maintaining her sobriety.

Stakeholders also shared that there is not enough recovery-based housing stock for young adults that would allow them to live among peers or mentors who are also in recovery. For many young people, recovery-based housing is the driving force behind maintaining their sobriety and avoiding homelessness.

Youth-specific recovery support services must be provided when a young person leaves treatment or we can expect homelessness shortly after re-entry into the family and/or community.

– Family Advocate

Stakeholders expressed that for youth leaving either MH or SUD inpatient treatment, it is ideal to have some sort of short-term, stepped-down residential program that better prepares youth for a transition “home” if

that is a potential pathway. Once home, the supports identified above such as peer support, respite care, and sibling support, were considered crucial to ensure a youth's successful transition home.

Stakeholders shared that the gold standard for young adults leaving MH inpatient treatment, is community-based independent living coupled with education, employment, and health care. While versions of these programs exist around the state, stakeholders did not believe that young adults leaving MH inpatient programs were targeted for these housing and supportive services nor were the programs created with young adults' unique developmental needs in mind.

Absent a comprehensive housing continuum prepared and tailored to support young people's MH, SUD, and housing needs, young people show up in the homeless shelter and housing programs. Once there, young people are likely to experience shelter or housing programs that involve mixed milieu. This means that young people who have just completed SUD treatment may be placed in a housing environment with others who are actively using drugs or alcohol, thereby threatening young people's sobriety.

For young people who discharge from MH inpatient programs, cycling through the homeless shelter or housing system may mean that their continued MH needs are not met. If homeless service providers do not have the professional capacity or funding to support young people with serious MH issues, providers may deny service to the young person due to behavior problems that put program staff or other young people's safety at risk.

A 19-year-old had multiple diagnoses, including bipolar disorder, schizophrenia, post-traumatic stress disorder, and had a long history of self-harm. During his stay at a temporary housing program he was regularly transported to the emergency room (ER) for threatening to harm himself. At the ER he was treated with medication and sent back to the housing program. He repeatedly told program and hospital staff that he needed to be hospitalized because he wanted to die. The housing program staff explained to hospital staff that the program was not equipped to deal with near-daily trips to the ER nor did it have the clinical capacity to support the young man's acute mental health needs. Hospital staff explained that the hospital could not keep him once he was medically stable and no longer presented an immediate safety threat to himself, to program staff, or other residents. After the young man's most recent hospital discharge, he returned to the housing program, continued to struggle with his mental health, and then disappeared.

IV. Inpatient BH Provider Reflections on Discharge Planning

AWHWA conducted guided telephone interviews with seven individuals involved in discharge planning at five different facilities that serve youth under 18. The guided interview template can be found in Appendix VIII(e).

The purpose of the interviews was to determine the types of challenges faced by the facilities to find aftercare and stable housing for youth, and to understand the barriers and resources that currently exist. Staff were interviewed at facilities that ranged in size from small to large and urban to rural. The average lengths of stay ranged from quite short (5-7 days) to long (6-9 months). Because AWHWA talked to only inpatient and residential programs, the symptoms of youth in the programs were serious and severe, including psychosis, suicidal ideation, self-harm, aggression, debilitating anxiety, and co-occurring substance use disorders.

Below is a summary of AWHWA's findings from its interviews with youth-serving inpatient programs:

- ◆ Youth who receive treatment in MH and/or SUD facilities always receive discharge planning services.
- ◆ All facilities were actively involved in discharge planning starting at the point of admission and in some cases, at pre-admission meetings.
- ◆ All facilities had designated staff assigned to discharge planning and all attempted to involve key people in the process including the youth, family, guardians, probation officers, and other agencies.
- ◆ Family involvement was cited as a key factor in successful discharge plans. However, many young people do not have the advantage of stable, available guardians. For example, at one facility, a high percentage of youth were involved in failed adoptions (generally, the adoptive families were not interested in continuing to support the youth upon admission to an inpatient facility), and in other cases families are themselves homeless and young people are sometimes admitted directly from homeless shelters. In other instances, discharge planning is challenging because the youth, parents, or guardians are not fully engaged or in agreement with the plan.
- ◆ The facilities see youth who may or may not have a stable situation to return to following discharge. Successful behavioral health follow-up

treatment depends on the youth having a stable environment where they can pursue educational, vocational, and behavioral health goals.

- ◆ There is no centralized, standardized database that has community or outpatient resource availability in real time. Discharge planning staff often seek post-treatment community resources for young people by searching the internet, making phone calls, and through building a network of informal relationships with individuals and agencies. Many planning staff work closely with case managers at insurance companies to locate available and appropriate services for young people upon discharge.
- ◆ Facilities are unfamiliar with homeless and housing services in the community where inpatient facilities exist. Facilities are even less familiar with homeless and housing services in communities outside their geographic area where young people return home.
- ◆ Timely follow-up and outpatient care are more difficult to arrange for youth returning to rural parts of the state. Furthermore, some facilities treat youth from out of state, especially Idaho and Montana. There is a scarcity of outpatient providers in rural areas, but there can also be a lack of specialty providers in both urban and rural settings, for example, specially trained applied behavioral analysis (ABA) providers for children and youth with autism.

Because there appears to be no inpatient MH or SUD programs that specifically serve the unique developmental needs of young adults in Washington State, AWHWA was unable to interview programs to gain unique insight into discharge planning processes tailored to support young adults transitioning from inpatient facilities.

Mental health and substance use disorder services are very limited in this state, and sadly those limited resources do not extend to small rural communities. For young people whose needs are so acute that they must enter inpatient treatment, they are often left to fend for themselves after treatment, and they rely on homeless shelter providers to assist them with their very complex issues. Shelters do not have the resources to do that intensive kind of work.

– Rural Homeless Youth Service Provider

V. Key Findings

AWHWA's findings are shaped by the reflections of the many stakeholders who informed this report.

