Oregon Council of Behavioral Health

Statement and Recommendations; on the current collapse and needed modernization of the Oregon youth and family SUD system of care.

As Behavioral Health care providers we are experiencing a radical loss of services in our statewide youth and family SUD multi-system. Closures and reductions in youth SUD programing have reached a state of collapse, both in access and concrete infrastructure. The sector's workforce, operations and functional funding levels suffer from historic unresolved issues and new COVID-19 impacts include a workforce exodus. This history includes health equity failures and poverty, stigma biases that are ingrained in the system operations and continue to inextricably burden the work. The crisis at hand leaves us with the stark reality that as access collapses, closures of services will exacerbate Oregon's already poor outcomes.

While Oregon lingers in the bottom of states in its ability to achieve equitable Behavioral Healthcare access levels that support mental wellness (substance use disorder and mental health) in adults, it has done even less for youth and families.

This is not a new request. Oregon has not provided resources, meaningful strategy, and the support payors and provider networks need to modernize the Behavioral Healthcare continuum for youth and families. OCBH has been seeking leadership, investment, and attention to convene a strategic planning table to overhaul the youth and family system with all BH partners (including government, CCO, BH providers, hospitals and other youth serving healthcare partners). This would include modernizing payment, 309 COA licensing, and Oregon rules and supports for payors and providers to implement modern infrastructure and practice. OHA and ODHS have continuously, under a variety of leaders, lacked resources and not leveraged the expertise of the professional community to support these requests. As providers we have seen our ability to meet the needs of youth and families constrained at every juncture.

The longstanding approach of spending the majority of state resources and attention on trouble shooting adult BH service crisis has left the state with a bifurcated, disconnected, and antiquated youth and family service array which lacks access for youth.

Our membership of providers is under resourced and forced to operate under antiquated structures that do not support full fidelity modern practices, innovations, or technology to communities and those seeking care. The death knell of the system lies in services that do not

make sense in 2021 for equitable, co-occurring, whole family care. Nor does the state of the system entice recruitment or retention of a workforce to serve these youth and families. Outdated technology, lack of resources, and uncompetitive wages, frustrates and disappoints our workforce, leading to burn out and turnover.

Youth referred to care today in OCBH member's remaining services, both outpatient and residential, arrive often with little to no early intervention and severe co-occurring acuity and often intergenerational ACES impacts, regardless of income levels, and a lack of equitable referral. Typical struggles of youth referrals in 2021 include.

- daily and poly substance drug use of alcohol, opioids, methamphetamine, and marijuana.
- co-occurring mental health problems
- frequent criminal thinking patterns
- Impacts of sex trafficking
- Impacts of racism, stigma, poverty bias and the commiserate trauma
- Eating disorders
- High-risk sexual/self-harm behaviors
- unstable substance using family systems in severe poverty.
- Houseless or unstable housing
- Educational deficits, literacy, and anxiety to engage with school.
- Developmental interruption
- Our members are also witnessing a higher level of processing disorders and developmental delay most often from fetal exposure and/or trauma present in referred youth and present in their parents. Sadly, these disorders are being diagnosed late in adolescents vs. earlier. (We are gravely concerned with recent data on continuing meth overdose and use rates with adults who are of childbearing/rearing age).

Without modernization of SUD system services certified under the antiquated burden of operations cannot meet the needs of youth and families.

The systems current structures and resources do not match the modern needs of clients and are unable to support the BH organizations and workforce in the delivery BH care that they have been trained to provide. A history of stigma, race and poverty bias has left the system without the necessary tools to implement the training and skills of the sectors workforce and researched practice. As a community we would not and do not accept this outcome in our sister services of physical healthcare.

Technology, clean modern facilities, access to medicines and fidelity treatments are provided and more importantly unquestioningly resourced in physical healthcare. The lack of parity and the acceptance of this lack of parity is deep and lays at the foundation of our poor mental wellbeing and substance use disorder outcomes as a state. A health care provider cannot heal without the tools of their clinic, regardless of that diagnosis.

OCBH's most recent sustainability survey (June 2021) indicates that one of the top reasons the workforce leaves the field is the lack of tools and resources, some cited examples include:

- Serving consumers in the wrong level of care because the right level of care is not accessible.
- Antiquated technology systems, excessive paperwork, and numerous redundant audits that have not been streamlined for efficacy but layered over decades including DHS, OHA, Payors and Accreditations.
- Not being able to provide the client with the most effective intervention, such as co-occurring care, integrated care (physical, MH and SUD), or a full fidelity model of practice.
- Care coordination redundancy and dead ends, such as payor approvals, denials, gatekeeping, multiple care coordinators, and a system where BH professionals spend more time trying to help consumers access care than providing care.

