Youth Advisory Group
Minutes
November 5, 2018

Contents

Morning Discussion

WELCOME

Denise Galvez:

- Denise gave an overview of the agenda.
    - Welcome and Opening Remarks
    - Membership Update
    - Department of Health Care Services (DHCS) Efforts and Next Steps
    - World Café Exercise - New Beginnings
    - World Café Report-outs
    - Other Business and Planning for the Next Youth Advisory Group (YAG) Meeting
    - Wrap-up and Meeting Evaluation

Jennifer Kent:

- Director Kent commented on establishing the YAG membership.
- Department of Finance will update us on when Proposition 64 funds are available to spend.
- Closing comments included a discussion of current events, such as the election.

Don Braeger:

- Don provided a brief history of the YAG and highlighted the mission and vision statement.
- There is a Request for Offer (RFO) that has posted for a contracted facilitator for the YAG meetings.
- 40 applications for YAG membership were received by DHCS, and 15 applications were accepted. The two criteria considered for membership were longevity with the YAG and expertise in Substance Use Disorder (SUD) with youth.
- Don asked members to introduce themselves.

Members at the table:

- Dave Neilsen
- Brett O’Brien
- Al Senella
- Liz Stanley-Salazar
- Clara Boyden
- Ian Evans
- Jan Ryan
- Jim Kooler
- Phillip Hernandez
- Razelle Buenavista

- Sue Nelson
- Paula Wilhelm

Members by phone:

- Kathleen Brown
- Howard Padwa

Denise Galvez:

- Denise informed the group that the list of members is available on the YAG website.

Don Braeger:

- Don thanked the participants for volunteering. He expressed an interest in forming a workgroup on residential services for youth. He displayed a heat map showing the location of youth residential programs using data from October 18, 2018.

Denise Galvez:

- The Youth Services Provider Manual (YSPM) has been edited, and comments are being incorporated.
- Regarding the RFO for a contracted facilitator, February is the target date that the awardee will be announced.
- She discussed recent staffing changes.

Don Braeger:

- Don opened up the room for questions.

Question by Dave Neilsen:

- Dave asked whether this is the year that youth can have access to the rest of the continuum that we know exists on the mental health (MH) side.

Response by Jennifer Kent:

- Director Kent stated that the Department of Social Services (DSS) has been revamping child welfare. For youth that have been removed from homes, there's a deadline for group homes to be recast as short term residential. The goal is to focus more on permanency, reducing institutional and congregate care as much as possible.
- DHCS has been working on increased oversight and enforcement on a path of evolution.

Comment by Liz Stanley-Salazar:

- Liz commented that the issue of coordination and continuum-of-care (COC) reform is important.

Don Braeger:

- Don stated that one of the things he would like workgroups to consider is how to resolve issues without depending on historical models.

World Café Exercise

Denise Galvez:

- Denise gave instructions for the World Café.
    - There are six stations, each with a different question. Groups will rotate taking turns brainstorming responses to the questions.

World Café Findings (as written on easel paper)

Question One: What successes and barriers/gaps exist in the provision of youth Early Intervention (EI) services?

Successes	Barriers/Gaps
• Juvenile justice improved, lesser offenses not criminalized • Student Assistance Programs (SAPs) • Community-defined approaches to MH/SUD • Mental Health Services Act (MHSA) innovation projects • Office of Health Equity pilot projects • Hilton Foundation has funded research projects for best practices • Youth collaborative courts • Availability of MHSA Prevention and Early Intervention (PEI) funds have helped EI, increased flexibility • Friday Night Live and prevention programs • In-school, after-school, summer programs • School-based Memorandum of Understanding providing setting for services • 12-15 counties have strong SAPs • COC can allow for partnerships • Room for growth in mentorship programs	• Differences in funding/access/coverage between Drug Medi-Cal (DMC) and non-DMC for EI • Uncertainty of quality of care/EI provided by schools • Collaboration between schools and providers on identifying EI, tiered approach • Not receiving referrals, not mandated. • Enforcement around cannabis law, not writing citations • Lack of confidence in billing for EI • MOUs for DMC-Organized Delivery System (ODS) • Define EI for the Managed Care Plans (MCPs) • Pilot projects are short term • Dissemination of best practices • Nobody wants to own EI, Managed Care is doing nothing with EI • Integration between MH/SUD, dual diagnosis, data sharing • Lack of trained clinicians, inadequate screening and assessment tools/questions • Educate on use of Substance Abuse Prevention and Treatment Block Grant (SABG) funding

Successes	Barriers/Gaps
	• Challenges with engagement • Insufficient: access into schools; use of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); access to family-based; outreach to youth not in school • Lack of attention to unaccompanied homeless youth • Lack of collaboration with juvenile justice and between health/education, state and local • Lack of collaboration between public section and non-profit service providers • Responsibility: schools vs. Behavioral Health • American Society of Addiction Medicine (ASAM) Level 0.5 should be funded through DMC • School suspensions without services • Inconsistency in policies and practice • Lack of restorative justice component in schools

Question Two: What additions and/or changes need to be made to policies or statutes regarding the provision of youth EI services?
(What can DHCS do?)