- ◆ Of the roughly 1,800 young people leaving all state public systems of care who subsequently experience homelessness or unstable housing every year, **almost two thirds (1,178) of them come from the inpatient behavioral health system**. The remaining one third who experience homelessness come from foster care (130), the state juvenile justice system (132), or the state adult corrections system (384).
- ◆ Of the nearly 1,200 young people who become homeless or unstably housed after an inpatient behavioral health episode, around 85% of them are young adults (ages 18 – 24).
- ◆ There is a general system disconnect between behavioral health and youth/young adult homelessness planning efforts. Behavioral health system leaders and on-the-ground experts engage in regular and intensive dialogue about how to improve the inpatient programs that serve young people, but it does not appear that this work sufficiently connects to homelessness prevention or that youth housing or homeless providers are part of those conversations.
- ◆ The authors were unable to identify any inpatient mental health or substance use disorder programs or specific program design, including discharge planning, that serves the unique developmental needs of young adults.
- ◆ The bed capacity needed for young adults to receive inpatient mental health or substance use disorder treatment is unclear. Likewise, the bed capacity needed for youth (ages 12 – 17) for inpatient mental health or substance use disorder treatment is unclear.
- ◆ Washington does not have enough comprehensive, less restrictive forms of treatment and intensive in-home support that allows young people to stay with their families and avoid institutional care altogether.
- ◆ Families and young people's support systems experience challenges to meaningful engagement in discharge planning. Facilities accept youth

from all regions of the state, and families often struggle to visit and get involved in discharge planning due to transportation barriers and the demands of work and caring for other children in the family. Families also experience 'burn out' due to a young person's intensive and long-term mental health or substance use disorder needs. Additionally, the families of minors may also encounter barriers to engaging in discharge planning due to the youth's legal right to exclude their caregivers from their behavioral health treatment planning.

- ◆ Washington lacks a comprehensive post-inpatient treatment community-based support system for young people and their families. Caregivers may not have the skills to assist in post-discharge treatment plans and may not know how to manage problem behaviors at home. Many young people feel abandoned by parents and caregivers who have given up. Young people and their families/caregivers need access to comprehensive, in-home, skill-based behavior support wraparound services, regardless of the young person's age or Medicaid eligibility. Peer support to young people and respite care for families are also important components of an ongoing treatment plan.
- ◆ There is no centralized, standardized database that identifies post-treatment services. Inpatient facility providers struggle to find appropriate, community-based or outpatient resources.
- ◆ Washington lacks a comprehensive, post-inpatient treatment housing and step-down program continuum. One example is that there are not enough recovery-based housing programs available for young adults or minors leaving substance use disorder treatment.
- ◆ Foster youth leaving inpatient behavioral health programs experience significant challenges in finding supportive placements capable of meeting their mental health and/or substance use needs.
- ◆ Young people leaving inpatient behavioral health programs do not have sufficient connections to legal advocacy to ensure they can access housing, supportive services, and public benefits.
- ◆ There are massive initiatives underway that will impact how system partners will interact with each other. It is essential that the system initiatives underway adopt an intentional, dedicated effort to address youth homelessness.

VI. Opportunities and Recommendations

Below, AWHWA highlights what it believes will be a starting platform for many conversations to come regarding how to prevent young people's homelessness or housing instability after inpatient BH treatment.

a. The Voices of Young People and Their Families

Work on a plan to implement SSB 6560 is just beginning and will be submitted to the Legislature by the end of 2019. This means that the child welfare, juvenile justice, and behavioral health systems will have increased shared responsibility to ensure young people discharged from BH facilities and programs are released into safe and stable housing and have access to comprehensive follow-up treatment.



AWHWA believes that the SSB 6560 planning process should incorporate the voices and experiences of youth and young adults and their families who have navigated the complex, and often heartbreaking, mental health and substance use disorder inpatient landscape.

Based on the feedback collected from stakeholders and individuals with lived experience, AWHWA anticipates that young people will clearly express they do not want to be institutionalized. If treatment is necessary, they want to transition to home or to community-based housing programs and services quickly to outpatient programs that do not look or feel like institutions. AWHWA believe that families will express a desire for more intensive in-home support that allows young people to stay with their families and avoid institutional care altogether, and equally intensive in-home supports upon discharge if a young person does require inpatient treatment.

b. System Ownership

There exist many meaningful opportunities for system improvement, and there are several entities and active workgroups that already discuss these issues. The true challenge and opportunity will be how system leaders determine which entity or entities will own the intersection of behavioral health and youth/young adult homelessness so that these conversations result in specific policy, practice, and funding recommendations.

We can do better for our youth and young adults. This issue must be tackled through a multi-systemic perspective. Vast opportunities exist for significant improvements across all of our child-serving systems to identify and secure access to a wider continuum of resources and services that support family home environments that are free of violence and abuse, strengthen placement resources and support permanency for youth in state care, and pave avenues that allow youth inpatient care providers to offer aftercare services post discharge.

— System Leader

AWHWA encourages the OHY, DCYF, DBHR, OHY's Interagency Workgroup on Youth Homelessness²⁸ and the SSB 6560 planning team to look to existing workgroups, partnerships, and coalitions that engage inpatient providers, community-based supports, families, and young people in dialogue around how to improve the systems that serve young people with acute BH needs.

Below is a list of existing groups with deep expertise on these issues.

HCA / Behavioral Health and Recovery

Children's Long-term Inpatient Program Improvement Team (CLIP-IT)

Self-initiated improvement team that began meeting in November 2010 in response to providers' requests to address problems between the residential and community treatment mental health systems. Focused on improving the transition of youth into and out of children's long-term mental health inpatient programs. CLIP-IT attendees include CLIP program administrators, community care coordinators, and Evaluation & Treatment program representatives.

CLIP-IT presents an opportunity for the SSB 6560 planning team to learn more about the discharge planning issues and challenges identified by CLIP and E&T facilities that serve minors.

Family Youth System Partner Round Tables (FYSPRTs)

Provides a "forum for families, youth, systems, and communities to strengthen sustainable resources by providing community-based approaches to address the individual behavioral health needs of children, youth and families. ... informs and provides oversight for high-level policy-making, program planning, decision-making, and for the implementation of [the T.R. Settlement Agreement], including the implementation of Wraparound with Intensive Services (WISe)." Challenges brought forth by the FYSPRTs are addressed by the Children's Behavioral Health Executive Leadership Team.

FYSPRTs present an opportunity to seek out information from regions around the state, and to communicate useful information out as needed. FYSPRTs also provide a venue to get youth and family voice involved in the SSB 6560 planning process.