Oregon's unfulfilled ambitions of youth and family SUD services

The promise of global budgets and CCO innovations **have not manifested** in the promise of a stronger community-based youth and family Behavioral Healthcare continuum, **in fact Oregon has less access to services, fewer relevant services, less workforce and fewer pathways to meaningful care for youth and families today**. Bridges to the right service at the right time across partners serving youth and families are more strained than ever. Each partner as the system degrades has turned inward and is scrapping for resources ineffectively.

Today, there are functionally less than **40 Residential Substance use disorder treatment slots** for youth experiencing the most acute level of need in Oregon. In less than two years two of the largest youth SUD programs, one a provider of culturally and linguistically accessible services, have closed. **With recent Legislative and federal investment, the unfortunate but predicted collapse of the youth acute SUD system has the opportunity for redesign before facilities are closed, liquidated, or repurposed for adult services.** As the operators and healthcare providers of these programs, our members desire support from our leadership and payors to collaborate in supporting services that relevant, co-occurring, trauma informed, culturally responsive, and whole family engaging. **Youth SUD outpatient** is scattered and disconnected, and a variety of services are provided in various settings with a broad array of quality control and oversite in non-clinical settings across the state. **Prevention and early intervention** are woefully inadequate and

uncoordinated. Stigma persists within youth and child serving professions including mental health services. This impacts **quality, screening, and referral.**

These pleas have fallen into kind ears but resulted in no meaningful action. The system is so reduced that both Medicaid recipients and families who have resources including commercial insurance or other means **must often send their children and youth to programs outside of Oregon**. First this lack of access places Oregonians at risk, as we are aware, other states may or may not have strong quality controls or equivalent consumer protections and safeguards to those in Oregon. Second it is out of scope of research as the delivery of family therapy is drastically impacted. And last it is a significant parity issue regarding network adequacy. Would we accept that it is appropriate to treat a diabetic youths basic physical health services required for their diagnosis and follow up care in an out of state location over three hundred miles or more from their home and family, no.

Through lack of action, Oregon leaders have abandoned the needs of our youngest generations leaving their health issues to become exacerbated over time. As BH providers we have a front row seat to stigma and misunderstanding that children and youth are not impacted before 14 or will "grow out of it." Those who do not "grow out of it" may get appropriate and more expensive care as adults, or they may get sicker or die from the disease. It is frustrating to the field when it is researched and known that access to appropriate interventions, provided by trained BH workforce, save lives, and restores families.

Long standing research has shown that adverse childhood experiences (ACES), substance use and co-occurring mental health challenges left unaddressed in youth and families lead to **higher long term/lifelong** physical health care cost, poorer health outcomes and other avoidable tragic outcomes including suicide, overdose, multisystem involvement and compromised social determinates including housing and employment challenges.

OCBH implores state leadership to utilize portions of the impressive resources created this 2021 session to create and staff a table that leverages the expert of system partners and providers and implement activities specifically focused on youth serving partners to modernize the system.

- Create payment practices that support a modern youth SUD, whole family-focused system.
- Create licensing, rules and oversite that support the activities of a modern equity-focused co-occurring system.
- Provide access to modern technology for client care, data, and referral.
- Create a system workflow that reduces redundancy placing the right job in the right place from oversite, payment, care coordination, through service delivery and follow up.
- provide a full continuum of health-focused services for families including prevention through treatment.

- Support training for the reduction of SUD stigma, including health care approach with educators, pediatricians, mental health providers, law enforcement, and others who engage with youth and families.

Detailed concepts and recommendations

As noted, we are in a unique time where resources, consumer need, professional research, and willing BH organizations are ready to go.

Leadership does not have to be innovative; they need to harness the assets and support the remaining system to lift and perform care that is modern and delivered with fidelity, supported, and known.

Short term

Pilot co-occurring outpatient and residential whole family youth SUD care.

Work with the few (6?) remaining youth residential programs including culturally specific services to modernize the residential and withdrawal management services and create local outpatient services for ASAM outpatient levels of care including aftercare. Include payors in this process (the remaining youth residential SUD providers are a statewide system and work with all payors.) Convene a focus group of referral partners including pediatricians, schools, school health centers, hospitals/ED, juvenile justice, and child welfare. The pilot will need to ensure facilities meet needs of appropriate level of care delivery, support continuing program development and enhancements, and ongoing funding to support maintenance and program expansion/enhancement.