- More guidance for policies or statutes
    - Sample infrastructure, examples
- Child and Adolescent Needs and Strengths (CANS) should not be used to determine SUD needs
- Description of indicated preventions should be made explicit within the policies for youth; EI services would help describe the tool
- EPSDT policy; EI allowable in ODS
- Clarity on who owns EI
- More direction from state in policies for care for EI
- Consider MHSA model and expand Alcohol and Other Drug prevention to include EI; fund application
- Better support as youth move from services (changing level-of-care/service-level)
- Define EI in the context of the full COC

- “Shall and should” is misleading; expectations in YSPM
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) needs to be developed for youth screening beyond alcohol
- More clarity on how to access EPSDT for providers and counties
- MCP’s accountability for services
- Understand SUD services for primary care
- Standards for SBIRT and other brief interventions
- Return juvenile cannabis violation to a misdemeanor with restorative response
- Encourage policy to enforce infrastructure on cannabis violation
- MCPs to do more in screening and detection
- Access added to Individualized Education Plan and 504 educational plan
- Clarity for COC for SUD services and where EI fits in
- Clarity or training on funding streams and interagency roles, fewer silos
    - What can funding streams be used for?
    - Is prevention and EI included?
- Policies that encourage partnership with education and after school
- Roles and expectations
- “Encouraging collaboration” across the COC (Prevention, EI, treatment)
- Exchange and disseminate information regarding policies; i.e., 42 Code of Federal Regulations (CFR) Part 2
- What is youth “say” in policies or statutes
- Peer services
- Ability to do more non-clinic care in the community
- Field-based service (funding)
- Foster care needs better screening tool for SUD welfare

Question Three: What can the YAG do to address the youth EI services barriers/gaps?

- Advise DHCS around California Department of Education and other state agencies, and partner with afterschool programs for continued care
- Examine prevention and treatment infrastructure, get rid of silos, navigate partnerships
- Prevention and treatment roles
    - What are policies and expectations for EI services?
- Needs assessment on current policies: cross-state youth analysis on what is working
- How can we spend the set-aside money for EI
- Create a long-term vision for DHCS for collaboration across COC
- Look at EI across COC funding: SABG and ODS
- Map out the diversified available funding and clarify (matrix)

- Connect and cross-utilize different funding sources
- Clearly define what is prevention, EI, and treatment
- Guidelines for prevention strategic planning (Center for Substance Use Prevention criteria on PEI)
- YAG members get together to share information and current practice (assessment tool)
- States can come together to recommend to DHCS, to define ASAM Level 0.5 and systematic defining of EI
- Proposition 64 funding to fill gaps
- Identify two funded entry doors to EI (from prevention to treatment)
- YAG to ensure screening tool to address EI services for prevention and treatment
- Separate screening and assessment tools
- Los Angeles was mentioned in that currently they have a risk assessment process: if a risk is detected, the patient goes straight into treatment
- Develop youth services standards/requirements
- YAG to be active in waiver renewals
- Have youth in YAG: develop a youth-centric system
- Advise on improvement of ODS system for youth SUD, especially on outreach, EI, and field-based services
- Review policy regarding EI in prevention and treatment, then make recommendations
- YAG to identify best/promising practices in regards to EI: what is working and build upon it
- Agree on standards and criteria for levels and referrals
- Support a recovery-services oriented standard of care
- Issue a value/position statement to address cultural awareness
- Explore access points and other metrics other than just residential
- Develop a comprehensive data system and a central dashboard
- YAG to have a conversation about what data are being collected
- Set incremental goals for improvement
- Request outreach assessment of young people (what success/gaps); i.e., surveys and town halls
- Develop process to get a snapshot of what's working and not working for youth
- Leverage social media to engage youth (using text messaging, app-based)
- Use MHSA as a model for technology to be SUD specific
- SBIRT: expand to include SUD and primary care

Question Four: What successes and barriers/gaps exist in the provision of youth residential services?