Adolescent SUD, Co-occurring Stakeholder Work Group

Began meeting in December 2017 with the goal of identifying system needs and solutions for youth and transition age youth with SUD and co-occurring (COD) with mental health needs. Participants meet monthly and include representatives from SUD, COD outpatient, residential treatment providers, parents with lived experience, BHOs and MCOs, juvenile justice, HCA, Office of Superintendent of Public Instruction (OSPI), and other system partners including the Washington Recovery Alliance. Works to address areas of:

- Admissions
- Effective treatment approaches for youth
- Increasing youth and family voice in services and system development
- Increasing culturally appropriate interventions and workforce
- Funding options/challenges

The SUD, Co-occurring group presents an opportunity for the SSB 6560 planning team to learn more about SUD/COD facility discharge practices, coordination of services prior to exit (institution-to-outpatient) and regional and county outpatient referral contacts.

Washington State Legislature

Children's Mental Health Work Group

Established through legislation in 2016 to identify barriers to access of mental health services for children and families, and to advise the Legislature on statewide mental health services (focus on children ages birth to 5).

The SSB 6560 planning team should look to this group for guidance on whether any legislative conversations around the connection between mental health and youth homelessness are occurring and, if so, how those can be tied to the planning team's work.

c. Cross-system Coordination Opportunities

There exists a great opportunity to look to emerging systems changes and identify cross-system budget and policy barriers and priorities and blended funding opportunities.

MCO Integration Opportunities

As BH providers actively engage in contract negotiations with MCOs, providers should elevate the needs of young people who access inpatient BH programs and how inpatient experiences may result in subsequent homelessness, hospitalization, and other experiences that can worsen the young people's physical and behavioral health.

MCOs should build in-house expertise around the connection between behavioral health issues and youth and young adult homelessness. MCOs should engage experts to develop and lead strategies around behavioral health and housing and homelessness service provider partnerships and identify funding opportunities to providers who bridge the BH and housing disconnect. Likewise, BH and homeless youth providers should proactively seek out partnerships that may improve outcomes for young people and, thereby, attract MCO funding opportunities.

BH Supportive Housing Administrator Opportunities

System leaders should look to lessons learned from the Department of Commerce's BH supportive housing administrator. This is a position created through a budget proviso that paired Commerce's expertise in housing with DBHR's expertise in behavioral health and with a laser focus on supporting individuals leaving state psychiatric hospitals. The proviso allowed for cross-agency collaboration and innovation to meet the needs of a vulnerable population.

The SSB 6560 effort should explore how the blended approach to fund housing and services to improve housing-related outcomes for people with acute BH needs can be duplicated and tailored to meet the needs of young adults leaving MH and SUD inpatient facilities, and what level of staffing support is required to ensure effective cross-system collaboration.

Medicaid Transformation / Foundational Community Supports Opportunities

As the FCS program continues to roll out and given the eligible health and risk criteria identified, the HCA should prioritize young adults leaving inpatient MH or SUD facilities for FCS Supportive Housing programs (youth are ineligible for housing due to their inability to sign leases). Likewise, the HCA should prioritize youth and young adults leaving MH or SUD facilities for FCS Supported Employment programs.

WISe Opportunities

System leaders must explore expanding WISe eligibility to all young people who are discharged from inpatient MH and SUD programs, regardless of Medicaid eligibility so long as the young person's diagnosis would otherwise make them eligible. Given that data indicates that youth who participate in WISe experience reductions in mental health needs and other risk factors, it would behoove our systems to ensure that vulnerable young people leaving treatment have access to this service.

Any young person in inpatient treatment who is determined to be eligible for WISe should be connected to their WISe team well before facility discharge occurs. If provider billing issues create a barrier to early engagement, stakeholders should explore how to dismantle the billing challenges for the benefit of the young person's transition planning.

Additionally, WISe eligibility should be expanded to young adults ages 21-24. If that is not possible, a comparable wraparound program that is developmentally appropriate for young adults should be created to support the inpatient discharge of young adults leaving MH and SUD inpatient facilities. Stakeholders should consider the interplay between WISe referrals and the Program of Assertive Community Treatment (PACT)—an intensive wraparound community-based treatment program for people aged 18 and over with severe mental health disorders, who frequently need care in a psychiatric hospital or other crisis service.²⁹ System leaders should examine under what circumstances young adults leaving inpatient BH facilities who have a history of hospitalizations are more appropriately matched with PACT or WISe.

On the pre-inpatient treatment/prevention side, stakeholders should work with the HCA to determine whether WISe could be available to youth upon the filing of an At-Risk Youth (ARY) or Child in Need of Services (CHINS)

petition if a young person's MH or SUD issue is at the core of family discord. When youth and families seek out the assistance of courts because of family conflict related to adolescent MH or SUD issues, early intervention by a WISe team could avoid or reduce costly and disruptive out-of-home placements.

Finally, as the WISe data team continues to evaluate the program's efficacy, it should consider adding homelessness prevention and other housing-related outcomes to future WISe data dashboards.

DCYF Opportunities

The DCYF, DBHR, and OHY should work together to explore whether families whose adolescents have MH and SUD needs can access Family Reconciliation Services (FRS), with the goal of strengthening the family and keeping a youth at home if it is safe to do so. If a youth must enter inpatient treatment, agency leaders should examine whether FRS can be accessed upon a youth's discharge from treatment so the transition to home/community is as supported as possible. DCYF should explore whether FRS eligibility must be expanded to accommodate these young people and their families or whether additional funding is required to do so.

FFPSA Implementation Opportunities

As Washington begins FFPSA implementation, it should consider using IV-E prevention dollars to address the MH and SUD issues of youth if a youth's issues are a root cause of family disruption. While FFPSA may imply that IV-E dollars be spent to remedy parental deficiencies, DCYF could identify programs and services to support the MH and SUD needs of youth with the goal of reducing family disruption and, thereby, youth's entry into foster care or into homelessness.

This issue is complex and multi-layered. Ideally, we will move the interventions to support families to stay together and to be available much sooner. In the absence of that, we must recognize where our systems have unintended/punitive consequences and where there are gaps and get busy fixing those parts of the system together.