Long term 1 to 5 years

Recommended guiding principles to ensure project success is a building block for further system of care improvement.

- Use lessons learned and expertise of partners from the recommended pilot project to continue ongoing improvements in continuum of care over the next five year.
- Create structures and process that ensure all listed recommendations here in are informed with health equity lens and support culturally responsive and specific programs/services.
- Support workforce education.
- Incentivize early referral to lower levels of care.

Long term 1-5 years continued

- Create efficiency and support best practice in funding and implementation modalities. Integrate, and improve coordination between current siloed youth and family (Medicaid and commercial) services from non-clinical youth sectors such as criminal justice, DHS, and school systems.

    - Oregon's funding and delivery strategies have created inefficient redundancies and under-operationalized silos.
    - This approach overextends the workforce and places systems at risk for providing well-intentioned, but poor-quality SUD healthcare by performing the wrong job in the wrong place.
    - Historic practices of youth SUD treatment groups provided without fidelity evidence based trained professionals or resources. Group therapy practice provided without its fidelity components including, robust group practice training, supervision support and family participation, can have negative outcomes for participants. This form of treatment to be effective requires the use of fidelity practices and workforce with an expert level of training particularly with youth. If done poorly or without appropriate clinical tools and supports, new research points to concerns it be unintentionally harmful to attendees. Family therapy and supports, (including cultural responsivity), one of the most proven approaches to care, in the current system is not widely offered or supported.
        - Challenges and opportunities of group therapy for adolescent substance abuse: A critical review, November 2005Addictive Behaviors 30(9):1765-74 DOI:10.1016/j.addbeh.2005.07.002
        - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-3991.pdf Source PubMed
    - Moving billable health care services into the BH care continuum allows community-based providers to leverage public and private health insurance to provide clinically billable services and saves general fund dollars. It frees partner workforce (criminal justice, schools, DHS) to focus on prevention, screening, early intervention and referral, social determinants, and core competencies.
- Scale training and resources to expand consistent prevention, parenting, and healthy life skills within pediatric practices, schools, juvenile justice, child welfare to shift the dial on population impact level outcomes.
    - https://www.samhsa.gov/brss-tacs/recovery-support-tools/youth-young-adults
- Scale youth and family peer support. Lack of peer support and youth alumni services. This important service that is youth driven is not supported in the current system structure. (This also includes commiserate, lack of parent peer support).

Long term 1-5 years continued

- Scale technology to coordinate the above-mentioned referral to Behavioral and Physical healthcare.
- Scale consumer access to childcare, afterschool programming, parenting supports and education.
- Use Incentives structures, such as metrics to encourage CCO's, to increase equitable access to modern whole family SUD and MH co-occurring care including telehealth innovations.
- Create Youth SUD centered CCO metrics and incentives to expand further recovery success (particularly culturally specific family services).
- Retool SUD and MH billing and operations and rules and certifications to ensure co-occurring clinical setting are available and incentivized to grow to scale from outpatient through secure services.
- Support providers both directly and through CCO APM structures to support comprehensive and integrated programing to meet population needs more successfully as a statewide system.
- Retool workforce related operations rules to support a diverse workforce in race, ethnicity, and training for peers through doctorial level practitioners competent in co-occurring care.
- Utilize and support ASAM levels of care for youth.
- Increasing workforce of trained family and child development clinicians and paraprofessionals.

Multisystem ecosystem factors to consider in development of SUD care and prevention system.

The youth and families OCBH members serve are frequently involved in multiple systems impacting their stressors and compounding the complexity of their service delivery. We understand large system collaboration is occurring and requires time to implement. But we hope the below items could be prioritized in this long-term process particularly within a health equity lens.

- Child Welfare funded programing is similarly dwindling and under duress (including the loss of foster homes and closure of hundreds of BRS beds.) Staff turnover over and lack of caseworker system knowledge of local resources compounds access issues.

Multisystem ecosystem factors to consider in development of SUD care and prevention system continued.

- Current Oregon drug use trends for Methamphetamines, Alcohol, Fentanyl and Opioids indicate that the impacts of drug use in child rearing/bearing age adults will likely impact local birth rate outcomes in fetal drug exposure affected children.
- With the typical onset age for high-risk youths (age 12 or younger) it is imperative and developmentally appropriate that we implement holistic family SUD treatment. We sadly can only expect more need for programing to intervene and support health and save long term costs. Comprehensive, integrated, family focused care is essential for success.