Successes	Barriers/Gaps
• Excellent facilities do exist • Evidence-based practices • Increase in accountability • Ability to use EPSDT when limit of stay has been reached • Acknowledgment of trauma for youth • Development of youth program in Marin county • Available access where programs do exist • Integration of MH • Availability in the system of care • ODS has added to revitalization of youth residential services • More youth choosing to participate in 30-day programs	• School districts have a lack of understanding of EI vs. residential services, which causes incorrect services for youth • Lack of family counseling • Lack of flexibility in length of stay; predetermined length doesn't take individual needs into account • Supplemental EPSDT services; i.e., tobacco cessation • Lack of leverages on other parts of youth's life • Providers need to financially survive • Conflict between school and ODS • Lack of development funding (buildings, staff, etc.) • Physical infrastructure unavailable • Poor linkages between system of care • Stigma, worry of failure • Lack of program standards • Funding/workforce/licensure issues • Billing confusion, daily rate limitations • Risk management, increased liability • Language-specific services • Cross-county care coordination • Understanding EPSDT and other funding streams • Lack of youth-specific treatment model • Mandating vs. volunteering • Creation of resistance to treatment • Treatment seen as a punishment • Collaboration with Department of Justice • Focus is on youth and not environment

Successes	Barriers/Gaps
	• Lack of attention and resources to unaccompanied homeless youth • Lack of supportive housing, transitioning youth from treatment

Question Five: What additions and/or changes need to be made to policies or statutes regarding the provision of youth residential services? (What can DHCS do?)

- Broader county technical assistance for the use of EPSDT
    - Limited resources
- Policies focused on youth and their needs
- Data sharing (assessment of best practices)
- Residential licenses administered by DHCS, not DSS
- Develop more SUD into California Code of Regulations (CCR)
- State advocate for other funding
- Identify standards and evidence-based practices for youth
- Policies to encourage collaboration across the COC
- System infrastructure: electronic health records, technical assistance
    - Infancy: state needs to promote
- Combine education and treatment
- Increase funding for staff (staff turnover)
- Length of stay
- Credits being honored by education system for youth moving or coming from treatment
- Residential licenses with DHCS, for youth, with appropriate legislation behind it
- Legislative grant programs specifically for SUD, and define the competencies to work with youth
- Expanded access points for screening across systems; i.e., schools, primary care, health clinics
- Changing 30-day residential stay into outpatient
    - Is it working?
- Prohibitive costs for new providers (state help with the resources)
- Allowing for other factors in addition to ASAM for access to care
- Incentives for treatment; i.e., college credit
- Appropriate interaction allowed between youth and adult population: Health Insurance Portability and Accountability Act (HIPAA) allowed 42 CFR Part 2
- Geographic placement barriers
- Change in foster care and welfare system regarding SUD assessment
- “Can” the CANS

Question Six: What can the YAG do to address the youth residential treatment barriers/gaps?

- Expand education on how to utilize funding for provider and counties; i.e., access to EPSDT services and funding
- Simplify license process: needs to be streamlined for SUD residential license
- Address room and board issues: i.e., cost and availability
- Create a resource guide for funding and grant possibilities
- Trainings for smaller targeted cultural and ethnic populations
- Invite youth stakeholders to participate in YAG
- Include others in treatment and not just youth
- Identify multiple pathways to obtain youth input
- Include prevention (and others) for representation in YAG
- Advice regarding collaboration across COC
- YAG to advocate and provide insight on how to improve treatment fund use (Federal opioid grants: survey, research, white papers)
- Identify partnerships between/with providers, MH, SUD, schools, primary care
- Identify more ways to share information and public education on residential services
- Define residential as a whole COC
- Identify ways to establish more access points for residential treatment
- Strengthen the effectiveness of COC
- Create minimum standards for treatment, including license requirements for facilities that are SUD specific: move licensing review process to DHCS
- Identify and add additional stakeholders (child welfare and social services)
- Establish core competencies for SUD workforce
- Establish and maximize EPSDT use for residential use: specific billing coding for youth residential services, specifically
- Youth need to be in school while receiving treatments
- Input from youth on what works and doesn't for residential treatment (both successful and non-successful treatment outcomes)
- Improve workforce for treatment of youth: training, pay, improve employee retention
- YAG identify ways to bring local level experience and insight to state level activities and policies: i.e., assessments
- Amend CCR to be inclusive of SUD in every step of administrative process
- Advocate for Proposition 64 funds to be used for startup funds and treatment services, as well as COC services from EI to prevention to treatment
- Advocate for parity and funding for residential care to reduce staff turnover

Parking lot: What additional issues does the YAG need to create recommendations for resolution?