– System Leader

d. Data Quality Opportunities

The RDA data dashboard provides an excellent starting point to better understand the connection between inpatient BH treatment and young people's subsequent homelessness. However, there exists an opportunity to better understand the data and identify gaps in services.

Gathering the following data could help system planners build a more robust response system to support these young people:

- ◆ The housing or homelessness status of young people prior to entering inpatient treatment, including whether they were homeless with their family, homeless and unaccompanied, unstably housed, in foster care, or have some other housing status.
- ◆ Whether the young people who experienced homelessness or unstable housing post-treatment did so unaccompanied or with their family.
- ◆ The rates of homelessness or housing instability at a point in time closer to program discharge, for example, 30, 60, or 90 days following discharge.
- ◆ The post-discharge rates of homelessness from short-term programs (for example, from psychiatric evaluation and treatment facilities) versus long-term programs.
- ◆ Whether young people are counted in more than one system, for example, if they are in foster care at the time of an inpatient treatment episode.
- ◆ The LGBTQ+ status of the young people who experienced homelessness or unstable housing after an inpatient episode.
- ◆ The racial and ethnic identity of young people who experienced homelessness or unstable housing after an inpatient episode.
- ◆ The number of young people who entered inpatient treatment voluntarily, through a parent-initiated treatment referral (youth), or through an Involuntary Treatment Act referral (young adults) and who subsequently experienced homelessness or unstable housing.

- ◆ The number of young people discharged to various caregivers—including parents, legal guardians, the child welfare system, the juvenile justice system, or others—and who subsequently experienced homelessness or unstable housing.

It is also critical to understand whether young people with certain health statuses or diagnoses are more likely to access homeless services or become homeless or unstably housed after leaving treatment. Specifically,



we need to better understand the post-inpatient treatment outcomes for young people on the autism spectrum or who have another identified intellectual or developmental disability or have received services from the Developmental Disabilities Administration (DDA) providers. System leaders must engage disability data experts and advocates to better understand what data is needed so we know who is entering the system, what is their profile, and what is their intersectionality (disability, race/ethnicity, LGBTQ+, and others) in order to track outcomes.

To be successful, planning efforts must explore with the RDA what data collection is possible in real time and in future data dashboards or what privately funded evaluations could illuminate how young people so closely held by the BH system later experience homelessness and/or unstable housing.

e. Discharge Clinical and Practice Opportunities

In AWHWA’s conversations with discharge planners, they shared constructive ideas about how their part of the system could be improved, including expansion of step-down and transitional care services. They also identified a need for more resources for hard-to-place youth who are suicidal or aggressive. There is also a need for practical help with transportation, especially in rural areas.

AWHWA suggests the following work be addressed through SSB 6560 planning or through the workgroups inpatient providers already participate in:

- Develop discharge planning toolkits with specific focuses on:
 - (1) **Discharging minors from**
 - (a) SUD or co-occurring treatment;
 - (b) CLIP facilities;
 - (c) E&T facilities; and
 - (2) **Discharging young adults from**
 - (a) SUD or co-occurring treatment;
 - (b) psychiatric facilities;
 - (c) E&T facilities.
- Implement therapeutic approaches like Motivational Interviewing to work with youth and families to clarify and unify them around future plans.
- Connect WISe teams with facility discharge planners early on to ensure smooth facilitation from program to community.
- Increase the use of Peer Support Specialists to work closely with families before and immediately after discharge. Peer Support Specialists can help bridge the transition from residential care to community care, especially when youth are not eligible for services from a WISe team.

AWHWA also encourages the development of a family or relative search tool for inpatient providers to utilize when trying to identify potential placement/housing options or supportive and caring adults for young people. Unlike in the child welfare system where these skills and tools exist to cast a wide placement and support network for youth, there exists no similar model for the BH inpatient community to ensure young people's post-treatment permanency.

f. Housing Continuum Opportunities

Young people and families who shared their stories with AWHWA described young people leaving treatment and returning to unstable family situations, couch-surfing, and sleeping on the street or in shelters. This instability has a profound impact on young people's ability to maintain their MH or SUD treatment plan.

System planners must listen to the stories of young people, families, and providers and respond by creating a full continuum of housing support for young people struggling with MH and SUD issues. AWHWA believes this means creating meaningful step-down MH and SUD options, including community-based independent living settings and recovery programs that are available through public and private insurance options.

Core principles in exploring MH and SUD housing options must include the notions that:

- MH and SUD transition planning should include housing and placements that are the least restrictive and promote young people’s independence.
- MH and SUD inpatient facilities and post-treatment housing and support services must be culturally competent to serve youth who identify as LGBTQ, and youth of color, especially youth who are Black or Native American or Alaska Native.

With homelessness prevention as a guiding principle, AWHWA suggests the SSB 6560 planning team engage in dialogue, informed by young people, families, and provides, focused on developing inpatient step-down systems of care, that includes (among other things):

Youth whose MH needs require inpatient treatment	<ul style="list-style-type: none">● Adding E&T (short-term) and CLIP (long-term) beds for youth● Developing a model for community-based, step-down MH programs for youth who do not meet medical necessity for CLIP / long-term care and for youth stepping down from CLIP that incorporate:<ul style="list-style-type: none">• Connection to clinical MH services and comprehensive medication management• Intensive transition / community re-engagement planning• Connection to Peer Support Services• Connection to education and/or employment support, and transportation• WISe team or other wraparound case management engaged in transition planning, regardless of Medicaid eligibility• Intensive family engagement, including family visits to program and youth weekend visits home, prior to transition home; Functional Family Therapy• Respite care & other support to family, including siblings● Identifying comprehensive post-treatment housing options for youth, including:<ul style="list-style-type: none">• Home to family• Foster care• Kinship care• Host Homes• Expansion of transitional housing programs for older adolescents
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<p>Young adults whose MH needs require inpatient treatment</p>	<ul style="list-style-type: none"> ● Creating a young adult /TAY inpatient care and discharge planning model ● Identifying a range of independent community-based living options, including scattered site, clustered housing (one location), and Host Homes ● Identifying primary components for post-treatment support, including: <ul style="list-style-type: none"> • Connection to clinical MH services and comprehensive medication management • Intensive transition / community re-engagement planning • Connection to Peer Support Services • Connection to housing specialist or housing organization • Connection to education and/or employment support, and transportation • TAY-specific WISe team or other wraparound case management, regardless of Medicaid eligibility • Connection to family supports
<p>Youth whose SUD needs require inpatient treatment</p>	<ul style="list-style-type: none"> ● Adding youth-specific secure detox beds ● Developing a model for community-based, step-down SUD recovery programs and support for youth that includes: <ul style="list-style-type: none"> • Comprehensive SUD and MH case management • Intensive transition / community re-engagement planning • Connection to Peer Support Services • Connection to education and/or employment support, and transportation • WISe team or other wraparound case management engaged in transition planning, regardless of Medicaid eligibility • Intensive family engagement, including family visits to program and youth weekend visits home, prior to transition home; Functional Family Therapy • Respite care & other support to family, including siblings ● Identifying comprehensive post-treatment housing options that center the youth’s recovery, including: <ul style="list-style-type: none"> • Home to family • Foster care • Kinship care • Recovery-based Host Homes • Recovery-based transitional housing programs for older adolescents <p>As noted above, three youth secure facilities are “pending approval,” with the hope they will open in 2019 and offer 13-14 total youth beds. While this is promising, the Raikes Landscape Scan identified the need for more youth-designated SUD Withdrawal Management beds in 2016—the SSB 6560 planning team should feel a sense of urgency to hear from the community and propose a full continuum that will support the SUD needs of youth.</p>

Young adults whose SUD needs require inpatient treatment

- Creating a young adult /TAY inpatient care and discharge planning model
- Identifying a range of independent community-based living options, including scattered site, recovery-based clustered housing (one location), and recovery-based Host Homes, among others
- Identifying primary components for post-SUD treatment support, including:
 - Comprehensive SUD and MH case management
 - Connection to Peer Support Services
 - Connection to housing specialist or housing organization
 - Connection to education and/or employment support, and transportation
 - TAY-specific WISe team or other wraparound case management, regardless of Medicaid eligibility
 - Connection to family supports

Ultimately, the SSB 6560 planning process should ensure that continuum developed offers models that provide young people with choices, knowing that each young person and their journeys are unique.³⁰

The great tragedy of being a residential substance use disorder treatment provider for adolescents is knowing that while they've been in our care they've gone through withdrawal, experienced relief from the burden of family trauma and housing instability and have begun to imagine a future of promise. They must then begin to prepare for the abyss of what's next — the next uncertain foster placement, the instability at home, and often, the likelihood of homelessness. Maintaining sobriety or a pursuing a life free of anxiety and depression seems impossible. They experience the cycle of despair, hope, back to despair in 60-90 days. Treatment costs \$10,000 a month, imagine how far those resources could go to support housing stability.

– Adolescent Inpatient provider

VII. Conclusion

Young people who access inpatient mental health and substance use disorder treatment are already vulnerable, and it is tragic that our response systems are unable to better plan for and support their discharge from residential facilities. Thousands of young people experience homelessness or unstable housing post-treatment. A secondary consequence, beyond the negative impact on young people and families, is the inefficiency of dollars invested in the treatment process only to have young people become homeless.

We can prevent homelessness for these young people if systems collaboratively approach this complex problem with shared responsibility and innovative thinking. The voices of young people and families, alongside providers, must guide the menu of housing and support options. Developing and funding a comprehensive housing continuum for young people with MH and SUD needs will reduce our reliance on homeless shelter and service providers to be all things to all young people in crisis.



Young people have a lifetime of potential. Washington has a responsibility to help them reach that potential and can do so by responding to young people's behavioral health needs while in treatment. We must also ensure they are discharged

to safe and stable housing and have access to comprehensive community-based support, so they can engage in education and employment opportunities and are surrounded by family and a community of other caring individuals.

The SSB 6560 planning initiative presents a multi-system opportunity to do this work and do it right, not just for the young people who are experiencing homelessness now, but for the youth who do not yet know they will struggle with mental health or substance use issues. AHWHA is ready to stand with young people, families, state leaders, and private funders to do this critical work.

VIII. Appendix

a. Glossary of Terms and Acronyms

Aged, Blind and Disabled (ABD): A Washington State program that provides cash assistance to eligible low-income adults who are 65 years or older, blind, or meet Supplemental Security Income (SSI) disability criteria based on a physical or mental impairment that is of at least twelve months duration.

Basic Food: In Washington State, the US Department of Agriculture (USDA), Supplemental Nutrition Assistance Program (SNAP) is called Basic Food.

Behavioral Health: A term that is sometimes used interchangeably with 'mental health' but usually includes the idea that both mental health and the absence of substance use disorders contribute to overall behavioral health, and that appropriate behavioral health care includes the treatment of both mental illness and substance use disorders simultaneously.

Centers for Medicare and Medicaid Services (CMS): A federal agency under the US Department of Health and Human Services (HHS) that administers the Medicare program and works with state government to administer Medicaid and the Children's Health Insurance Program (CHIP).

Co-occurring Disorder: A term that describes the presence of both mental illness and substance use disorder in one individual. Co-occurring disorder was previously termed 'dual diagnosis'.

Couch Surfing: Short-term, marginal lodging with relatives, friends or acquaintances.

Gender Specific Programming: Residential or community programs that are specifically designed to develop resilience and emotional and physical health and growth by providing adolescents with opportunities to develop relationships with those of the same gender, and with same gender role-models and mentors who demonstrate strengths and positive approaches to solving problems. Gender specific programs are conducted in emotionally and physically safe environments.

Housing and Recovery through Peer Services (HARPS): A Washington State program that uses peer counselors to help homeless or near homeless

individuals with mental health and/or substance use disorders to find and maintain permanent housing.

Housing and Essential Needs (HEN): A Washington State program that provides access to essential needs and housing assistance for low-income adults who are unable to work due to physical or mental incapacity and are not eligible for Aged, Blind, or Disabled (ABD) assistance.

Job Corps: A program administered by the US Department of Labor that offers free counseling, educational and vocational training to low-income young people aged 16-24 who are legal US residents, are not under court supervision, are drug-free, not behavior disordered and who have the consent of a parent or guardian if a minor.