- Reduce documentation
- Workforce and survey
- Integration of assessment with MH
- Align funding stream rules for MH/SUD; get rid of silos
- Regional programs for residential recovery
- Get rid of current co-residency rule
- Access to Medication Assisted Treatment and Narcotic Treatment Program services for minors (tobacco cessation)
- Get the field ready for Family First Prevention Services Act
- Cannabis-specific SUD treatment

World Café Report-out and Discussion (as stated by participants)

Report-out/Discussion on World Café Question One: What successes barriers/gaps exist in the provision of youth EI services?

- On the criminal justice side, they use sequential mapping, looking at the client by intercepts. This did a good job of capturing about three of the intercepts
- EI needs a definition
- There is difficulty scaling the successes due to funding
- ODS and DMC are clinic based. This creates difficulty in doing prevention work. Guidance from DHCS is required
- Funding issues are barriers
- For students that may need psychological education and/or SUD services, we need to fund the school to be able to treat both. It's important to remove the funding issue that says, "I'll get paid more if I refer them into treatment." This allows a youth to enter EI through both doors
- If we think of every service being a funding code, then we are stuck in a clinic as the place where these things happen
- We should help other groups to understand that EI is a goal and not a funding code
- A better definition of EI is needed
- We need more information notices so that it's flexible yet still standardized in some ways
- We need a lot of collaboration to make progress
- Tracking of youth care needs attention. It's important to look at it across systems
- Training is an important aspect

- There are good examples to look to. For instance, in Pennsylvania, they had an interagency group that used funds, primarily SABG, to place SAPs in every high school in the state
- It's important to put ourselves back into the interagency way of thinking and doing
- It's important to bring EI to where the youth are, and the SAPs are the blueprint for that
- EI could be 15 seconds, or a series of 15 minute sessions. We need to figure out which is needed, not whichever widget they are able to bill for
- Develop better EI for cannabis. Youth don't see the downsides like they do with alcohol

Report-out/Discussion on World Café Question Two: What additions and/or changes need to be made to policies or statutes regarding the provision of youth EI services?

- Information notices would be helpful
- A comprehensive SABG manual is needed
    - DHCS response: DHCS is working on a document
- With the reform going on, and the quality of the Federal Financial Fiscal Monitoring Report, we'll be able to see where counties are spending the dollars, and how much. Maybe we can shift funds between counties, to get it to the counties who can use the funds
- It becomes a prioritization process. In a perfect world, where does the money start and end, and what priorities exist within your infrastructure
- Tools that diagnose or screen for substance use would help. To find it early we have to look early

Report-out/Discussion on World Café Question Three: What can the YAG do to address the youth EI services barriers/gaps?

- Getting input from youth is important, possibly by focus groups with youth who have been involved with the criminal justice system, child welfare, schools, MH programs, etc.
- Get involvement from DSS
- Address needs of ethnic populations and cultural groups for whom traditional models might not work

Report-out/Discussion on World Café Question Four: What successes and barriers/gaps exist in the provision of youth residential services?

- There is a lack of funding
- There is a lack of understanding and collaboration

- Counselors need to have a bachelor's degree, yet they are only paid $15 per hour
- Courts can't order more than 30 days
- County of residency is a barrier
- Distance between providers is a barrier
    - DHCS response: Behavioral Health Services may fund transportation
- Providers have different operational criteria and recognize different credits. Standards need to be set
- Employee morale and retention are barriers

Report-out/Discussion on World Café Question Five: What additions and/or changes need to be made to policies or statutes regarding the provision of youth residential services?

- Youth participation is important
- Receive input on what works and what doesn't
- Seek involvement of providers and different departments
- Advocate for Proposition 64 funds
- Create minimum SUD-specific standards for treatment
- Identify and add additional stakeholders, child welfare, and social services
- Establish and maximize EPSDT
    - DHCS response: Aside from information notices, the YSPM would be the resource to go to
- We need to find a way to build capacity and physical infrastructure

Report-out/Discussion on World Café Question Six: What can the YAG do to address the youth residential treatment barriers/gaps?

- Address HIPAA constraints regarding sharing of best practices
- Have ASAM specifically for SUD, in the foster system
- Define competencies
- Address prohibitive costs for providers
- Educational credits
- Length of stay
    - Is 30 days the right length?
    - What can be done to see if that's working or not?

Closing

Next YAG meeting on March 28, 2019.