Predictive Risk Intelligence System (PRISM): A predictive modeling support tool used by Washington State to identify at-risk complex Medicaid clients in need of comprehensive care coordination services.

Respite Care: A planned period of care that is provided to offer a break to a primary caregiver, which can be temporary full-time or intermittent.

Ricky's Law E3SHB 1713 (also known as the Ricky Garcia Act): took effect in April 2018 and allows for involuntary commitment to chemical dependency treatment if a person is at risk of serious harm to themselves or others, and/or is gravely disabled by an addiction to drugs or alcohol. This is a new requirement under Involuntary Treatment Act (ITA), which previously addressed serious harm related to mental illness only.

Substance Use Disorder (SUD): The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), discontinued the use of the terms substance abuse and substance dependence and now uses the term to 'substance use disorders', which can be mild, moderate, or severe. SUDs occur when the habitual use of alcohol and drugs leads to significant social, vocational and educational impairment at home, work or school as well as health problems.

Unaccompanied (homeless) Youth: The U.S. Department of Education defines homeless youth as youth who do not have a regular nighttime residence or whose nighttime residence is a supervised or publicly operated shelter designed to provide temporary living accommodations,

or welfare hotel, or any place not normally used as regular sleeping accommodations for human beings. This definition includes both youth who are unaccompanied by families and those who are homeless with their families. Unaccompanied homeless youth are without family, guardians or caretakers.

b. Stakeholder Interviews or Resource Partners

Name	Agency / Role
Dawn Anderson	Coordinated Care / Substance Use Disorder Systems of Care Liaison
Kate Baber	Washington State Health Care Authority / Health Policy Analyst
Rachel Barrett	Ryther / Senior Director Outpatient Services
Karen Brady	Ryther / Executive Director/CEO
Julie Brown	AcceleratorYMCA / Director of Foster Care Transitions
Jon Brumbach	Washington State Health Care Authority / Senior Health Policy Analyst
Bridget Cannon	Volunteers of America, Eastern Washington & Northern Idaho / Director of Youth Services
Paulette Chaussee	Family Behavioral Health Advocate; Washington Recovery Alliance / Public Policy Chair
Lana Crawford	Director / Pioneer Human Services
Peggy Dolane	Parent Advocate; King County Family & Youth Council, FYSPRT / Family Tri-lead
Stacy Dym (Gillett)	The Arc of King County / Executive Director
Andrea Estes	Ballmer Group / Portfolio Manager, Washington
Jennifer Estroff	Coordinated Care / Liaison, Tribal Outreach and Apple Health Core Connections Regions 5 & 6
LaRessa Fourre	Washington State Health Care Authority, Division of Behavioral Health & Recovery / Children's Long-Term Inpatient Program Administrator
Melinda Giovengo	YouthCare / CEO & President
Christopher Hanson	YouthCare / Director of Engagement Services
Ramona Hattendorf	The Arc of King County / Director of Advocacy
Mandy Huber	Washington State Health Care Authority, Division of Behavioral Health & Recovery / Child, Youth & Family Behavioral Health Policy
Christina Hulet	Christina Hulet Consulting / Principal
Roger Iino	AcceleratorYMCA / Behavioral Health Integration Specialist
Patty King	Washington State Health Care Authority, Division of Behavioral Health & Recovery / Family Liaison
Annette Klinefelter	Daybreak Youth Services / Chief Executive Officer

Annarose Krug	YouthCare / Detention Case Manager
Amanda Lewis	Washington State Health Care Authority, Division of Behavioral Health & Recovery / Adolescent Substance Use Disorder, Co-occurring Treatment Lead
Laurie Lippold	Partners for Our Children / Director of Public Policy
Evelyn Maddox	Washington State Health Care Authority, Division of Behavioral Health & Recovery / Youth Liaison Program Manager
Jim Mayfield	Washington State Department of Social and Health Services, Division of Research and Data Analysis / Senior Research Scientist
Benjamin Miksch	UnitedHealthcare Community Plan / Housing Specialist
Johnny Ohta	Ryther & YouthCare / Chemical Dependency Professional
Sierra Phillips	Youth Advocate
Terry Pottmeyer	Friends of Youth / President & CEO
Kris Sanborn	AcceleratorYMCA / Clinical Director
Morgan Silverman	YouthCare / Director of Homelessness Prevention
Andi Smith	Ballmer Group / Executive Director, Washington
Katherine Switz	The Stability Network / Founder and Executive Director
Robin Tatsuda	The Arc of King County / Director of Information & Family Support
Dr. Eric W. Trupin	University of Washington School of Medicine, Department of Psychiatry & Behavioral Sciences / Professor & Vice Chairman; Division Public Behavioral Health & Justice Policy / Director
Dr. Sarah Cusworth Walker	University of Washington, Department of Psychiatry and Behavioral Sciences / Research Associate Professor
Richard Watkins	Parent Advocate
Shoshana Wineburg	YouthCare / Public Policy & Communications Manager
Emma York-Jones	YouthCare / Director of Under-18 Housing and Shelter Services

c. Project Advisors

Name	Agency / Role
Jane Beyer	Washington State Office of the Insurance Commissioner / Senior Health Policy Advisor
Diana Cockrell	Washington State Health Care Authority, Division of Behavioral Health & Recovery / Section Manager, Prevention and Children's Behavioral Health
Erin Hatheway	A Way Home Washington / Deputy Director
Kim Justice	Washington State Office of Homeless Youth / Executive Director

Melodie Pazolt	Washington State Health Care Authority, Division of Behavioral Health & Recovery / Section Manager, BH Programs & Recovery Supports
Regina McDougall	Washington State Office of Homeless Youth / Interagency Workgroup on Youth Homelessness
Cary Retlin	Washington State Department of Commerce / Behavioral Health Housing Administrator
Jim Theofelis	A Way Home Washington / Executive Director
Casey Trupin	Raikes Foundation / Program Officer, Youth Homelessness
Elizabeth Venuto	Washington State Health Care Authority, Division of Behavioral Health & Recovery / Supervisor, Child, Youth, & Family Behavioral Health Unit

d. Youth Focus Group Discussion

AWHWA is incredibly grateful to the young people at Daybreak Youth Services, as well as the staff who facilitated the focus group conversations. The youth were incredibly brave in sharing their stories and providing recommendations on how to improve the systems serving young people's BH needs.

A Way Home Washington Environmental Scan 2018 Youth Reflections on Treatment Discharge and Post-Treatment Support

- 1) Just prior to entering treatment (this time), where were you living?
 - a. With your family?
 - i. Parent(s)? Extended family? Chosen family?
 - b. Homelessness or unstably housed?
 - i. Unaccompanied / by yourself? Homeless with your family? Couch surfing?
 - c. In foster care?
 - d. In the juvenile justice system (JRA or county detention)?

- 2) If you were in treatment before, did you experience homelessness after leaving treatment?
 - a. What do you think were the reasons behind that experience?
 - b. What were the biggest contributors to your homelessness experience?

- 3) After your current treatment program ends, what does an ideal, safe home / housing environment look like to you?

- 4) Do you feel like you know what you need to do to access ideal safe and stable housing post-treatment?
 - a. What do you need to know?
 - b. Who do you need to have help you navigate the search for safe and stable housing?

- 5) What types of case management, medication management, outpatient treatment, and other support do you think is most critical for you upon discharge that will allow you to find and maintain a safe and stable place to live?

- 6) If you are moving “home” after treatment—with biological family, chosen, foster, or other)—what support does your family need to help you maintain your post-discharge plan and, thereby, maintain your housing?

- 7) Would having a temporary place to live, like a step-down program, host home, or some other arrangement, help you and your family receive support and resources you need to reconcile with your family of origin if returning home immediately is not an option?

- 8) If you were able to meet with a lawmaker or someone who could fund a program to help prevent homelessness among young people who leave substance use and mental health treatment programs, what would you tell them is most critical to fund?

- 9) Is there anything else we should know?

e. Guided Interview Format Questions for MH and SUD Inpatient Providers

AWHWA is grateful to the inpatient providers who agreed to be interviewed for this report and share their perspectives on what does and does not work for young people in inpatient programs. The providers do very challenging work every day and are dedicated to system improvement and high-quality client interactions. Many thanks to the clinical and administrative staff from Daybreak Youth Services, Excelsior Youth Center, Pearl Street Center, Seattle Children’s Hospital, and Smokey Point Behavioral Health Hospital.

A Way Home Washington Environmental Scan 2018 Discharge Planning Interview

Name of Facility/Location _____

Date _____

Staff Name(s)/ Credentials _____

1) Introduction

2) What is your role with the program?

3) What are the populations and age groups served? Do you have gender-specific programs?

4) Where do most of your referrals originate?

5) What is the average length of stay (LOS)?

6) Can you tell me a little about your residential (MH and/or SUD) program(s)?

7) Are there designated discharge planners? If not, who is responsible for discharge planning?

8) At what point in time does discharge planning start following admission?

9) What is the typical discharge planning process? Are there standard policies and procedures? Do you use templates?

10) Who is typically involved in the discharge planning? (e.g. parents, guardians, youth, state agencies, outpatient agency staff).

11) Can you tell me about a discharge plan that went really well? (No names or identifying info please.)

12) What are the factors that contribute to a successful discharge plan?

13) Can you tell me about a discharge plan that didn't go so well? (No names or identifying info please.)

- 14) What are the barriers that contribute to a sub-optimal discharge plan?
- 15) What are the major client/resident characteristic that impact discharge planning, including diagnoses?
- 16) What system changes could be made to improve discharge planning at all inpatient and residential facilities?
- 17) Do you ever get feedback about the longer-term outcome of a discharge plan?
- 18) What resources do you use to help with the discharge planning process?
(e.g. internet, directories, established relationships, affiliated programs)
- 19) What did we forget to ask?

f. Table I — Landscape of Inpatient MH and SUD Facilities that Serve Minors

Facility Name	MH	SUD	#Beds	F	M	City
Child Study Treatment Center (CSTC)	CLIP		47	x	x	Lakewood
Daybreak/Bush Prairie	x	x	58	x	x	Brush Prairie (Vancouver area)
Daybreak/Spokane	x	x	33	x		Spokane
Excelsior Youth Center	x	x	14		x	Spokane
Fairfax Hospital Adolescent Unit	x		26			Kirkland
Gray Wolf Ranch	x	x	26		x	Port Townsend
Healing Lodge of the Seven Nations/Cedar	x	x	30		x	Spokane
Healing Lodge of the Seven Nations/PelPalWichiya	x	x	15	x		Spokane
Kitsap Youth Inpatient Unit	x		10	x	x	Port Orchard
MultiCare Behavioral Health	x		24	x	x	Tacoma
Sunstone Youth Treatment Center/Navos	CLIP		12			Seattle
Pearl St.	CLIP		13	x	x	Tacoma
Providence Sacred Heart Medical Center	x		24	x	x	Spokane
Ryther Center for Children and Youth	x		36	x	x	Seattle
Sea Mar Renacer	x	x	16		x	Seattle
Sea Mar Visions	x	x	34	x		Bellingham
Seattle Children’s Hospital	x		41	x	x	Seattle
Smokey Point Behavioral Health Hospital	x		14	x	x	Marysville
Sundown M Ranch		x	60	x	x	Yakima
Tamarack	CLIP		13	x	x	Spokane
Two Rivers Landing (8-10 beds are Acute Short-Term beds for 16 total beds that “flex” based on need)	CLIP	x	6-8	x	x	Yakima
Total			554			

- 1 The data does not include rates of homelessness or housing instability for young people leaving county juvenile detention centers.
- 2 RDA's data dashboard considered youth as "homeless" if at any time their living arrangement included "Homeless without Housing," "Emergency Housing/Shelter" or "Battered Spouse Shelter" or if their housing services included "Emergency Shelter," "Homeless Prevention," "Rapid Rehousing," or "Transitional Housing." Youth were considered Homeless or Unstably Housed if they are homeless as described above or their living situation is "Homeless with Housing" (e.g. couch surfing). For more information about what data sources RDA relied upon to determine housing status, see Housing Status of Youth Exiting Foster Care, Behavioral Health and Criminal Justice Systems, at 1 (June 2017), available at <https://www.dshs.wa.gov/sites/default/files/FFA/rda/documents/research-11-240.pdf>.
- 3 RDA Dashboard at 7.
- 4 Laws of 2018, ch. 157. See also <http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6560-S.SL.pdf>.
- 5 Noble, Courtney. Youth Homelessness in Washington: Landscape Scan, at 3 (June 2016), available at http://www.awayhomewa.org/wp-content/uploads/2016/09/YouthHomelessnessWA_LandscapeScan_August-2016.pdf.
- 6 Laws of 2018, ch. 15. See also <http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/1630.SL.pdf>.
- 7 RDA Dashboard at 7. The FY15 17% rate of homelessness/unstably housed is a decrease from FY14 and FY13: 19% in FY14 at 12 months; 22% in FY13 at 12 months.
- 8 Mayfield, Jim. "Youth numbers" Message to Erin Shea McCann. August 6, 2018. E-mail. The FY13 and FY14 estimates were similar: 57 (13.4%) youth / 368 (86.6%) young adults in FY13, and 63 (16.2%) / 325 (83.8%) young adults in FY14 experienced homelessness or unstable housing within 12 months of an exit from inpatient MH treatment.
- 9 RDA Dashboard at 7. The FY15 28% rate of homelessness/unstably housed is a decrease from FY14 and FY13: 30% in FY14 at 12 months; 35% in FY13 at 12 months.
- 10 Mayfield, Jim. "Youth numbers" Message to Erin Shea McCann. August 6, 2018. E-mail. The FY13 and FY14 estimates were similar: 135 (14%) youth / 826 (86%) young adults in FY13, and 97 (12.5%) / 677 (87.5%) young adults in FY14 experienced homelessness or unstable housing within 12 months of an exit from inpatient SUD treatment.
- 11 RDA Dashboard at 11.
- 12 Lewis, Amanda. "RE: Friday call info for Pam" Message to Pamela Martin and Erin Shea McCann. June 18, 2018. E-mail; Treatment for Adolescent Substance Use Disorders Referral and Resource Guide, Washington State Department of Social & Health Services (July 2015), available at <https://www.hca.wa.gov/assets/billers-and-providers/youth-treatment-referral-guide.pdf>; Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Services Locator, available at <https://findtreatment.samhsa.gov>; Washington State Directory of Certified Mental Health, Substance Use Disorder, and Problem and Pathological Gambling Services, Washington State Department of Social and Health Services (June 2018), available at <https://www.hca.wa.gov/assets/free-or-low-cost/directory-certified-behavioral-health-agencies.pdf>.
- 13 For more information about the integration work, see <https://www.hca.wa.gov/about-hca/healthier-washington/integrated-physical-and-behavioral-health-care>.
- 14 Laws of 2017, sec. 128 (25), (27). See also <http://leap.wa.gov/leap/Budget/Detail/2017/2017195883-S.PL.pdf>.
- 15 For more information about HARPS, see <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/HARPS.pdf>.
- 16 Retlin, Cary. Phone conversation with Erin Shea McCann. September 20, 2018; "Follow up – job duties" Message to Erin Shea McCann. October 4, 2018. E-mail.
- 17 See WAC 182-559 <http://apps.leg.wa.gov/WAC/default.aspx?cite=182-559&full=true>. For more information, see <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation>.
- 18 For more information about the FCS, see <https://www.hca.wa.gov/about-hca/healthier-washington/initiative-3-supportive-housing-and-supported-employment>.
- 19 Eligible health criteria for Supportive Housing include at least one of the following: mental health need; or outpatient substance use disorder need; or need for assistance with 3 or more activities of daily living; or need for hands-on assistance with 1 or more activity of daily living; or complex physical health need. Eligible risk criteria include at least one of the following: people who are experiencing chronic homelessness; or people who have experienced frequent or lengthy stays in an institutional setting ; or people who have frequent stays in adult residential care settings; or people who experience frequent turnover of in-home caregivers; or people who have a Predictive Risk Intelligence System (PRISM) risk score of 1.5 or above.
- 20 For more information about the FCS, see <https://www.hca.wa.gov/about-hca/healthier-washington/initiative-3-supportive-housing-and-supported-employment>.
- 21 Eligible health criteria include: mental health need; or outpatient substance use disorder need; or assistance to perform three or more activities of daily living; or hands-on assistance to perform one or more activity of daily living; or physical impairments that interfere with basic work-related activities. Eligible risk criteria include: people enrolled in the Aged, Blind, or Disabled program or Housing and Essential Needs program; or people with a serious mental illness or co-occurring mental and substance use disorders; or people with substance use disorder and multiple treatments; or people who have difficulty obtaining or maintain employment due to age, physical or mental impairment, or traumatic brain injury.
- 22 For more information about WISE, see <https://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/wraparound-intensive-services-wise>; <https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-1594.pdf>.
- 23 Pavelle, Bridget. "WISE homelessness prevention data?" Message to Erin Shea McCann. September 17, 2018. E-mail. For more information about WISE's program data, see https://fortress.wa.gov/hca/wisebhasreports/QuarterlyWISEReport.html#recommendations_for_wraparound_with_intensive_services.
- 24 For more information about Ricky's Law, see <https://www.hca.wa.gov/about-hca/behavioral-health-recovery/ricky-s-law-involuntary-treatment-act>.
- 25 For more information about DCYF, see <https://www.dcyf.wa.gov/>.
- 26 For more information about FFPSA, see <https://www.dcyf.wa.gov/practice/performance-improvement/ffpsa>; <http://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx>.
- 27 Raikes Landscape Scan, at 15.
- 28 For more information about the Interagency Workgroup on Youth Homelessness, see <http://www.commerce.wa.gov/serving-communities/homelessness/office-of-youth-homelessness/>.
- 29 For more information about PACT, see <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/program-assertive-community-treatment-pact>.
- 30 The SSB 6560 planning team should look to existing resources for more information on supporting young adults with mental health conditions in their housing transition. See, Friesen, B., & Koroloff, N. (2018). Housing and Transition: Meeting the Needs of Young Adults with Mental Health Conditions. Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University.